



District of Columbia Department of Health

# Five-Year Maternal and Child Health Needs Assessment Summary 2021-2025

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# Acknowledgements

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## Introduction

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As part of the federal Title V Maternal and Child Health Services Block Grant Program, states are legislatively required to report on the MCH populations by conducting a comprehensive and statewide Five-Year Needs Assessment and presenting findings through a Needs Assessment Summary.

## Five-Year Needs Assessment Process

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From February 2019 to March 2020, the DC Health Title V team utilized quantitative and qualitative methods to gather information to assess strengths and needs of the MCH population of the District of Columbia in each of the five population health domains - women, infants, children and youth, including children with special health care needs, and adolescents. The team engaged the MCH Advisory Council at the beginning to serve as an advisory board and provide input on unmet needs and positive factors affecting the district's MCH populations. The team conducted a literature review of existing, recently published health reports, an analysis of health outcome data provided by the Center for Policy, Planning and Evaluation (CPPE) at DC Health, and nationally available datasets. In keeping with needs assessment best practices from other states, we conducted a community Discovery Survey for input on important MCH topics from a public perspective. The team conducted key informant interviews with stakeholders who serve as experts in the administration, delivery of services and care for MCH populations, as well as a focus group with the Youth Advisory Council. In addition, we incorporated focus group and listening session data gathered as part of the District of Columbia's Office of the State Superintendent (OSSE)'s Preschool Development Grant: Birth to Five Needs Assessment.

## Methodology

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The methods used for gathering data included a literature review, the administration of electronic surveys (English & Spanish) to the MCH Advisory Council and the District community, key informant interviews, family listening sessions and focus groups. The Community Health Administration vetted questions for surveys, interviews and focus groups prior to distribution. The Title V team held discussions with department of health staff from other states and reviewed needs assessment best practices. Best efforts were made to use the most recent data available for reporting on health indicators. A list of topics was compiled from a review of the data collected. Topics were then prioritized based on frequency of mention and ranking by Title V staff and senior leadership. The final list of topics was selected based on needs assessment findings and agency funding priorities.

## MCH Population Health Status

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Key findings of the needs assessment suggest the following priority areas: well-woman visits, breastfeeding, reducing perinatal disparities, mental health including grief and trauma-informed care, implicit bias/discrimination, positive youth development, early childhood developmental screening, medical home identification/place-based care, and community safety including safe and affordable housing. The findings point to persistent health disparities by race/ethnicity and immigrant, and socio-economic status. In addition, they emphasize the need to address social determinants of health such as housing, education, violence and discrimination/implicit bias as these were among the top factors community members identified as the biggest unmet needs of District women, children and families, as well as things needed to live their fullest lives. Factors

identified through the Discovery Survey as positively influencing families to thrive within the District community were community support activities, access to public spaces, a safe environment, food access, social support, community-based services, public transportation and quality education. The full report on the District of Columbia's MCH Needs Assessment describes the findings, strengths and needs of each population domain and will be shared on the DC Health website, Title V page: <https://dchealth.dc.gov/page/title-v>.

### The Covid-19 Pandemic and Impact on the District of Columbia MCH Population

The 5-year Needs Assessment presents data collected before the start of the COVID-19 pandemic. District residents and families, like many across the nation have been impacted by this public health emergency. The District of Columbia Mayor implemented an early and swift response to Covid-19 with an executive order issued on February 28<sup>th</sup> directing District agencies to prepare for potential impacts of the Coronavirus. This included directing the Department of Health and Department of Homeland Security and Emergency Management to coordinate the District's response, and the activation of the Emergency Operations Center on March 2<sup>nd</sup>. DC Department of Health confirmed the District's first coronavirus case on March 7<sup>th</sup> and the Mayor declared a public health emergency on March 11<sup>th</sup> which initiated a series of city-wide public health safety measures over the next few days to help prevent spread of the virus including limiting mass gatherings to 250 or less on March 13<sup>th</sup>, shifting Spring Break for DCPS students to March 16<sup>th</sup> (and ultimately suspending in-person learning for the rest of the school year), shifting District Government operations to an agency-specific telework schedule as of March 16<sup>th</sup>, and prohibiting mass gathering of 50 or more on the same day. On March 24<sup>th</sup>, the Mayor announced the closure of non-essential businesses and prohibition of gatherings of 10 or more through April 24<sup>th</sup>, however this was ultimately extended through late June. Guidance on mask wearing and social distancing was also issued early on in the pandemic in April, when the public health emergency was extended. Free Covid-19 testing sites for residents experiencing symptoms were set up across the District. The Mayor established a Contact Trace Force to hire hundreds of additional tracers at DC Health on April 23<sup>rd</sup>. DC Department of Health, in its role as one of the primary public health responders, has developed and continued to implement timely guidance and provide resources to help mitigate the Covid-19 crisis.

As of early September 2020, the District had approximately 14,362 known cases of Coronavirus, a test positivity rate of 2.8%, and 611 lives lost. Approximately 51% of cases are among Black/African Americans and 22% among Whites with 19-30 and 31-40 as the age groups with the greatest percent of cases (22 and 20%, respectively). While the incidence of any new cases or deaths are undesirable outcomes, the District's rates of Covid-19 have been relatively stable as compared to other states. Much of this stability can be attributed to the decisive safety measures described above. Nevertheless, the Covid-19 pandemic is still present in District residents' lives, as the jurisdiction is presently in Phase 2 of re-opening, and thus schools, many businesses, etc. have not yet returned to full, pre-pandemic operational status.

The pandemic has paralleled and exacerbated existing socio-economic disparities. The preliminary rate of unemployment for May 2020 was 9% (triple the 3% rate of May 2019). Lack of, or reduction in employment can have domino effects on health outcomes. Connected to financial stability, food insecurity is relevant to all MCH populations. On average, over 2016-2018, D.C. had a 10.6% prevalence of household food insecurity, this represents a 1.8% decrease from the 2006-2008 rate of 12.4%. Despite this improvement, approximately 11% of areas in the District are food deserts, with more than three-quarters located in Ward 7 and Ward 8, areas with the lowest median incomes and highest needs. To help combat these issue during the pandemic, WIC has been deemed an essential service and grocery distribution sites have been set up in high-need areas, among other efforts to help vulnerable during the pandemic.

Several of the already pressing needs identified by the 5-year MCH Needs Assessment have the potential to be greatly exacerbated. In terms of women's health, between 2009 and 2016, the percent of infants born to mothers receiving prenatal care beginning in the first trimester decreased from 74.7% to 65.7%. Neighborhoods across Wards 7 and 8 experience lower rates of first trimester prenatal care initiation, ranging from 44.16% to 64.19%. Violence against women was echoed in key informant interviews as an important issue for District residents. Unfortunately, with Covid-19 and stay-at-home orders to help mitigate virus risk, there is also an unintended higher risk of interpersonal and domestic violence. An FQHC and Title V grantee, La Clínica del Pueblo, which serves a predominantly immigrant, low-income population, has continued working with the DC Coalition Against Domestic Violence (DCADV) on the planning activities associated with staff training on gender-based violence prevention. La Clínica's Gender and Health team is revising and updating the DCADV content to respond to the challenges that gender-based violence victims are facing as a direct consequence of the COVID-19 pandemic context.

As far as perinatal health is concerned, breastfeeding efforts including lactation on-site assessments at Howard University Hospital had to be cancelled or rescheduled. Because Children's National Medical Center (CNMC) reduced their in-person pediatric visits, there has been a decrease in breastfeeding consults. Efforts to maintain consultations are ongoing through telephonic consultation. La Clínica del Pueblo has been under a modified operating status since March 16<sup>th</sup>. Under this status, well-women, well-child, prenatal and maternal care visits are ongoing either via telehealth or through a limited number of on-site visits. These MCH visits, in addition to immunization and family planning services continue to be prioritized at the clinic, with the focus for well-child visits on infant care, due to existing perinatal health disparities among this population.

In reference to children and children with special health care needs, the immunization coverage average rate for MMR, Varicella, and DTaP was around 86% as of Fall 2019 – these rates have decreased as health and medical facilities have modified operations, and families navigate priorities during the pandemic. In June, DC Health identified about a 70% decrease in vaccine administrations from March through May 2020. This is similar to trends identified in Maryland and nationwide per the CDC. This decline in number of vaccines administered over the course of those three months has resulted in a 3-4% decrease in total immunization coverage among school children. DC Health took the following immediate actions to increase childhood immunization access and coverage including: a public messaging campaign to highlight the importance of childhood vaccinations and overall preventative care; public messaging campaign to reinforce that it is safe to see your doctor or visit a hospital; coordinating and strategizing with pediatric health centers across the District to improve access to care via opening weekend, evening, and walk-in hours, mailing out over 25,000 letters to families notifying them of which vaccines are overdue and points of access, and more. In July, the District saw a four-fold increase in vaccine ordering when compared to April (11,690 doses ordered in July compared to 2,807 in April). Vaccine ordering is an early indicator that typically corresponds to an increase in overall vaccine coverage later. Although the vaccine administrations are still overall lower when compared to 2018 and 2019, DC Health is encouraged the District is moving in the right direction and will continue efforts to increase these rates.

The initial closure of schools had a major impact on the work of Title V MCH grantees as several operate in conjunction with the School Based Health Centers (SBHC). The American Academy of Pediatrics (AAP) recommends limiting the amount of time that babies and toddlers spend in front of a screen which was impractical for some families to do even pre-pandemic.

Keeping babies and toddlers away from TVs, tablets, computers, smartphones, and gaming systems is particularly impractical now during the pandemic, when many families have been required to engage in virtual learning, or need tools to help keep children occupied while parents engage in work duties. As an example, the school year has started, but will be executed through virtual learning at least through November. Parent Navigators who assist other parents of children with special health care needs have struggled to take care of their own children while still providing care for those most vulnerable. Thus, in accordance with hospital guidance, navigators of the CNMC Parent Navigator program were allowed to telework.

Adolescent health issues are also impacted. Adolescent mental health and mental disorders were among the health indicators that got worse over the last few years. The provision of the Wendt Center’s Resilient Scholar program, group and individual trauma-informed therapy sessions were drastically altered – either delayed or moved to telephone or online platforms, which presented with its own challenges for families with limited internet, electronic resources or those experiencing trauma related to family dynamic issues who were now required to stay at home. Efforts to pilot test projects focused on health care transition within several SBHC’s were halted.

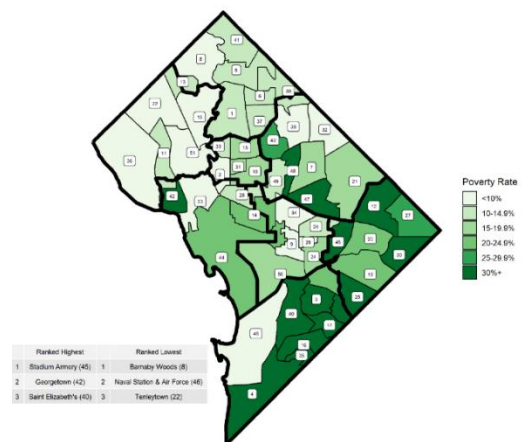
As described previously, DC Health, other local government agencies and community-based organizations have all had to modify operations to adapt to a “new normal” to continue to serve District residents, in particular those most vulnerable. As the Covid-19 pandemic continues, DC Department of Health will remain at the forefront of helping to stem the health impact of this crisis. Title V funds and programming remain vital to keeping mothers, children, including, and in particular, those with special health care needs, adolescents and families, safe and healthy.

### Women’s/Maternal Health

Women comprise the majority of the of the District’s population (52.4%) with more than a quarter of reproductive age (15 – 44 years of age). By race, 47% of women in the District are African American, 40% are White and 11% are Hispanic. Heart disease and cancer are the two leading causes of death among women (and men) accounting for half of deaths in the District in the last five years. Although insurance rates (96.7%) for the maternal health population exceed the national average (92.1%), disparities in health for different age and racial/ethnic groups continue to exist.

According to Figure 1, nearly 20% of women living in the District had incomes below the federal poverty level in 2016, with the highest concentration living in neighborhoods in Wards 7 (Twining, Stadium Armory) and Ward 8 (Douglass and St. Elizabeth’s), followed by some neighborhoods in Wards 2, 5, and Ward 6. **The District’s priorities for Women’s/Maternal Health include: well-woman visits, prenatal care, mental health, safe and affordable housing, implicit bias/discrimination.**

Figure 1. Women with Incomes below the Federal Poverty Line



### Access & Quality of Healthcare

The District is home to seven hospitals and hospital systems, of which five are birthing facilities. Providence Hospital, in Ward 5, closed as part of a revised strategic plan and United Medical Center (Ward 8) permanently closed the labor and delivery unit after temporary closure by the

Department of Health due to quality of care concerns. Hospitals, are concentrated in the Northwest and Northeast quadrants of the District, thus particularly those who live in the east end of the city, and are predominantly Black and low-income have difficulty accessing birthing services.

### **Maternal Mortality**

From 2005-2014 there was an average of 39 deaths among women per 100,000 live births from causes related to pregnancies - one of the highest rates in the U.S. This is more than twice the national average of 17, and far higher than non-Hispanic white mothers at 13 deaths per 100,000. Differences also exist between racial and ethnic groups and coverage type. Only 36% of women in the District on Medicaid and CHIP received at least 81% of the expected number of prenatal visits and only 49% had a postpartum care visit between 21 and 56 days after giving birth. The District of Columbia Maternal Mortality Review Committee, established in 2019, is working towards collecting data to identify key causes of maternal mortality in the District. Testimony by the District's chief medical examiner at a December 2018 hearing revealed that 75% of the maternal deaths recorded in DC between 2014 and 2016 were black women. Equity issues are present alongside high infant mortality creating what some perceive as a maternal care crisis in DC.

### **Well-Woman Visits and Preventive Care Utilization**

In 2018, the Behavioral Risk Factor Surveillance System (BRFSS) reported that 82.4% of women in the District had a routine check-up by a doctor within the past year. Nevertheless, there continues to be a disparity in preventive care use by income levels. Those with a lower income (64%) are less likely to visit the doctor regularly than those with middle income (74%) or high income (89%).

### **Prenatal Care**

Although District women are engaging in some preventive care services, rates of women accessing prenatal care are significantly lower. Between 2009 and 2016, the percent of women who initiated prenatal care in the third trimester or had no entry to prenatal care increased from 5.8% to 6.3%. Women in neighborhoods across Wards 7 and 8 have lower rates of first trimester prenatal care initiation, ranging from 44.16% to 64.19%. Approximately 2.39% of women in the District who had a live birth did not receive any prenatal care. The percentage of women who did not receive prenatal care was higher in most Ward 7 and 8 neighborhoods (2.54% to 9.52%). Mothers who did not initiate prenatal care were more likely to have a pregnancy that resulted in a preterm birth (26.9%) as compared to those who initiated pregnancy during their first trimester (10.2%). Characteristics such as previous preterm birth, smoking prior to pregnancy, mother being overweight or obese, history of diabetes, history of hypertension have all been associated with a higher risk of preterm birth and are disproportionately experienced by non-Hispanic black mothers. Several key informants also highlighted late entry to prenatal care as a contributing factor toward maternal and infant health disparities.

### **Maternal Mental Health**

The mental health of women emerged as an important finding as women often prioritize the needs of their family before their own. According to 2018 BRFSS data, 13% of women in the District reported experiencing 14 days or more of their mental health not being good compared to 12.1% of men.

### **Programmatic/District Strengths**

- **Targeted Messaging to Improve Health Literacy:** DC Health has embarked on a health literacy “Well Women” campaign (part of DC its overarching Perinatal Health Initiative) to bolster awareness of the importance of routine well care.
- **Improved Data:** DC Health has prioritized gathering additional data to better understand barriers for reproductive age women, particularly among women not traditionally engaged in care, including a Title V supported literature review as part of a study on understanding the effects of racism on maternal health outcomes. Title V provides financial support to enhance DC PRAMS, leveraging findings to develop programming.
- **Integration of Population Health and Social Determinants of Health (SDOH) tools and Gender-based Violence Support:** Title V funds have supported La Clinica del Pueblo who serves primarily immigrant and low-income Latinas, in integrating population health and SDOH tools into their electronic medical records systems. The program also expanded its approach to gender-based violence by including strategies that engage men and boys as allies, and address harmful social norms.



### **Needs and Areas of Opportunity for New Activities**

- **Mental Health Services:** In order to ensure women in the District have an equitable opportunity to access mental health resources, DC Health must be mindful of funding services that diversify the workforce as well as placement of services.
- **Address Barriers to Prenatal Care, Especially for Mothers on Medicaid:** As DC Health considers the definition of a “well woman,” it will be important to continue to consider programs that offer opportunities for healthy eating, living and early access to prenatal care.
- **Promoting Safe and Fair Public Spaces:** Generational stress, racial discrimination, and other forms of discrimination were identified as impacting women in the District. Black and Hispanic/Latinx District residents are more likely to interact with police officers, making them feel unwelcomed in public spaces.
- **Expanding Access to Healthcare:** Healthcare systems data and key informant interviews emphasized issues women face associated with the closure of hospitals in the District, limiting patient choices for care and increasing travel distance to the nearest hospital.
- **Improving Postpartum Care:** Strengthening linkages to care through existing programs (Healthy Start; DC Maternal, Infant, and Early Childhood Home Visiting (MIECHV); School-Based Health Centers) will allow women to receive timely services during the postpartum period.
- **Diversifying the Workforce/Mitigating Differences in Healthcare Delivery:** Several key informants stated that diversifying the workforce and providing implicit bias trainings will allow healthcare agencies and clinics to provide culturally and linguistically appropriate care and mitigate differences in healthcare delivery based on race/ethnicity, sex, gender, nationality, etc.

### **Infant/Perinatal 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. In 2018, DC Health published a comprehensive report on Perinatal Health and Infant Mortality. Key findings regarding demographics of District mothers include that from 2010-2012 to 2013-2016, DC experienced an increase in births to



non-Hispanic white women, women with more than a high school education, women aged 30-39 years, and women who are married. In addition, births to mothers aged less than 20 years continued to decline as compared to 2010-2012. Births to mothers aged 15-19 years decreased significantly by 50% from 2006-2016. **The District's priorities for Infant/Perinatal Health include: reducing perinatal disparities including infant mortality, preterm birth, low birth weight, and breastfeeding.**

### **Infant Mortality**

Infant mortality rates (IMR) in the District have been on a downward trend from 2007 through 2016 from 13.1 infant deaths per 1,000 live births and 7.1 per 1,000 live births, respectively. This rate is still higher than the Healthy People 2020 target rate of 6.0 per 1,000 live births. Although the overall IMR declined by 45.8%, significant disparities between racial and ethnic groups persist with the rate for African American mothers three times higher than for Whites.

### **Health Characteristics of Women Prior to Pregnancy**

Health characteristics of women who had live births during 2015 – 2016 demonstrate stark differences when stratified by race/ethnicity. Non-Hispanic Black women had higher proportions of experiencing a previous preterm birth (4.92%), smoked prior to pregnancy (7.05%), being overweight or obese (55.44%), had diabetes prior to becoming pregnant (1.26%), and had hypertension prior to becoming pregnant (3.52%) than their White counterparts (1.04%, 0.94%, 21.31%, 0.25%, and 1.12%, respectively). Similarly, Hispanic women had a higher proportion of experiencing a preterm birth prior to the current pregnancy (2.55%), were overweight or obese (46.48%), had diabetes prior to their current pregnancy (1.42%) compared to their White counterparts.

### **Health Characteristics of Women during Pregnancy**

Women's health experiences during pregnancy also differ significantly. For example, non-Hispanic White women initiated prenatal care during their first trimester at a higher rate (86%), with Hispanic women falling second (64%) and non-Hispanic Black women experiencing the lowest rate (52%). Non-Hispanic Black women also experienced higher percentages of having smoked during their pregnancy (4.6%) compared to Hispanic (0.56%) and non-Hispanic White women (0.43%).

### **Birth Outcomes: Preterm Births (PB) and Low Birth Weight**

Premature births (births to infants less than 37 weeks old) can lead to significant morbidity and mortality. The total number of PB suggested little change from 2011 at 11.0% to 10.6% in 2017. During 2015 – 2016, the number of women who experienced a preterm live birth and had diabetes prior to becoming pregnant was about 2.6 times higher than women who did not have diabetes prior to pregnancy. The proportion who experienced a preterm live birth and were either overweight or obese was 33% higher than women who were normal or underweight. The proportion of PB for non-Hispanic Black women was significantly higher (12.8%) compared to non-Hispanic White women (7.77%). This rate exceeds the 6.5% target for 2020. In 2018, 6.71% of births were between 34-37 weeks of gestation in the District. The PB rates were higher in neighborhoods located in Wards 5, 7, and 8. Most neighborhoods in Wards 4, 6, 7, and all of Ward 8 had a higher percentage of women who delivered between 34-37 weeks compared to the District average. According to 2015-2016 birth data, 74% of low birth weight babies were from Ward 5, 7, and 8.

## **Breastfeeding**

The 2020 Breastfeeding Report Card states that 88.0% of infants in the District of Columbia have ever breastfed, this is almost 4% higher than the national rate. Breastfeeding generally decreases as the age of the infant increases, with rates in the District at 64.7% by 6 months and 39.3% by 12 months. The latest rates demonstrate an increase over the last few years with the rate at 82.8% for ever breastfeeding, 57.4% and 33.1% for 6 and 12 months, respectively, according to the 2016 Report Card. While the overall ever breastfed rate is high, breastfeeding initiation rates can vary widely by race and socio-economic status – the DC WIC breastfeeding initiation rate in 2018 was 62% (up 5% from 2017, largely due to peer counselors and 24/7 access to an IBCLC from Pacify), but can be as low as 30.9% at DC WIC clinics in predominantly African American areas of the city.

*Culturally & Linguistically-appropriate Breastfeeding Support and Education:* Several key informants highlighted that women first turn to their family and friends and then their medical provider, if applicable, for breastfeeding support. One informant stated that women of color typically get their breastfeeding advice from women who have children and are from their immediate family, and another stated that women typically ask their mothers or grandmothers for guidance, but the physician is usually last. Because of this, it is possible that women may or may not always be delivered the proper breastfeeding education that fully supports a woman's decision to breastfeed.

## ***Programmatic/ District Strengths***

- **Strong Community-Based Breastfeeding Support:** Title V funds the **DC Breastfeeding Coalition (DCBFC)**, to provide maternity facilities with financial support and technical assistance to achieve and maintain Baby-Friendly designation, provide Lactation Certification Preparatory Programs with a focus on historically underserved populations, breastfeeding peer educators, linkages and referrals to WIC for prenatal and postpartum women. Also, the District established a Lactation Commission.
- **Safe Sleep Program (SSP):** Title V supports the Safe Sleep Program that aims to reduce the risk of SIDS/Sudden Unexpected Infant Death through empowering parents.
- **Comprehensive Perinatal System:** DC Health has developed a comprehensive approach that encompasses seven priorities that collectively work to improve perinatal outcomes. Title V supports staff that oversee many of DC Health's federally funded maternal and child health programs, including Healthy Start, the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program and the Supplemental Nutrition for Women, Infants and Children (WIC) Program.
- **Targeted Messaging to Improve Health Literacy:** DC Health's Perinatal Health Initiative includes campaigns and messaging to address perinatal health disparities and improve maternal and child health in the District.

## ***Needs and Areas of Opportunity for New Activities***

- **Pregnancy Risk Assessment Monitoring System (PRAMS):** The District's PRAMS collects state-specific, population-based information from women to assess their experiences and attitudes before, during, and after pregnancy. DC Health plans to include questions that will provide additional insight on women's postpartum care and postpartum depression.

- **Immunizations:** Efforts will focus on the enhancement of data collection, tracking, sharing of data from hospitals, and partner organizations complying with immunization requirements and case management.
- **Strengthen Data Systems, Newborn Hearing and Metabolic Screenings:** DC Health's Universal Newborn Hearing Screening Program and the Newborn Metabolic Screening Program are both supported by Title V. Although newborn screenings have been completed for all infants born in the District, the newborn screening database requires additional support.

## Child Health

About 18% of the District's population is comprised of children under 18 years of age, with the majority of children under six (43%). Most children are Black/African American (58.5%) followed by White (26.5%) and Hispanic/Latino (15.9%). The median income for families with children is \$78,633, yet 25% of families live below poverty level and about 39% use public assistance (i.e. SSI, cash public assistance, or Food Stamp/SNAP benefits). Within households, most children live with their biological parent (83.5%), followed by their grandparent (11.6%). A strong predictor of positive health outcomes is one's health at birth. Poverty during a child's life under the age of five can increase the risk of experiencing lower socioeconomic status later in adulthood, and contribute to a cycle of poverty among future generations. Neighborhoods in Wards 7 and 8 (Lincoln Heights, Stadium Armory and Douglass, St. Elizabeth's, respectively), and some neighborhoods in Wards 2 and 5, have the highest concentrations of children under five living in poverty. **The District's priorities for Child Health include: Developmental Screening, Mental Health/Grief & Trauma-Informed Care, Oral Health.**

### **Developmental Screening**

To ensure children have early and appropriate access to services the American Academy of Pediatrics recommends that all children receive a developmental and behavioral screening during their well-child visit at 9, 18, and 30 months. However only approximately 31% of children in the District between 9 – 35 months were reported to have received a developmental screening using a parent-completed screening tool. Given that multiple points of access can serve as the opportunity to screen children for developmental delays (e.g. DC Early Intervention Program/Strong Start led by OSSE for children 0-3 and the DC Early Intervention Program led by DCPS for children 3 years and older), the developmental screening rate may be underreported.

### **Grief & Trauma-informed Care for Children**

About 13% of children 3 – 5 years of age, 21% of children 6 – 11 years of age, and 29% of children 12 – 17 years of age have at least one reported (and/or qualified on the children with special health care needs screener) for a mental, emotional, developmental, or behavioral problem. Following traumatic death experiences, children may develop Childhood Traumatic Grief (CTG), which is a condition where trauma symptoms interfere with adaptive child grieving. A mental health key informant indicated that training teachers to identify what trauma exposure looks like in children would prevent school staff from reacting punitively toward students and that there are an insufficient number of mental health providers trained in grief and trauma.

### ***Programmatic/District Strengths***

- **Place-based Initiatives:** Title V staff provide oversight of locally funded place-based early childhood initiatives in five District communities. Resilient Communities-DC, for example,

provides a holistic health strategy in Ward 8 through the development and implementation of Neighborhood Family Champions (NFCs).

- **Strengthening Food Access Programs:** Title V provides programmatic oversight of locally funded food access programs geared to serve low-income children and their families, particularly those living in food deserts.

### ***Needs and Areas of Opportunity for New Activities***

- **DC Health-Medicaid Agreement:** Expand opportunities that promote access to care and better support the federal mandate for collaboration between Title V and Title XIX.
- **Improving Mental Health Support for Children:** Agencies must move towards offering mental health services that are flexible and consider school/work hours, in addition, that expand beyond mental health providers to train others that interact frequently with children, such as teachers.
- **Grief & Trauma-informed Care for Children:** Despite the mental health expansion led by the District's Department of Behavioral Health (DBH) and Title V grant-supported work with the Wendt Center for Loss and Healing, gaps in services still exist.
- **Oral Health Services:** Efforts must ensure that resources are equitably distributed to allow access to affordable dental care, in particular, for those who are Medicaid-eligible and under 2 years old.
- **Developmental Screening:** Efforts to create and implement use of a centralized database (i.e. Ages and Stages Questionnaire (ASQ) Hub) that will collect ASQ screening data from state and local organizations, early intervention programs, and early childhood education programs to reduce the duplication of services and connect families to timely and appropriate services should continue.

### **Children with Special Health Care Needs (CSHCN)**

There is a dearth of data illustrating the needs and challenges of children with special health care needs in the District. However, rich qualitative data from partners in the field allowed for assessment of this population. It is vital to support CSHCN and their families given that nearly 19% of DC families reported that their child has a special health care need. **The District's priorities for CSHCN include: Medical Home Identification/Place-based care, Mental Health, Reducing Implicit Bias/Discrimination.**

### **Quality of Care/Access to Medical Care**

The District of Columbia has a first-of-its kind health system - HSC Health Care System is a nonprofit health care organization committed to serving people with complex health care needs and eliminating barriers to health services by providing the resources of a health plan, a pediatric specialty hospital, home health agency, rehabilitative therapy centers and parent foundation assistance. The District offers a Medicaid health plan for CSHCN through Health Services for Children with Special Needs, Inc. (HSCSN). HSCSN serves children and young adults up to age 26 who live in Washington, D.C. and receive SSI. A care manager helps ensure an individual or their child gets the care or services prescribed by a physician. A healthcare system professional stated that additional work is required to increase quality of services throughout the entire continuum of care. This includes helping CSHCN integrate back into their communities, and allowing CSHCN to practice skills learned in speech therapy, developmental therapy, etc. to engage in social interactions, participate in physical activity, and live more independent lives.

*Care Coordination:* Despite the District's improvements in expanding access to care, CSHCN continue to face challenges accessing supportive services within the community. 35% of CSHCN in the District reported having a personal doctor/nurse, usual source for care, family-centered care, and if needed, referrals or care coordination through a medical home, compared to 39.2% of CSHCN from the previous year.

*Home-based Care:* Focus groups held with home-based child care providers revealed that an insufficient amount of funding is provided to their centers in order to support CSHCN compared to Child Care Centers that can acquire funds to hire specialists since they care for more CSHCN. Home-based child care providers stated that with limited funding, the centers could not meet the District's regulations required to support CSHCN ages 2 or younger without added staff.

*Implicit Bias in Care:* The systemic issues aforementioned trickle down to the experience families receive when they interact with agencies to receive services. Listening sessions with families of CSHCN revealed concerns over quality of care as children transition from a community-based organization to DCPS. Families reported that the therapy services provided by school differed and were not up to par with the quality of services provided by Strong Start, for example.

*Culturally and Linguistically-Appropriate Services:* Non-English speakers and immigrant families, in particular, face difficulty when interacting with the medical system or other points of care. Listening sessions with immigrant families, and focus groups with early childcare professionals revealed barriers regarding the communication of available services. In some cases, families also felt they were being discriminated against as they were not offered the same resources as their English-speaking counterparts. Another key informant mentioned that mental health services are predominantly set up to serve English-speaking individuals, so parents who do not speak English and who depend on their children to translate, have a difficult time when their child also has a special health care need. Healthcare professionals stated that cultural competency trainings are needed for tailored care of CSHCN.

### **Mental and Behavioral Health**

CSHCN may be at higher risk of experiencing adverse childhood experiences (ACEs), which include witnessing violence towards a parent/guardian, experiencing violence themselves, living with someone who suffered from poor mental health, and more. Approximately 37% of CSHCN in DC were reported to have two or more ACEs which is almost double the rate of children with no special health care needs at 17.2%; the national rates are (33.1% and 15.3%, respectively).

*Bullying:* CSHCN are at increased risk of being bullied. In fact, in the District, parents of CSHCN between 12 – 17 years of age reported a higher rate of their children experiencing bullying (24.9%) compared to parents with children without a SHCN (8.5%).

*Access and Quality of Care:* Several key informants and the youth focus group highlighted that mental health services in the District needed to reach children with special healthcare needs, they further stated CSHCN in crisis tend to interact more with the police or emergency department as their first point of behavioral or mental health care instead of preventative care. Two key informants familiar with healthcare transition indicated that families experience barriers with receiving specialty appointments within a reasonable timeframe, such as long waitlists for behavioral and mental health services. They continued that CSHCN experience long wait times

to receive developmental evaluations and community-based centers cannot support the services.

### ***Programmatic/District Strengths***

- **Coordination & Transition Services in a Medical Setting:** DC Health's Title V Program funds Children's National Health System's Parent Navigator Program which provides practice-based navigation and "Tele-Navigation" services, including transition, to families of CSHCN that receive primary care services at one of six primary care sites and/or through the Complex Care Program.
- **HSC Health Care System & HSCSN Plan:** HSC is a first-of-its-kind health system in the District and the HSCSN Medicaid plan offers special benefits to enrollees up to age 26 who receive SSI, including a care manager.
- **DC Department of Behavioral Health Initiatives:** To better reach adolescents, the DC DBH and DC Health began implementation of DBH's School Mental Health Program during the 2017-2018 school year that provides services to all public and charter school students in the District.

### ***Needs and Areas of Opportunity for New Activities***

- **Implicit Bias Training:** There is a dire need for well-trained staff in providing appropriate services to District residents regardless of race/ethnicity, age, gender, ability, etc.
- **Culturally and Linguistically Appropriate Services:** Although hospitals and clinics have their own interpreting services, there is still a need for multi-lingual support so families do not have to rely on their children for translation services.
- **Transition from Pediatric to Adult Care:** Only 17% of families with CSHCN reported receiving services necessary to make transitions to adult health care. Even when families do receive transition services, they have a difficult time transitioning to adult care because of the lack of trust and unknown around providers with whom they have no relationship.
- **Mental and Behavioral Health:** Increasing the mental health workforce capacity to include play therapy, not solely language-based services, could assist younger children who are pre- or non-verbal, as well as CSHCN. Improvements in specialized urgent care to be equipped with trained CSHCN providers and behavioral and developmental services could reduce CSHCN's unnecessary interactions with police and emergency departments.
- **Caregiver Support:** Providing caregivers with waivers for respite care and increasing CSHCN workforce capacity that addresses caregiver burnout would allow caregivers to prioritize their individual health and needs in order to fully care for their child(ren) and family.

### **Adolescent Health**

According to Healthy People 2020, adolescents and young adults are in a unique phase in which they are faced with the issues of transitioning to adulthood both physically and socially. It is particularly important to focus on the economic and racial disparities that may arise or worsen during these periods of transition by addressing factors most vulnerable to change such as academic success, mental health, and safety, etc. In the District of Columbia, there are 70,954 (10.1%) adolescents between the ages of 10 to 19 years of age. Academic success is strongly correlated with future health outcomes. The Institute of Medicine indicates that high school graduation is a point of transition and opportunity where adolescents can be supported to enhance the opportunities available to them and encourage success. DC Public Schools

(DCPS) recently celebrated a 4-year high school graduation rate of 68.5% during its 2017-2018 school year, a 17% increase from its 2010-2011 school year at 58.6%. **The District's priorities for Adolescent Health include: Community Safety, Mental Health and Positive Youth Development.**

### **Community Safety**

National surveys and informants revealed that community safety continues to be a significant issue for District residents, particularly adolescents. 12.1% of parents with children under age 18 reported feeling that their child lived in a somewhat or definitely unsafe neighborhood compared to 4.7% for the nation. A higher percentage of Non-Hispanic Black parents than non-Hispanic White parents reported that their child lived in a somewhat or definitely unsafe neighborhood (15.9% vs 5.6%, respectively). The top three causes of death among youth between the ages of 15 – 24 in the District from 1999 – 2018 were assault (homicide), accidents (unintentional injuries), and intentional self-harm (suicide). The age-adjusted violent death rate per 100,000 in 2011-2015 was highest in neighborhoods located in Wards 7 and 8 (above 40%) compared to affluent Wards in the District (below the District's average 19.5% and as low as 1.1%).

### **Mental Health and Wellbeing**

Adolescent mental health and disorders were among the health indicators that got worse over the last few years: the proportion of adolescents that experienced major depressive episodes (MDEs) increased from 6.5% in 2011 to 10.5% in 2017 - above the 2020 target goal of 5.8% within this population. The 2019 YRBS data indicated that about 33% of high school students experienced feelings of sadness or hopelessness almost every day or equal to two weeks. Students who identified as gay, lesbian, or bisexual or were unsure of their sexual identity had higher rates of feeling sad or hopeless (51.9% and 41.2%, respectively) compared to students who identified as heterosexual (29.1%).

### **Positive Youth Development (Life skills)**

The U.S. Department of Health and Human Services defines positive youth development as an approach that is assistance that incorporates youths' strengths and skills and supports their development to achieve goals and effectively assume adult responsibilities. The youth focus group identified life skills they wanted included in high school curriculums to help youth transition out of school and into adulthood including: time management, tax preparation, and financial literacy skills. The youth expressed that counselors at school are limited, making scheduling appointments with current counselors difficult. They emphasized the desire for mentors and additional support to provide guidance as they complete high school and prepare for a college education.

### ***Programmatic/District Strengths***

- **School-Based Health Centers (SBHC) Program:** DC Health's Community Health Administration funds the SBHC program to improve the physical, social, emotional, and behavioral health of students, while addressing the impacts of poverty and other adverse childhood experiences, to allow students to thrive in the classroom and outside of school.
- **Transition Services in School Environments:** DC Health supports The National Alliance to Advance Adolescent Health (NAAAH) in their work focused on improving access to evidence-informed health care transition (HCT) support, particularly to youth in low-income households and those with chronic conditions.
- **DC Health's HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA):** Leads and supports efforts to reduce the incidence of disease among adolescents. All

programs provide low-barrier access to services that meet the needs of the District's youth. These programs include: A Condom Distribution Program, School-Based Screening Program, Youth STD Screening Program, Sex Is... campaign and DC Health and Wellness Center.

- **El Camino Program:** Through a partnership with the Office of Human Rights (OHR), DC Health has supported the development and pilot of El Camino – an evidence-informed program targeted to mitigating and preventing bullying and cyberbullying among adolescents.
- **Resilient Scholars Project-School Based Program (RSP-SB):** DC Health's community-based partner, Wendt Center, implemented RSP-SB in District public schools and community based settings located in low-income, high risk neighborhoods. Resilient Scholars provides evidenced-based behavioral health services for children ages 6-17 years suffering from affective disorders resulting from trauma exposure.
- **Youth Advisory Council (YAC):** DC Health established its first ever YAC in FY19 to promote health and build leadership skills among DC youth. The YAC is comprised of 20 young people, ages 14-21, who live in DC and have an interest in ensuring better health outcomes for other young people and their communities.

### *Needs and Areas of Opportunity for New Activities*

- **Positive Youth Development:** The youth focus group identified life skills that could be included in their current high school curriculum to help them transition out of school and into adulthood.
- **Community Safety:** Non-Hispanic Black and Hispanic/Latinx adolescents are disproportionately impacted by violence compared to non-Hispanic White adolescents. Upstream programs that support positive youth development will be vital in assisting adolescents to build healthy relationships, thrive and become successful adults.
- **Mental Health and Wellbeing:** In order to address adolescent mental health, services should be tailored to adolescents' needs, delivered with a trauma-informed approach, and located within the community to meet adolescents who require the most support.
- **Physical Activity:** Adolescents are not meeting CDC recommendations of at least one hour of moderate-to-vigorous physical activity per day. The Youth Advisory Council highlighted the need for an increase in physical activity opportunities in their communities where safety is a concern.
- **Transition Services:** Although the National Survey of Children's Health (NSCH) reports a higher percentage of adolescents who have received transition services from pediatric to adult care compared to the national average, that rate can be improved and more work should focus on transitional needs of children with special health care needs.

## Organizational Structure

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The District of Columbia is governed by the Mayor who has the sole authority and responsibility for the daily administration of the District government. 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 (DC Health). There are six administrations in DC Health, including the Community Health Administration (CHA). CHA is responsible for administering the Title V grant program.

Within CHA the Deputy Director for Programs and Policy serves as the state Title V Director providing strategic direction while a Program/Evaluation Manager oversees the



programmatic activities for Title V grantees, and program evaluation for CHA. The Grants and Budget Monitoring Unit within the Office of the Deputy Director for Operations provides grant support through fiscal monitoring of contracts and grant awards. CHA is comprised of four bureaus with various staff that are responsible for Title-V supported programs.

## Agency Capacity

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DC Health'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 Community Health Administration (CHA) of the District of Columbia Department of Health promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of mortality and morbidity in the District. CHA focuses on nutrition and physical fitness promotion; cancer and chronic disease prevention and control; access to quality health care services, particularly medical and dental homes; and the health of families across the lifespan and is organized into four respective bureaus: Nutrition and Physical Fitness Bureau, Cancer and Chronic Disease Prevention Bureau, Health Care Access Bureau and the Family Health Bureau (see Appendix #1 for Office & Bureau descriptions). Each bureau addresses at least one of the six population health domains. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change.

## MCH Workforce Capacity

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The District of Columbia Title V staff includes 43 full time equivalent staff. Senior level management include Ankoor Shah, MD, MBA, MPH, CHA Deputy Director for Programs & Policy and DC Title V State Director; Erica McClaskey, MD, Family Health Bureau Chief and CSHCN Director, (both new to DC Health as of FY20 and FY19, respectively); Robin (Diggs) Perdue, Healthcare Access Bureau Chief; Anita Thurakal, MD, MPH, Perinatal & Infant Health Division Chief (new as of FY19); Kafui Doe, EdD, MPH, Child, Adolescent & School Health Division Chief; and Omotunde Sowole-West, MPH, Early Childhood Health Division Chief. After years of rapid turnover of senior management, CHA underwent a reorganization in FY16. This realignment of staff, creation of new positions, and increased opportunities for staff development trainings has enhanced the state's ability to serve our MCH populations. The program filled a missing key analytic function in hiring an MCH Epidemiologist, Patricia Lloyd, PhD, ScM in FY18. Jasmine Bihm, DrPH, MPH, subsequently joined the Title V team in FY19 as Program Manager and additionally oversees CHA program evaluation. Nadia Khan, MBA, MPH, RDN, LD serves as the Title V Project Officer, coordinating with grantees and the MCH Advisory Council. Moriam Animashaun, MPH, CPH and Marcella Hernandez, MPH serve as Data Analysts for the Title V Program and provide evaluation assistance for CHA. Other Title V staff are embedded throughout CHA Bureaus, and work on a variety of MCH programs. Jasmine Davis, Public Health Advisor serves as the State Family or Youth Health Leader focusing on CSHCN. The MCH workforce has strong medical, public health, program planning and evaluation capabilities and a core cohort of staff with several years of MCH experience. CHA anticipates expanding the MCH workforce capacity by supporting the MCH leadership development of mid-level managers for retention and transition into senior level roles.

## Title V Program Partnerships, Collaborations, and Coordination

The DC Title V program partners with other District agencies to implement important MCH work. Title V, through its partnership with the Office of the State Superintendent (OSSE) Division of Early Learning (DEL), works to implement the Strong Start Early Intervention Program (Strong Start) - a statewide, comprehensive, coordinated, multidisciplinary system that provides early intervention therapeutic and other services for infants and toddlers with disabilities and developmental delays and their families. Title V and OSSE DEL provide staff oversight of the Help Me Grow (HMG) program. HMG provides services to District residents through a comprehensive and integrated system designed to address the need for early identification of children at risk for developmental and/or behavioral problems and to prenatal women. Title V funded the Office of Human Rights (OHR) to develop a series of lessons (El Camino Program) to target bullying and help middle school students learn how to use technology and social media in a healthy and supportive way. CHA actively participates with several District wide MCH collaborative groups, including the State Early Childhood Development and Coordinating Council, Child Fatality Review Committee (CFRC) and Infant Mortality Review subcommittee, Department of Health Care Finance Perinatal Quality Improvement Collaborative, the Thrive by Five Coordinating Council, DC Home Visitation Council, DC Food Policy Council, CSHCN Advisory Council, Maternal Mortality Review Committee and the D.C. Healthy Communities Collaborative, among others.

<b>Sub recipient</b>	<b>Purpose</b>	<b>Grant Award</b>
Children's National Medical Center-Parent Navigator Program	Navigation and transition services for children and youth with special health care needs.	\$ 352,200.72
DC Breastfeeding Coalition	Provide technical assistance and financial support four maternity facilities to navigate the 4-D Pathway and achieve and maintain Baby Friendly designation; increase peer counseling services to low-income postpartum women in the District.	\$ 632,354.07 (\$539,354.07 Title V funds + \$103,000.00 Local Funds)
La Clinica Del Pueblo	Provide increased opportunities for preventive care, including well-women visits for Latina immigrants of reproductive age.	\$ 300,000.00
The National Alliance to Advance Adolescent Health	Extend availability of health care transition to school-based health centers to community-based mental health providers and primary care providers.	\$ 300,000.00
The Wendt Center for Loss and Healing	Provide behavioral support services within the DC Public and Charter School setting and youth with special healthcare needs suffering from affective disorder resulting from trauma exposure.	\$ 300,000.00
Breathe DC	Provide smoking cessation services to perinatal and pregnant woman and adults who live with children.	\$ 288,040.99

Partnerships/Collaboration	Women/ Maternal Health	Perinatal/ Infant Health	Child Health	Adolescent Health	CSHCN
Breathe DC	X		X		
Health Care Access Bureau Programs (Relevant to Title V- i.e. Care Transformation (CaT) grant program)	X	X			
Healthy Start	X	X			
La Clinica Del Pueblo, Mujeres Saludables	X				
School Based Health Centers	X			X	
PRAMS	X				
Community Action Network (CAN)		X			
DC Breastfeeding Coalition (DCBFC)		X			
Newborn Hearing Screening Program (Early Hearing Detection and Intervention (EHDI) Program)		X			
Newborn Metabolic Screening Program		X			
Safe Sleep Program		X			
Early Childhood Innovation Network (ECIN) Placed Based Initiatives			X		
Healthy Corner Stores Partnerships			X		
Help Me Grow			X		
Joyful Food Markets			X		
MIECHV			X		
Mobile Farmers Markets'			X		
Office of State Superintendent, Division of Early Learning (OSSE)			X		
Produce Plus Program			X		
Produce Rx			X		
Smart from the Start			X		
Office of Human Rights (OHR)				X	
Oral Health Program				X	
Rape Prevention Education (RPE)				X	
Teen Pregnancy Prevention (TPP)				X	
The Wendt Center for Loss and Healing				X	
Youth Advisory Council (YAC)				X	
Children's National Medical Center (CNMC)					X
National Alliance to Advance Adolescent Health (NAAAH)					X

## Identifying Priority Needs and Linking to Performance Measures

Over the past 1.5 years, DC Health has worked in partnership with communities, families, stakeholders, and public health professionals to better understand the needs of women,

children, and families living in Washington, D.C. Through the literature review, MCH Advisory Board and Community Discovery Survey, key informant interviews and focus groups, a prioritization ranking process by Title V staff and senior leadership, the following priority areas and corresponding NPM's and SPM's (where applicable) have been identified:

1. Well-woman Visits/Prenatal Care for Pregnant Women: Ensuring women and expectant mothers access to regular preventative health services including family planning, prenatal and postpartum care, in particular those who are Medicaid-eligible; NPM 1: Well Woman's Visit
2. Breastfeeding: Access to culturally & linguistically appropriate education and consultation; NPM 4: Breastfeeding
3. Reducing Perinatal Disparities: Reducing infant deaths, preterm and low birth weights especially in Wards 5,7 and 9; NPM 1: Well Woman's Visit and NPM 4: Breastfeeding
4. Mental Health and Well-being including Grief and Trauma-informed Care: Train teachers/providers who work with children and youth to help address generational stress and provide non-discipline assistance; SPM: Increase access to individual or group therapy to District residents, ages 6-21, who have been exposed to trauma and/or traumatic loss
5. Reduce Implicit Bias/Discrimination: Access to quality, culturally & linguistically-appropriate health and mental health services including respectful care during delivery; SPM: Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care.
6. Positive Youth Development/Tailored Adolescent Health Engagement: Life skills classes, interpersonal relationship skills, teen pregnancy reduction, LGBTQ awareness; SPM: Number of adolescents provided with peer-to-peer support
7. Increase Early Childhood Developmental Screening; NPM 6: Developmental Screening
8. Medical Home Identification/Place-based care for families, including CSHCN: Coordination of referrals/linkages to services and specialty care for Medicaid-eligible families; NPM 11: Medical Home and NPM 12: Transition
9. Oral Health in Children and Adolescents: Ensuring access and increasing preventive dental visits among children and adolescents; NPM 13: Oral Health
10. Community Safety including Safe and Affordable Housing

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## **Appendix 1. DC Health Community Health Administration Offices and Bureaus**

### **Office of the Senior Deputy Director**

The Senior Deputy Director provides overall oversight of all of the programs and operations of CHA. The Senior Deputy Director provides strategic direction for the administration and represents the agency within District government and to community stakeholders. The Senior Deputy Director sets priorities for administration activities and leads policy development, planning, and operational management.

### **Office of the Deputy Director for Operations**

The Deputy Director for Operations oversees the essential support functions for the Administration, including fiscal management, grants administration and monitoring, evaluation of sub-grant activities, human resources, information technology, facilities operations, and customer service. **Program Support Services:** ensures efficient and effective daily operations through the development, implementation, execution, and review of all administrative functions and policies. The **Grants and Budget Monitoring Unit:** addresses all of the fiscal duties, including the development of, oversight, execution of, and reporting of the fiscal year budget; provision of support for all local and grant-funded programs; procurement, implementation of comprehensive strategic fiscal plans, etc. **Program Evaluation:** The purpose of Program Evaluation is to collaborate with program and fiscal staff to ensure effective and efficient performance of sub-grantees.

### **Office of the Deputy Director of Programs and Policy**

The Deputy Director of Programs and Policy leads the activities of CHA that address the determinants of health in the District of Columbia. The DDPP oversees implementation of evidence-based programs and policies to prevent illness and injury, promote healthy behaviors and healthy environments across the lifespan, improve access to medical and dental homes, and foster clinical quality improvement and innovation. The DDPP ensures that CHA programs follow best practices and are aligned with the core public health functions and essential services. The DDPP serves as the Title V Maternal and Child Health Block Grant Director and oversees the four programmatic bureaus within CHA, the Cancer and Chronic Disease Prevention Bureau, the Nutrition and Physical Fitness Bureau, the Health Care Access Bureau, and the Family Health Bureau.

### **Cancer and Chronic Disease Prevention Bureau**

The Cancer and Chronic Disease Prevention Bureau develops, implements and evaluates programs and policy aimed at preventing and controlling the leading causes of death in the District. The Bureau implements cancer control and prevention initiatives aimed at reducing the high rates of cancer-related mortality among District residents. Its programs target treatable or preventable cancers, such as breast, cervical, lung, and colorectal, through primary and secondary prevention. The Bureau also works to reduce the impact of chronic conditions such as cardiovascular disease, hypertension, and diabetes mellitus, by developing innovative management approaches and building community partnerships. It supports clinical quality improvement initiatives, which includes developing decision support tools and participating in the design of clinical delivery systems, and it provides expert technical assistance to clinical and community settings around best practices for chronic disease prevention and management. The Bureau implements social marketing campaigns to change norms and introduces long-lasting protective interventions, like cancer screening and tobacco cessation and treatment programs. The Bureau also helps strengthen the infrastructure for chronic disease care and promotes population-based policy strategies to reduce the common risk factors for chronic disease, including tobacco use, poor nutrition, and physical inactivity.

### **Health Care Access Bureau**

The Health Care Access Bureau supports population-based programs to improve access to quality primary care services for residents. The Bureau works to support and promote medical and dental homes so all residents can access comprehensive preventive medical and dental services. The Bureau administers the State Oral Health Program, the Immunization program including its Vaccines for Children program and the immunization registry, and health care workforce development programs. By administering the District's Health Professional Shortage Areas and Medically Underserved Area programs, the Bureau is a key component of the District's health planning infrastructure. The Bureau also supports innovations in primary care service delivery and quality, diffusion of primary care access to underserved communities, and fosters linkages to primary care services regardless of resident's ability to pay. The Bureau also ensures that underserved populations maintain access and linkages to healthcare services and the services provided by other CHA bureaus.

### **Nutrition and Physical Fitness Bureau**

The Nutrition and Physical Fitness Bureau promotes health and reduces obesity among District residents by encouraging behavior change through direct nutrition and physical activity education and by facilitating policy, systems, and environmental changes that make healthy choices the easy choice in every community. The Bureau administers programs that supply food or funds for food such as the Supplemental Nutrition Assistance Program, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Produce Plus Program, pop-up community markets, and other programs to impact socioeconomic factors that influence access to healthy foods. The Bureau also provides food, health and nutrition assessments and intervention, as well as education and counseling aimed at improving dietary habits and overall nutrition. Nutritional support is coupled with programs to promote physical activity and to decrease obesity.

### **Family Health Bureau**

The Family Health Bureau works to improve perinatal, early childhood, and child and adolescent health outcomes so every child in the District of Columbia is healthy and able to thrive in school and beyond. The Bureau supports the development of a coordinated, culturally competent, family-centered health care delivery system; promotes community and clinical linkages for women, parents, children and adolescents; and works to align and integrate services to connect District families with resources they need. It also provides expert technical assistance and builds the capacity of clinical and community-based organizations to deliver evidence-based practices and innovative programs in perinatal, early childhood, child, and adolescent health directly in communities. In addition, the Bureau facilitates school-based health services and coordinates with education partners to implement policies and programs that support healthy school environments that support the whole child.