# 5 Year Maternal and Child Health Needs Assessment

2016-2020

## District of Columbia Department of Health

Community Health Administration

# District of Columbia Department of Health

I. State Overview

The District of Columbia is located in the urban center of the Washington Metropolitan Statistical Area (MSA). This geographic area is bordered by the county of Arlington and the city of Alexandria in Virginia; Prince George's and Montgomery counties in Maryland, and the Potomac River.

The District is divided into eight principal wards which are subdivisions founded for the purposes of voting and political representation. The political divisions of the wards allow for the comparison of subpopulations and the analysis of data that can offer insight about the health status of the District's residents.

The Northwest quadrant of the District includes Wards 1 and 4, both of which are home to a substantial number of Hispanic residents. In contrast, the Northeast quadrant's Wards 5 and 6 residents are predominately middle-class African Americans. While 96% of the residents in Wards 7 and 8 are also African American, the residents of the Southeast quadrant have higher poverty rates, earn lower incomes, and experience higher rates of unemployment than their counterparts in the District's other five wards.

The highest count for the Black population in the District occurred in 1970, when the Black population was 537,712, (71.1% of the total population). After 1970, the Black population has steadily declined. In 2010, U.S. Census Bureau data reported the Black population in the District totaled 305,125, comprising 50.7% of the total population (601,723).

As of 2013, 92% of District residents had some type of health insurance, 8% of the population had no insurance. During this time period, 55% of individuals had private coverage while 36% of individuals had public coverage.

School enrollment data for 2012 reported that 8.1% of the school aged population was enrolled in nursery school, 4.9% in kindergarten, 25.1% in elementary school, 16.8% in high school, and 45.1% were enrolled in college or graduate school. With regard to educational attainment for 2012, 18.4% of residents were categorized as high school graduates, 14.0% had completed some college, 3.2% had earned an Associate's degree, 23% had earned a Bachelor's degree, and 30% had earned a graduate or professional degree.

A review of economic well-being indicators show, the annual unemployment rate for DC almost doubled between the years 2007 and 2011. In 2007, the unemployment rate was 5.5%. By 2011, this rate had increased to 10.2%. Annual household incomes also increased during this period. The median annual income for 2000 was $44,200, up to $49,600 for the years 2006 to 2010. In 2012, 18% of District residents were living below the federal poverty level.

**Table 1: 2010 D.C. Demographics by Ward**

| Ward | Total Population 2010[1] | Average Family Income 2006-2010 | % Population by Race and Ethnicity 2010 | | | | Household Total | Percent Children[2] |
|---|---|---|---|---|---|---|---|---|
| | | | Black | White | Hispanic | Asian/PI | | |
| **1** | 76,197 | $ 89,921 | 33 | 36 | 22 | 5 | 31,309 | 12 |
| **2** | 79,915 | $116,794 | 13 | 67 | 9.5 | 10 | 34,811 | 5.8 |
| **3** | 77,152 | $150,629 | 5.6 | 78 | 7.5 | 8.2 | 36,040 | 13 |
| **4** | 75,773 | $97,355 | 59 | 20 | 19 | 2 | 29,029 | 20 |
| **5** | 74,308 | $ 62420 | 77 | 15 | 6.3 | 1.7 | 29.340 | 17 |
| **6** | 76,598 | $103,014 | 42 | 47 | 4.8 | 5 | 34,449 | 13 |
| **7** | 71,068 | $ 48,305 | 96 | 1.4 | 2.3 | .2 | 29,838 | 25 |
| **8** | 70.712 | $ 44.550 | 94 | 3.3 | 1.8 | .5 | 25.827 | 30 |
| **DC** | **601,723** | **$92,959** | **51** | **38** | **9** | **4** | | |

**Table 2: 2010 D.C. Socio-Economic Indicators by Ward**

| Ward | % Population 16+ Employed | % Population Unemployed | % Population Without HS Diploma 2005-2009 | % Population in Poverty | % Children in Poverty | # of people Receiving Food Stamps | # of People Receiving TANF |
|---|---|---|---|---|---|---|---|
| **1** | 71.4 | 5 | 19 | 13 | 23 | 9.807 | 3.174 |
| **2** | 65.4 | 3 | 8.1 | 4.5 | 18 | 3.617 | 917 |
| **3** | 66.3 | 3 | 3.4 | 2.1 | 3.1 | 412 | 47 |
| **4** | 60.3 | 6 | 17 | 7.0 | 12 | 12.644 | 3.965 |
| **5** | 54 | 9 | 19 | 15 | 29 | 18.074 | 6.256 |
| **6** | 64.4 | 6 | 12 | 15 | 31 | 14.798 | 4.186 |
| **7** | 50 | 12 | 20 | 23.2 | 40 | 27.462 | 11.528 |
| **8** | 43.4 | 11 | 21 | 32.0 | 48 | 35.423 | 16.386 |
| **DC** | **58.0** | **8.2** | **7.9** | **14.1** | **22.5** | **86.814** | **30.073** |

## II. Five Year Needs Assessment

The District of Columbia Department of Health's (DC DOH) Community Health Administration (CHA) conducted the DC Title V Needs Assessment in the summer of 2014. The purpose of the needs assessment was to 1) identify and better understand the current health status and community needs within the District's maternal and child health (MCH) populations, 2) conduct a series of focus groups as well as key

[1] US Census Bureau 2010 American Community Survey

[2] US Census 2010 American Community Survey (Note: "Children" is defined as including all persons less than 18 years of age).

informant interviews of both internal and external stakeholders in maternal and child health populations and 3) utilize the findings and the national Title V priorities to best determine allocation of resources.

Key Findings point to challenges ranging from DOH infrastructure to effectively addressing social determinants of health. CHA staff and providers suggest that better care coordination and resource allocation could be achieved through data sharing tools. Adolescents site lack of education, abusive homes and unstable housing as reasons for their peers becoming pregnant and engaging in high risk behaviors. Parents feel strongly about the lack of services (e.g., medical, dental, transportation) available to them in their neighborhoods. Specifically cited were the lack of child care programs, appropriate care and activities for children with special needs, underemployment and food insecurity.

While participants agreed that these complex issues can be addressed with proper planning, it will take the commitment of District leaders, a concerted effort of multi-sector public and private entities, and effective community engagement to address the socio-economic, cultural and environmental factors affecting women, infants, children and adolescents in the District to improve long term health outcomes.

**A. Methodology/Process:**

Quantitative and qualitative methods were utilized to assess capacity, availability and quality of delivery of services provided to women, infants, children and youth, including children and youth with special health care needs, in the District of Columbia. An extensive literature review was compiled to inform constituents and analyze the current health indicators. All questions were vetted by the Community Health Administration prior to dissemination. Methods included distribution of electronic surveys (English), focus groups (both English and Spanish), and key informant interviews. Previous community health and Title V needs assessments were also reviewed to assist in identifying top priorities to inform key strategies and approaches to conducting the current needs assessment (See Section V Supporting Documents).

For the data driven indicators included in this report, data was obtained from local and national data sets from 2009-2014. Efforts to use the most recent data were made and where applicable comparisons were drawn to indicate trends in specific population measures.

*Survey Distribution:* ***The survey was adapted from the Parent's Place survey used in the Maryland Title V Needs Assessment in 2010. Surveys were disseminated via the online Survey Monkey tool to collect information and assess perceptions regarding services provided to women, infants, children, youth and children with special health care needs in DC. The parental survey was distributed to parents and guardians while another survey was distributed to other community stakeholders, including medical providers (ambulatory and hospital centers), government agencies, and non-profit organizations throughout the District of Columbia. Surveys were available online from 4/25/2014 to 6/30/2014. A total of 136 persons completed the survey (See Section V Supporting documents).***

**Focus Groups and Key Informant Interviews**: Over the course of 4 months, April through July 2014, the Community Health Administration conducted 33 key informant interviews and a total of eight focus groups for 30 providers, 29 youth and adolescents, and 23 parents. Providers consisted of pediatricians, family medicine physicians, social workers, nurses and other health practitioners. Youth ranged in age from 13-24 and parents/guardians ranged in age from 16-74. Race and ethnicity of participants were not captured in the focus groups. Each focus group took 60-90 minutes. A flip chart and tape recorder were used during the focus group. Participants completed a demographic sign in sheet and were assured confidentiality and anonymity throughout the focus group. For consumer groups, all participants were provided a metro card and food.

In April 2014, utilizing a convenience sample and an outside contractor, CHA held internal confidential key informant interviews with 19 staff members with varied roles in the organization. Internal informants were asked 14 questions including probes, while external informants were asked 9 questions including probes. Stakeholders and community based organizations recommended by CHA were invited via email and phone to participate in key informant interviews in April and completed in May 2014. Fourteen key informant interviews were conducted over the phone.

**Providers:** The Community Health Administration supplied a list of providers to participate in the focus groups. Providers' occupations ranged from program coordinators and managers in community based organizations to health care providers in outpatient health centers and hospitals. The Needs Assessment coordinator (Tamara A. Henry, Ph.D.) phoned and emailed over 80 providers in the

Washington DC area from April 10th to May 27th. Initial challenges in scheduling were overcome by conducting focus groups at worksite locations. A total of 30 participants provided information for the provider focus groups.

**Adolescents:** A number of organizations who work with teens, including several community based organizations and high schools, were contacted via telephone and email. Competing factors, including prom and graduation, contributed to low response rates. Working with the Healthy Mothers/Healthy Babies coordinator within CHA allowed the coordinator to conduct a focus group with this population of pregnant mothers. Partners at DC Public Schools worked with the New Heights program coordinator to secure teen moms for the focus group, and Sasha Bruce, Inc., in response to a flyer, also scheduled a focus group. A total of 29 participants were recruited for the adolescent focus groups.

**Parents/Guardians:** A list of parents and organizations who work with parents were provided by CHA, however recruitment was difficult. Twenty-two organizations who work with parents in the Washington DC area were contacted by phone and email (electronic flyers) from April 10th to June 13th, but few responses were received. After an exhaustive search and with the help of providers at Children's National Medical Center and Unity Health Care, the coordinator was able to partner with the grandparent/guardian fair at THEARC as well as the "We Can" Spanish speaking parental group through Unity Health Care. Dr. Henry conducted the focus group at THEARC and a local El Salvadorian Spanish speaking teacher, familiar with the community and trained in conducting focus groups, held the session at Unity Health Care. A total of 23 participants ages 18-74 provided information for the parent focus groups.

*Stakeholder Engagement:* ***The Community Health Administration compiled a list of stakeholders (including current grantees, non-profit organizations, community health centers, hospitals, academic institutions, and government agencies) to survey about District MCH priorities. The coordinator submitted an executive summary of the Needs Assessment to 95 stakeholders via email. Stakeholders were asked to rank the priority of needs for maternal and child health. A total of 90 responses were received over a two week period in September 2014. Of respondents, 86.3% indicated they were a service providing community based organization, and 58.4% of respondents identified themselves as a healthcare provider. Twenty-eight percent of respondents were District parents.***

**Data Sources and Gaps:** Data sources included a comprehensive literature review of materials from the National Children's Health Survey, National Survey of Children with Special Health Care Needs, Behavior Risk Factor Surveillance System (BFRSS), Youth Risk Behavior Survey (YRBS), The Food Research and Access Center 2012 Food Hardship In America, Center for Disease Control (CDC), National Women's Law Center, Healthy People 2020, U.S. Census data, DC WIC data, DC Immunization Registry, Medicaid Annual EPSDT Report, DOH Community Health Needs Assessment, DOH Center for Policy, Planning and Evaluation Infant Mortality Report) of women, infant and children health indicators in the District and comparable areas. The 2010 Title V Needs Assessments from Massachusetts, Kentucky, the District of Columbia and Virginia were reviewed. Quantitative and qualitative assessments took place in the form of online survey, focus groups and key informant interviews, as described above. Analysis of all data sources identified gaps in data regarding oral health. The District is also lacking a centralized system that can provide real time surveillance data about District maternal and child health metrics.

**Conclusion:** The focus groups provided an opportunity for staff, parents, health professionals and community based organizations to provide their perspective about the District of Columbia maternal and child health populations' strengths and needs. While the focus groups contained a limited number of participants, they offered fresh insights into some of the challenges and barriers faced with providing and receiving optimal health services for women and children in DC. The Community Health Administration values stakeholder input and used recommendations to inform the block grant process and other maternal and child health initiatives. The following is a list of the identified priorities by stakeholders for the District: 1) Mental Health; 2) Teen Pregnancy; 3) HIV/STIs; 4) Obesity/Overweight; 5) Injury and

Violence; 6) Diagnoses and Transitional Services for CYSHCN; 7) Intimate partner violence; 8) Health Literacy; 9) Access to Medical Homes and Coordinated Systems of Care (CYSHCN); and 10) Oral Health. These priorities were incorporated into overall priorities for DC Title V for 2015-2020.

**Findings: Summary of Maternal and Child Health Population Needs**

**Introduction:** This section provides an overview of key health status indicators for the District's maternal and child population organized by the following six population health domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; 5) Children with Special Health Care Needs; and 6) Cross-cutting or Life Course.

**Women/ Maternal Health:** Women comprise 52.8% of the District's population. Broken down by race, 55% of women in the District are African American, 32% are white and 8% are Hispanic. In 2010, 51.4% of deaths in DC were among females. Heart disease and cancer are the two leading causes of death among residents (regardless of sex and race) accounting for half of deaths in the District in the last five years. While average life expectancy in DC has climbed to a historic high of 77.5 years in 2010, a 10-year gain from the life expectancy in the early 1990's, disparities persist between gender, race, and ward of residence. Hispanic females are expected to live the longest in the District (88.9 years), while Non-Hispanic black females have a life expectancy of 76.2 years. Residents in Ward 8 are expected to live 69.8 years, versus 85.1 years in Ward 3.

Through support of staff in CHA Primary Care Bureau (PCB), DC Title V has expanded the capacity for the District to address the health needs of women in child bearing years. Specific initiatives include expansion of primary care, behavioral health and dental services in Wards 5 and 8; group model visits for chronic disease management; care coordination for residents in narcotic treatment services; and support to implement Centering pregnancy at local FQHCs. PCB is also working with the State Health Coordinating Committee to update the state's primary care needs assessment to better inform efforts to improve primary care access, utilization and quality.

**Preventive Care Utilization:** Data from the 2011 DC BRFSS revealed that overall 79.3% of females had a routine checkup within the past year. Among 18-34 year olds that rate decreases to 69.9%. Data for 2012 also indicated that more than three-quarters of women (81.2%) aged 18 and older reported that they received a pap test within the previous three years. Such findings indicate that District women are engaging in some preventive care services, however rates of women accessing prenatal care are lower. Between 2009 and 2012 the percent of infants born to mothers receiving prenatal care beginning in the first trimester decreased from 74.7% to 65.3%; and the percent of women who initiated prenatal care in the third trimester or had no entry to prenatal care increased from 5.8% to 8.2 %.

**Chronic Disease Burden:** From 2011 to 2013, 53.5% of District of Columbia women who gave birth to a live infant had healthy weight prior to pregnancy, 43.7% were either overweight or obese before their pregnancy, and 4.6% were underweight. Black and Hispanic mothers in DC were more likely to be overweight or obese (55.9% and 52.4%, respectively) than non-Hispanic white mothers (19.5%). Data for 2012 revealed that 3.5% of pregnant women were smoking in the third trimester of pregnancy, and overall 13.6% of women in DC are current smokers. Higher rates of tobacco use are seen among African-Americans (21.5% are current smokers). Women represent about half (52.6%) of the District's diabetic population.

**Substance Abuse:** Data for 2012 indicated that 30.6% of women of childbearing age (18 to 44 years old) disclosed that they engaged in binge drinking activity. This value is almost double the national percentage (17.4 %). As of 2006, binge drinking was defined as the consumption of at least four drinks on at least one occasion during the past thirty days.

**Perinatal and Infant Health:** Infant health indicators often serve as a gauge for the overall health of a community. In the previous five years the District of Columbia has prioritized reducing infant mortality and improving other perinatal outcomes, such as pre-term births, low and very low birth weight births and early maternal entry to prenatal care. DC perinatal health initiatives have focused on three major foci of effort: (1) increasing capacity of home visitation for pregnant women; (2) enhancing collaboration within DOH and between other agencies; and (3) increasing coordination between the government and community organizations. Title V has supported these efforts through funding DOH staff who support development of District home visitation programs; provide safe sleep and FASD training to providers and residents; and oversee newborn metabolic screening. DC Title V also facilitates collaboration with other locally

and federally funded programs that support improving perinatal and infant health outcomes, including MIECHV, Healthy Start, WIC, Help Me Grow, Baby Friendly Hospital Initiative, initiatives to increase availability of lactation support services, and Strong Start DC Early Intervention Program. Title V has also funded Children's National Medical Center to support developmental screening for infants of teen parents.

**Infant Mortality:** Infant mortality rates (IMR) in the District have been on a stable downward trend from 2007 through 2013, when the DC IMR reached a historic low of 6.8 infant death per 1,000 live births. Although the overall infant mortality rate declined by 31.3% between the years of 2009-2013, significant disparities between racial and ethnic groups persist. African-American infants are twice as likely to expire before their first birthday as compared to white infants. The District's IMR also remains higher than the national rate. Finally, in comparison, between 2009 and 2012, the neonatal mortality rate (number of neonates dying before reaching 28 days of age per 1,000 live births) increased by 6.1% in 2009 to 6.5% in 2012 . In contrast, the post neonatal mortality rate (number of infant deaths >28 days and <364 days, per 1,000 live births), decreased 61.1 % with 3.6% in 2009 and 1.4% in 2012. It is important to note, that due to the low number of infant deaths (less than 100) in the District, year to year changes should be interpreted with caution.

**Table 4: District of Columbia Infant Mortality Rate Five-Year Comparison 2008-2013**

| Year | Births | Infant Deaths | Infant Mortality Rate (per 1,000 live births) | Black Infant Mortality Rate | White Infant Mortality Rate |
|---|---|---|---|---|---|
| 2009 | 9008 | 75 | 9.9 | 15.2 | 17.2 |
| 2010 | 9156 | 73 | 8.0 | 10.5 | 5.3 |
| 2011 | 9289 | 69 | 7.4 | 11.7 | 1.8 |
| 2012 | 9370 | 74 | 7.9 | 12.3 | 3.3 |
| 2013 | 9264 | 63 | 6.8 | 9.9 | 1.7 |

Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

**Premature Births:** Premature births (births to infants less than 37 weeks old) can lead to significant morbidity and mortality. Premature births in the District increased from 9.9% in 2012 to 10.6% in 2013. Preterm births have increased across all racial groups in 2013, with the highest climb of 11.6 % among Asian Pacific Islander mothers. Approximately 12.8% of non-Hispanic black mothers delivered preterm babies compared to 7.5% non-Hispanic white mothers and 8.9% Hispanic mothers. Almost 60% of preterm infants died to mothers ages 15-34.

**Newborn Screening:** The District continues to do well in regards to newborn screenings. Between 2009 and 2012, all infants born in District hospitals received timely follow-up to definitive diagnosis and clinical management for conditions mandated by the Districts newborn metabolic and hearing screening programs. During that period newborn hearing screening increased from 67.6% to 92.7%.

**Breastfeeding:** The 2014 Breastfeeding Report Card reports 77.6% of infants in the District of Columbia initially breastfed. Breastfeeding rates drop dramatically by six months (53%) and twelve months (30%). Only 17% of women in the District are exclusively breastfeeding at six months. In DC, the breastfeeding initiation rates can be as low as 28% at WIC clinics in predominantly African American areas of the city.

**Developmental Delays:** In DC, a significant percentage of infants and toddlers live in low-income families, a known risk for developmental delays (26% live less than 100% FPL and 16% live 100-200% of FPL). The percentage of children (aged 4 months to 5 years old) at risk for developmental or behavioral problems decreased from 30.1% in 2007, to 29.4% in 2012, still higher than the national percentage of 26.2 %. About 21% children under 6 years receive developmental screening.

**Child Health:** A strong foundation for health in the first few years of life, and reinforcements through the school aged years, is critical to ensure the overall health and success of the District's population**.** Title V dollars fund a variety of efforts to support child health including: oversight of school nursing to help increase immunization compliance and provide care coordination between schools and primary providers District public and public charter schools; Primary Care and Mental Health Integration Project to improve primary care and behavioral health integration and linkages in pediatric medical homes; staff support of efforts to decrease childhood obesity, including technical assistance to implement physical activity guidelines in school; and participation in state planning efforts including the

State Early Childhood Development and Coordinating Council and the Early Learning Quality Improvement Network. Although improvements are being made regarding childhood obesity, certain areas of prevention, such as increasing physical activity and healthy food access, should be prioritized in the District.

**Routine Health Services:** In 2011-2012 89.8% of District children received a preventive medical visit in the past year, exceeding the national average of 84.4%. Additionally, during 2011-2012, the 50.3% of children received care within a medical home, lower than the national average of 54.4%. Between 2009-2012 the percent of 19 to 35 month olds who received the full schedule of age appropriate Advisory Committee on Immunization Practices recommended immunizations increased from 75% to 81%. Despite gains in child health indicators, the percentage of children in the District who were reported to be in either "very good" or "excellent" health decreased between 2007 and 2012.

**Obesity:** Childhood obesity continues to be a health concern for children in the District. According to the 2012 National Survey of Children's Health, the percentage of children considered overweight or obese in the District was 35% compared to 31.3 % nationally. While the DC Healthy Schools Act mandates physical activity for students K-8 in accordance with national guidelines, many schools are failing to meet those requirements. The 2013 YRBS reported the percentage of children ages 6-17 who participate in four or more days of vigorous physical activity per week is 54.7 % compared to the national rate of 64.3 %.

**Children with Special Health Care Needs (CSHCN):** It is critical that all children have access to high quality, coordinated systems of care in order to achieve and maintain good health. Children with special health care needs often face barriers in accessing needed health and social services. DC Title V has funded several programs to support our CSHCN population: Children's National Medical Center - Parent Navigator Program helps to empower families with CSHCN to better access and coordinate care, as well advocate and share in medical decision making; The National Alliance to Advance Adolescent Health works to expand evidence-based transition services with a focus on youth with the "priority condition" of mental retardation/intellectual disabilities; Georgetown University program aims to improve access to quality, comprehensive, coordinated community-based systems of services for CSHCN; Georgetown Center for Child and Human Development provide trainings for providers to improve CSHCN services; Howard University

provides care coordination and transition services for children with sickle cell disease; Advocates for Justice connects families and children with peer and community support resources. Additionally, Title V has supported efforts to fill gaps in mental health and asthma services including: asthma home visitation through Breathe DC; asthma care coordination and education by Children's Research Institute and Mary's Center; mental health services for children and families through Wendt Center, La Clinica del Pueblo and Community Connections.

**Care Coordination:** Between 2009 and 2014, the percent of CSHCN whose family's report partnering in decision making and satisfied with the services they receive, increased from 51.1% to 67.3%. This population aged 0-18 years who receive coordinated, ongoing, comprehensive care with a medical home decreased from 37% in 2009 to 34.2% in 2014. The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence increased from 24% in 2009 to 34% in 2014, but not achieving its target of 36.7%.

**Asthma:** Approximately 43% of CSHCN were diagnosed with asthma. For 2009-2010, asthma cases were highest among children ages 6 to 11 years, comprising 49.4% of all cases in children 17 years or younger. Asthma prevalence is almost equal along gender lines with males representing 43.4 % of cases and females representing 43.5 % of asthma cases. Children under 5 years accounted for the largest percentage (20%) of emergency visits due to asthma from 2008 to 2010.

**Anxiety and Depression:** In the District, anxiety and depression is most common in the adolescent population. Survey data estimated that 12.3% of children had an anxiety disorder. The largest percentage of children with this condition was in the 12 to 17 year old age range (16.2 %), with a slightly higher prevalence among females (14.9%) compared with males (10.4%). An estimated 1,365 of children with special health needs were diagnosed with depression, with the highest percentage of cases among children between the ages of 12 to 17 years. Overall, 8.7 % of these children are female and 7.1% are male. According to the 2013 YRBS, 25.5% of youth in grades 9-12 felt sad or hopeless almost every day for 2 or more weeks in a row.

**Adolescent Health**: Adolescence is a critical period of life for all individuals. Behavioral habits established during this developmental period influence health outcomes later in life, such as developing chronic disease. It is critical that adolescents are able to adopt healthy lifestyle habits in order to positively impact

their long-term health and wellbeing. Title V funds support oversight of school based health centers providing primary medical, oral and behavioral health services in six District high schools. DOH staff funded by Title V provide Health and Sexuality Education in public and public charter schools for grades K-12 and teacher/staff trainings. Title V also collaborates with The CDC funded Rape Prevention and Education Program (RPE) to provide sexual assault prevention sessions to elementary, middle, and high school students in Wards 7 and 8. DC Title V also provides oversight of community based teen pregnancy prevention programs.

**Reproductive Health:** Sexually transmitted infections (STIs) disproportionally affect District adolescents. A review of STI data indicated that the reports of chlamydia and gonorrhea infection increased 11% and 6% respectively between 2006 and 2010. With regard to chlamydia cases, 65.4% were among women, 64% were among Black individuals, and 69.6 % occurred among individual's ages 15 to 24 years old. For gonorrhea infections, 47.9% were among women, 51.9% were among men, and 61% of gonorrhea cases occurred among individuals who were between 15 to 24 years old. Higher prevalence of STIs are reported by residents in Wards 7 and 8. The 2012 teen birth rate for the District was 38.6 births per 1,000 teen girls. This rate represented a decline of 65% since 1991. Between 2009 and 2012, the rate of teen pregnancy declined by 34.2 %. The incidence of repeat teen births among girls less than 19 years of age in 2009 was 12.3% and increased to 18.6 % in 2012. Sexual intercourse and contraceptive use play an integral role in the reproductive health of adolescents. Data obtained from the 2013 YRBSS Report indicate that out of all District youth in grades $9^{th}$-$12^{th,}$ 14.9% had sexual intercourse before the age of 13, 21.7% had sexual intercourse with four or more persons during their lifetime and 36.6% are currently sexually active. In addition, 29.9% did not wear a condom during their last sexual intercourse and 92% did not use birth control pills.

**Obesity:** Weight control impacts at least one third of District area high school students, with 14.8% of YRBS respondents reporting obesity and 17.5 % reported being overweight. According to the 2013 YRBS, one-quarter (24.6 %) of students describe themselves as slightly or very overweight. The 2013 YRBS also indicates that the majority of District high school students do not engage in recommended physical activity. A total of 83.6 % of DC high school were not physically active at least 60 minutes per day on all 7 days and 40.1 % report watching television 3 or more hours per day. The majority of students report not eating breakfast every day (75.5%) and drinking soda (78.9%) at least one day out of a week. The Food Research and Action

Center 2012 Food Hardship In America reported that 15% of District households experienced food hardship (inability to afford enough food).

**Unintentional Injuries and Violence:** Many youth in DC have been engaged in activities that contribute to unintentional injury, and most youth have been affected by violence. According to the 2009 DC YRBS, 53% of middle school and 61.5% of high school students report that they or someone close to them has been wounded by a weapon or physically attacked. Results from the 2013 YRBS show 25.5% of high school and 19.5% of middle school students rode with a driver who had been drinking alcohol. In addition, 15% of high school students and 10.1% of middle school students never or rarely wore a seat belt when riding in the car with someone else. The high rates of violence among District adolescents remain a public health concern. In 2013, 7.9% of high school and 11.6 % of middle school students were electronically bullied, and 10.9% of high school and 29.9% of middle school students were bullied on school property. Other types of physical violence are also prevalent among youth in DC. More than one-third of high school students (37.6%) were in a physical fight, 12% experience physical dating violence and 9.3% report sexual dating violence. Twenty percent if high school students have reported carrying a weapon.

**Substance Abuse:** The majority of high school students in DC have used alcohol, tobacco or other drugs. The District of Columbia 2012 Youth Risk Behavior Survey indicates that the use of marijuana was reported more often than tobacco use. In 2012, 86% of high school students denied ever smoking cigarettes, while marijuana use was reported by 32% of students. In 2013, rates of alcohol use among 9$^{th}$ through 12$^{th}$ graders were highest, with 58% of students reporting use of alcohol at least once in their life, 22% of those experimenting before the age of 13. A more startling finding showed that 12.3% of high school aged students engaged in binge drinking (five or more drinks of alcohol in a row within the time period of a couple of hours). Use of synthetic marijuana increases as District youth age, with 6% of 6$^{th}$ graders reporting use in 2012, versus 21% of 12$^{th}$ graders.

**Cross Cutting or Life Course:** To ensure optimal health for the District's maternal child population, health issues that have longitudinal impacts on an individual's health must be addressed. CHA's Oral Health Program is supported through Title V. Current efforts to improve oral health in DC include increasing public and provider awareness to increase preventive services, oversight of school based preventive dentistry, and improving the District's capacity to monitor the population's oral health status.

**Access to Care:** Historically, the District has high rates of insured residents, with more than 93% of residents covered by a health plan. However, the 2014 Community Health Needs Assessment (CHNA) reports while the District has the one of the highest per capita number of health providers, a large percentage of residents live in Health Professional Shortage Areas. More than 80% of women received a preventive care visit in the last year. Additionally, 50% of the Districts children have a medical home according to data obtained by the 2011 National Survey of Children's Health.

**Oral Health:** During Fiscal Year 2014, 63% of Medicaid-enrolled children ages 3-9 years received preventive dental care. Utilization was 53% among Medicaid children 10-18 years of age, however only 19% of children under 3 years utilized preventive dental services.

**b. Title V Program Capacity**

**i. Organizational Structure**

(a) The District of Columbia is governed by the Mayor, who has the sole authority and responsibility for the daily administration of the District government. Currently, the District of Columbia's structure includes four Deputy Mayors, representing various public sectors. The Deputy Mayor for Health and Human Services serves as a liaison between the Executive Office of the Mayor and health and human service cluster, which includes the Department of Health (DOH). There are five administrations in DOH, including the Community Health Administration (CHA). CHA is responsible for administering the District of Columbia Title V grant program.

(b) Within CHA, the Supervisory Medical Officer (also known as Deputy Director for Programs) serves as the state Title V Director, overseeing the programmatic activities for Title V. The Office of Grants Management and Program Monitoring (OGMPM) provides grant support through program evaluation and fiscal monitoring. The Administrative Officer has general oversight of Title V finances, contracts and grant awards. The Title V Evaluator has responsibility for coordinating grant program evaluation. CHA is comprised of five bureaus (see Agency Capacity). Various program staff within the bureaus serve as Grant Monitors, with primary responsibilities for assuring that sub recipient program reports are submitted on time,

(c) conducting site visits, processing invoices, and ensuring that program goals and objectives are fulfilled. There are currently 16 grants funded by Title V: See Section V Supporting Documents for a list of grants funded under Title V.
(d) Please see Section V Supporting Documents for the organizational chart

**ii. Agency Capacity**

DOH's capacity to promote and protect the health of the District's maternal and child population is evidenced in its policies, programs, grants and collaborations with government, health systems and community based organizations. The mission of the Community Health Administration (CHA) is to improve health outcomes for all District residents, with particular focus to addressing health disparities. CHA's mission is implemented by promoting coordination within the health care system, enhancing access to preventive health and social services, and fostering public participation in the design and implementation of programs. The Administration is comprised of five bureaus: Nutrition and Physical Fitness Bureau (NPFB), Perinatal and Infant Health Bureau, (PIHB), Child Adolescent and School Health Bureau (CASH), Bureau of Cancer and Chronic Disease (BCCD) and the Primary Care Bureau (PCB). Each bureau addresses at least one of the six population health domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; 5) CYSHCN; and 6) Cross cutting/Life Course.

**Nutrition and Physical Fitness Bureau** administers the state's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Supplemental Nutrition Assistance Program-Education (SNAP-Ed). NFPB's primary focus is to increase access to healthy, locally sourced foods and nutrition education, and promote physical activity, among low income residents, with special focus on mothers, infants and children. NFPB works closely with local WIC agencies and the DC Breastfeeding Coalition to promote initiation and continued breastfeeding for infants. SNAP-Ed partners with University of District of Columbia, local education agencies, community based organizations and DC Office on Aging to provide both grants and direct services for educational programs around principles of healthy eating and benefits of physical activity. Additionally, through both local and federal funds, the Bureau administers grants to local small businesses, federally qualified health centers (FQHCs) and community based organizations (CBOs) to support

access to healthy, fresh foods (Farmers Market Nutrition Program, Healthy Corners Initiative, Fruit and Veggie Rx Program, Produce Plus Program, Home Delivered Meals Program and Freggie Bucks Program).

**Perinatal and Infant Health Bureau** aims to improve outcomes for women of child bearing age, including pregnant and parenting women, and their infants into early childhood. The overarching goal is to reduce infant mortality and perinatal health disparities in the District. Through partnerships with health systems (FQHCs, local birthing hospitals), district agencies (Department of Employment Services, DC Public Schools, Department of Human Services, Department of Behavioral Health, DC Housing Authority, Department of Health Care Finance Perinatal Collaborative, Department of Corrections) and CBOs (March of Dimes, DC Action for Children, Healthy Babies Project, East River Family Strengthening Collaborative, Edgewood/ Brookland Family Support Collaborative), the DC Healthy Start (DCHS) Program provides case management and health education to pregnant and parenting women and fathers throughout the District, with an emphasis in areas at greatest risk for poor health outcomes (Wards 5, 7 and 8). DCHS aims to achieve optimal health for all reproductive aged women, promote high quality health care and coordination of care, and increase accountability through rigorous program evaluation and monitoring. In 2014, DCHS was awarded a new five year Healthy Start 3.0 grant. As a level 3 grantee DCHS is shifting emphasis to upstream approaches (improving health for all reproductive age women) and use of collective impact models to decrease inequities in maternal health and birth outcomes. PIHB is also home to the Newborn Metabolic Screening Program (care coordination for newborns with abnormal screens), DC Hears (oversight of state's newborn hearing screening programs), Safe Sleep and Fetal Alcohol Spectrum Disorder Programs (education for residents and MCH service providers). PIHB staff are active members in the Child Fatality Review and Infant Mortality Review Committees housed at the Office of the Chief Medical Examiner (OCME). DCHS also participates with the Healthy Start and National Institute for Children's Health Quality CoIINs.

**Child, Adolescent and School Health Bureau** aims to improve and promote optimal health and quality of life for all District pre-school and school-age children and adolescents, including children and youth with special healthcare needs. Through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, CASH supports parents of children from birth to five years of age develop the skills they

need to raise children who are physically, socially and emotionally healthy and ready to learn.

CASH works with CBOs (Wendt Center, National Alliance to Advance Adolescent Health/NAAAH), and academic institution (Georgetown University) and the local pediatric health system (Children's National Health System/CNMC) to support programs that enhance health outcomes for children and youth with special health care needs. CYSHCN programs address mental health, developmental screenings, patient navigation/care coordination and care transitioning within this population.

CASH school health programs (School Nursing Program and School Based Health Centers) are run in partnership with local health systems (CNMC, Unity Health, Medstar-Georgetown Health, Howard University Hospital) to provide primary medical, dental and behavioral health services and care coordination on site in District public and public charter schools. Additional programs to address adolescent health outcomes include teen pregnancy prevention (in partnership with Florence Crittenton Services of Greater Washington); Health and Sexuality Education (reproductive health education curriculum administered by CASH staff for youth served by public and public charter schools, Department of Youth Rehabilitation Services/DYRS, Department of Parks and Recreation/DPR); and Violence Prevention and Education Program (prevention education curriculum administered by CASH staff in conjunction with local education agencies, DYRS; parenting education with DHS clients residing in shelters).

The Immunization program in the bureau provides promotion of recommended vaccines, surveillance and assessments. The District has an immunization program funded in part by the Center for Disease Control and Prevention (CDC). The Immunization Program works with a variety of health providers through the Vaccines For Children program, and multiple stakeholders with the Immunization Task Force (school administrators, managed care organizations, health providers) and Immunization Coalition (Every Child By Two and other child health focused organizations). CASH's Oral Health Program aims to promote and improve the oral health of all District of Columbia residents through application of data-oriented insights, public and provider outreach and education, policy development, and oversight of school based dentistry. Major initiatives include: School-Based Oral Health, Perinatal Oral Health, Adult Oral Health and Oral Health Surveillance.

**Bureau Cancer and Chronic Disease** use strategies of primary, secondary and tertiary prevention; clinical quality improvement; and community engagement and partnerships to reduce the incidences of morbidity and mortality of cancer and chronic disease in the District of Columbia. BCCD staff provide oversight of Title V funded asthma programs implemented by health providers (Mary's Center, CNMC ambulatory sites) and CBO (Breathe DC). Programs provide asthma education, case management and home visiting to improve care and outcomes for high risk children with asthma in the District. BCCD also administers CDC funding to decrease childhood obesity in conjunction with local education agencies; increase Baby Friendly Hospital designations in DC in partnership with Breastfeeding Coalition; and, to improve health of reproductive age women by supporting cervical cancer screening and follow up treatment with Project WISH (Women Into Staying Healthy).

**Primary Care Bureau** identifies health professional shortage areas for primary care, dental, and mental health care services and implements workforce and infrastructure development programs to increase access to primary and specialty care services for District residents regardless of their ability to pay for services and support integrated systems of care. Local FQHCs and hospital systems are key partners in PCB initiatives. Since 2009 the Bureau has provided oversight and technical assistance for capital expansion projects, allowing construction of six new health centers (Mary's Center – Georgia Avenue, Bread for the City, Unity – Anacostia, Unity – Parkside, Community of Hope – Conway Health and Resource Center, and KidsSmiles Nonprofit Children's Dental Center), increasing access to care in areas that were previously under resourced. PCB has provided funding to FQHCs and private providers to support expansion of primary care, dental, and behavioral health services in medically underserved areas.

Through its partnership with Advocates for Justice (AJE) and Education, DC Title V provides services to families of children under age 16 with disabilities, including deaf and blind children receiving benefits under Title XVI. AJE has partnered with Columbia Lighthouse for the Blind in the past, and currently partners with the DC Deaf-Blind Project- Connections Beyond Sight and Sound, to improve systems, programming and resources for children with blindness.

CHA has developed strong partnerships with other District government entities such as the local Public School System (DCPS), the Department of Health Care Finance who oversees Medicaid for the District, the Department of Parks and Recreation

(DPR), the Child and Family Services Agency (CFSA), the Department of Behavioral Health (DBH), and the Department of Human Services. These partnerships have also been extended to local colleges and universities as well as community-based youth service agencies. The synergy that exists among these entities serves to integrate services and systems for adolescents and youth to avoid duplication of resources and to ensure that District of Columbia youth are healthy and have access to services.

### iii. MCH Workforce Development and Capacity

(a) The District of Columbia Title V staff includes 45 full time equivalent staff. Senior level management staff include Djinge Lindsay, MD, MPH, CHA Deputy Director for Programs and DC Title V and CSHCN Director; Pierre Cartier, DDS, MPH, Supervisory Dental Officer, Oral Health Program Manager; Lauren Ratner, Primary Care Bureau Chief (partial); Charlissa Quick, MSA, RN, School Health Division Chief; and Vinetta Freeman, Child and Adolescent Health Division Chief. Jacqueline Proctor, MHS, recently joined the Title V program to oversee program monitoring and evaluation. While onboarding, she is assisted by a contractor for data analysis functions. Mary Frances Kornak, MPH, assists with Title V program coordination and is the liaison for the CYSHCN Advisory Board. Kristal Dail, MPH, assists with Title V special projects. Other Title V staff are embedded throughout CHA Bureaus, and work on a variety of MCH programs. The MCH workforce has fairly strong program planning capabilities and a core cohort of staff with several years of MCH experience. However, the program is missing key analytic functions, such as a MCH Epidemiologist, and has experienced rapid turnover of senior management over the last few years. The MCH infrastructure is currently being assessed to determine how CHA can better fulfill needed programmatic functions. It is expected that realignment of staff, creation of new positions, and increased opportunities for staff development trainings will occur in the upcoming months to enhance the state's ability to serve our MCH populations.

(b) Demographic information (including race/ethnicity, language, age, ward of residence) is collected for most participants served through Title V and other CHA programs. CHA uses demographic information to inform program development and evaluation. CHA also works with Executive Offices (Mayoral offices) with special interests in ethnically diverse populations including Asian and Pacific Islanders, Latinos and Africans on programs and initiatives tailored for those communities. CHA programs strive to use culturally competent materials (event fliers, health promotion and education literature, program forms) to assure services reach various cultures within the DC. The majority of program materials are available in Spanish, and CHA is currently working to expand to other languages, such as Amharic and French.

Residents may also communicate with any District staff through the language line which provides translation services in 13 languages. CHA also employees bilingual staff in the immunization and cancer prevention programs. DC Title V sub grantees are required to utilize evidence based practices related to cultural and linguistic competence including: the development of cultural competence policies designed to support culturally and linguistically competent practices; providing appropriate language access with current, accurate and culturally/linguistically appropriate information to families, while accounting for their health literacy levels; and engaging cultural brokers where appropriate.

**II.B2.cc: Partnerships, Collaboration, and Coordination**

The District's Title V Needs Assessment findings underscore the need for improved coordination of maternal child health resources. The District invests significant financial resources to support women and children, however many initiatives are done in silo, minimizing potential impact. As cited above, CHA has established several partnerships spanning government, academia, health care, private sector and community based organizations. As part of realignment efforts, CHA is also working to achieve more cohesion within its own programs, as well as with other District entities. For example, there are several organizations in DC involved in home visitation (HV), including two CHA programs and three District agencies funding local programs. This year, in conjunction with an evaluation team from Georgetown Center for Child and Human Development, CHA is leading the effort to develop shared outcomes for all District HV programs. This will allow the District to more

meaningfully evaluate current programs, to determine effectiveness and gaps, as well as track outcomes for those families receiving HV services. Another example of enhancing coordination is DCHS and MIECHV working with FQHCs receiving CMS Strong Start funding, to extend social support services to Strong Start families into interconception/infancy.

An example of a partnership for MCH programs, is CHA leading efforts to establish Help Me Grow (centralized resource and referral center for children 0-5 years old to support universal, early surveillance and screening and link those at risk for developmental and behavioral problems to appropriate programs and services) in DC. Key partners in this effort include the state's Part B and Part C IDEA program, Medicaid, CFSA, DBH, United Planning Organization (CBO with Early Head Start programs), The Family Place (CBO), Mary's Center (FQHC), pediatricians, and Children's National Health System.

CHA also actively participates with several District wide MCH collaborative groups, including State Early Childhood Development and Coordinating Council, DC Home Visitation Council, Healthy Youth in Schools Commission, DCPS Health and Wellness Advisory Committee, Adolescent Health Working Group, Safe DC Kids Coalition, DC Breastfeeding Coalition, Child and Infant Mortality Review Committees, Committee on Metabolic Disorders, DC Pediatric Oral Health Coalition and Immunization Coalition. DOH/CHA is currently working with OCME, ACOG, AMCHP, Pregnancy and Perinatology Branch at National Institute of Child Health and Human Development, birthing centers and local obstetricians to establish a Maternal Mortality Review.

| Sub recipient | Purpose | Grant Award |
|---|---|---|
| Advocates for Justice and Education, Inc. | DCPIN will connect children and youth with special health care needs and their families to health care, education, and supportive services through a multi-component community-based, family-centered, and culturally competent parent consultant program. AJE will respond to service gaps identified for CYSHCN through a robust parent consultant program. | $ 250,000 |
| Breathe DC, Inc. | To improve health outcomes for high risk children with asthma in the District of Columbia by implementing the Breathe EASY – Asthma Home Visiting Project, an evidenced-based approach of conducting home visitations to identify specific asthma triggers and educate families about methods to manage asthma. | $ 190,000 |

| Sub recipient | Purpose | Grant Award |
|---|---|---|
| Children National Medical Center - Program Area A | To improve access to mental health services for teen parents and access to developmental screenings for their children | $270,224 |
| Children National Medical Center - Program Area B | To provide support for further expansion of Children's National Medical Center's (CNMC) Parent Navigator Program for Children and Youth with Special Health Care Needs (CYSHCN) | $277,998 |
| Children National Medical Center - Program Area C | This agreement seeks to improve the mental health of children in the District of Columbia by: 1. Increasing the accessibility to mental health care for children.; 2. Promote the integration of mental health care into primary care; 3.Ensure that children are appropriately link to proper mental health clinicians and services; and 4. Examine the utilization rate of mental health of complex and high-risk children. | $299,101 |
| Children Research Institute - Asthma | To improve care and outcomes for high risk children with asthma in the | $249,891 |

| Sub recipient | Purpose | Grant Award |
|---|---|---|
| | District through a collaboration of three entities that together provide expertise in asthma care and education, community-based pediatric primary care, QI, and professional education: IMPACT DC, the Children's Health Center (CHC) at THEARC, and DC PICHQ (DC Partnership to Improve Children's Healthcare Quality). | |
| Community Connections | To improve services for children with serious emotional disturbance (SED) and their families. | $271,360 |
| Georgetown Center for Child and Human Development | To provide two complimentary training programs to MCH service providers for the purpose of improving services received by children with special health care needs (CSHCN) | $197,000 |
| Georgetown University | To improve access to quality, comprehensive, coordinated community-based systems of services for children with special health care needs. | $230,327 |

| Sub recipient | Purpose | Grant Award |
|---|---|---|
| Howard University - Dept. of Pediatrics | To establish a “one-stop shopping” model of comprehensive care for children with Sickle Cell Disease (SCD) that includes care coordination, navigation and continuous primary and specialty care. | $266,667 |
| Howard University | To design and implement an Adult Transition Program (ATP) for children and young adults with Sickle Cell disease to adult oriented care. | $267,664 |
| La Clinica del Pueblo | This agreement seeks to improve the health outcomes of Latino immigrant families of children and youth with special health care needs with emotional and behavioral disorders and their families. | $169,241 |
| Mary's Center | To improve care and outcomes for high risk children with asthma in the District by providing asthma education and case management, including incorporating the Medical-Legal Partnership model | $287,289 |

| Sub recipient | Purpose | Grant Award |
|---|---|---|
| | and coordinated health promotion activities. | |
| National Alliance to Advance Adolescent Health | To expand the availability of evidence-based transition services to Health Services for Children with Special Health Care Needs (HSCSN) youth with a focus on youth with the "priority condition" of mental retardation/intellectual disabilities. | $266,519 |
| University Legal Services | To implement The Way Home Research Initiative, that will analyze the systemic barriers to connecting youth to post-psychiatric hospitalization community-based mental health services. | $267,894 |
| Wendt Center for Loss and Healing | To increase the access of evidence –based mental health services for children and youth in the District of Columbia who have been victims of violence and other forms of trauma. | $284,261 |

| Partnerships/Collaboration | Women/ Maternal Health | Perinatal /Infant Health | Child Health | CYSHCN | Adolescent Health |
|---|---|---|---|---|---|
| Advocates for Justice and Education | | | X | X | X |
| American Heart Association | X | | | | |
| Breathe DC Inc. | | | X | X | X |
| Childrens' National Medical Center | X | X | X | X | X |
| Community of Hope | X | X | X | X | X |
| Community Wellness Alliance | | | X | XX | X |
| CYSHCN Advisory Board | X | | | X | |
| DC Asthma Coalition | X | X | X | X | X |
| DC Breastfeeding Coalition | X | X | | | |
| DC Campaign to Prevent Teen Pregnancy | | | | X | X |
| DC Dental Society | X | X | X | X | X |
| DC Department of the Environment | X | X | X | X | X |
| DC Hearing Advisory Committee | X | X | | | |
| DC Hunger Solutions | X | X | X | X | X |
| DC Immunization Program | X | X | X | X | X |
| DC Pediatric Oral Health Coalition | | X | X | | |
| DC Primary Care Association | X | | | | |

| | | | | | |
|---|---|---|---|---|---|
| DC Tobacco Coalition | X | | | X | X |
| Department of Housing | X | X | X | X | X |
| Fetus and Newborn Committee | X | X | | | |
| Georgetown Center for Child and Human Development | | | X | X | X |
| Howard, Georgetown, Washington Hospital Center, Providence Hospitals | X | X | X | X | X |
| Howard University Department of Pediatrics | | | X | X | X |
| La Clinica del Pueblo | X | X | X | X | X |
| March of Dimes | X | X | X | X | X |
| Mary's Center | X | X | X | X | X |
| Managed Care Organizations | X | X | X | X | X |
| Metabolic Screening Advisory Committee | | X | | | |
| National Alliance to Advance Adolescent Health | | | X | X | X |
| Office of the Medical Examiner | | X | X | X | X |
| OSSE, DC Public Schools (DCPS) | | | X | X | X |
| St. Elizabeth's Psychiatric Health | X | X | X | X | X |
| Unity Healthcare | X | X | X | X | X |
| University Legal Services | | | X | X | X |
| Wendt Center for Loss and Healing | | | X | X | X |

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