Committee on Health
FY 2024 Performance Oversight Post-Hearing Questions
DC Health

Agency Management Program (AMP)

1. **Please provide an update to the vacancy rate for DC Health per administration. DC Health indicated at the hearing that the chart in its response to Question #3 of the pre-hearing questions is out of date.**

DC Health adjusted the vacancy rates to remove positions that are no longer funded from the vacancy calculation. There are additional positions that are supported by federal grants for which funding will end later in 2025. Therefore, additional vacancies will be removed from the total.

FY 2024: Vacancy rate was 11% overall and the average time to fill vacant positions was 47. days.

Administration	**Vacancy Rate**	**Time (in days) to Fill Vacancies***	**Total of FTE's**	**Total Vacancies**
Community Health Administration (CHA)	7%	57	141	11
Center for Policy, Planning and Evaluation (CPPE)	21%	49	80	20
HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)	14%	48	134	26
Health Regulation and Licensing Administration (HRLA)	7%	43	168	12
Health Emergency Health Preparedness and Response (HEPRA)	17%	38	26	6
Office of the Director	8%	41	82	8

FY 2025, to date (March 11, 2025): Vacancy rate is 16% overall and the average time to fill vacant positions was 49 days.

Administration	Vacancy Rate	Time (in days) to Fill Vacancies*	Total of FTE's	Total of Vacancies
Community Health Administration (CHA)	15%	52	141	26
Center for Policy, Planning and Evaluation (CPPE)	12%	46	72	21
HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)	14%	53	130	26
Environmental Health Administration (EHA)	1%	41	78	3
Health Systems and Preparedness Administration	14%	63	132	26
Office of the Director	10%	42	79	17

**Time to Fill is calculated from the date the job was posted until the candidate starts their first day in the position.*

Community Health Administration (CHA)

2. **Regarding the charts in DC Health's response to Question #29 of the pre-hearing questions, why did CHA select 233/10,000 births as the 2026 Target for severe maternal morbidity? Is it still a feasible target given the current trends?**

The District remains committed to providing a transparent picture of what the trends are for severe maternal morbidity (SMM) and providing programming support. In 2019, when the rate was 259 per 10,000 deliveries, the goal was to reduce it to 233 by 2026. This rate was calculated given resources dedicated to this area at that time and quantitative analysis of realistic improvements. However, DC Health made an adjustment to its 2019 rate given the reclassification of three cases. Since then, the District of Columbia Perinatal Quality Collaborative (DC PQC) has focused in part on improving identification of severe maternal morbidities. These efforts are likely responsible for the increase of cases in later years. Based on this new baseline number from 2019 and the improved identification of cases, the Community Health Administration is working to identify a new target for 2026.

3. **Please provide the severe maternal morbidity rates for each of the last 5 years.**

Severe Maternal Morbidity (per 10,000 deliveries) by Year

Year	Severe Maternal Morbidity	Rate (per 10,000 deliveries)
2019	214	263
2020	233	299
2021	233	314
2022	254	361

2023	286	415

Data Source: 2021-2023 DCHA Inpatient Hospital Discharge Data, Data Management and Analysis Division, Center for Policy, Planning and Evaluation, D.C. Department of Health.

4. **Regarding the charts in DC Health's response to Question #29 of the pre-hearing questions, why does DC Health set a target of 145 at-risk families with children under the age of 5 enrolled in home visiting, when 300 families were served in 2023? Why does the chart state that the target was not met, when the target appears to be exceeded?**

This was a reporting error to Council. The true number of families served in FY24 was 236. The funded number (or the "target") of home-visiting families is 521 for FY25.

Center for Policy, Planning and Evaluation (CPPE) & State Health Planning and Development Agency (SHPDA)

5. **We discussed reducing the number of SHCC seats from 15 to 9. Which seats does DC Health recommend cutting?**

The Statewide Health Coordinating Council (SHCC) was initially created with 15 seats, however, two of those seats (the Commissioner of Public Health and the Commissioner of Health Care Finance – or their respective designees) were removed over twenty years ago. Therefore, the current number of SHCC seats is 13. The table below outlines how DC Health recommends reducing the SHCC seats from 13 to 9 by taking the following steps:

- Reducing the number of consumers of health care services in the District who are not affiliated with any health care provider or facility from four to two;
- Reducing the number of public members from three to two; and
- Removing the representative of an incorporated association of health care insurance industry in the District.

Each of these areas have presented challenges to fill resulting in vacancies. Making these adjustments will allow the SHCC to more readily fulfill its review and certification requirements.

Current Configuration (13 members)	**Recommendation (9 members)**	**Current Status**
Four consumers of health care services in the District who are not affiliated with any health care provider or facility	**Two** consumers of health care services in the District who are not affiliated with any health care provider or facility	**One** Active
Three public members	**Two** public members	**Two** Active
Two representatives of incorporated associations of health care facilities in the District	**One** representatives of an incorporated association of health care facilities in the District	**One** Active
	One representative of an incorporated association of hospitals in the District	Pending
One physician representing an incorporated association of professional physicians in the District	**One** physician representing an incorporated association of professional physicians in the District	Vacant

One nurse representing an incorporated association of professional nurses in the District	**One** nurse representing an incorporated association of professional nurses in the District	Vacant
One representative of an incorporated association of the health care insurance industry in the District	Repeal	Vacant
The Director of the Department of Mental Health, or his or her designee	The Director of the Department of Mental Health, or his or her designee	Active

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

6. **How many participants are currently in the PrEP DAP Program?**

Currently there are two participants enrolled in the PrEP DAP program. This low participant is due to the program serving as the payor of last resort, which is rare given that the District has a high medical insured rate. In FY24, DC's Health and Wellness Center prescribed PrEP to 790 individuals. Of these, 446 (56.5%) were already taking PrEP, 309 (39.1%) were new to PrEP, and 35 (4.4%) were restarting PrEP. Additionally, in FY24, 4,039 individuals were prescribed PrEP through HAHSTA's Status Neutral Care Continuum program.

7. **How much would it cost to expand the DC Health and Wellness Center hours to include some evening and weekend hours? Please provide a description which hours/days you propose to expand to, which populations would most benefit from evening and weekend hours, and an estimate of how many more patients would be served.**

DC Health has estimated it would cost approximately $543,506.10 to expand the DC Health and Wellness Center to include some evening and weekend hours. Specifically, these expanded hours would include one evening per week (4 hours each) and two Saturdays per month (4 hours each). This cost is driven by health professional staffing needs (including an Advanced Practice Registered Nurse and Registered Nurse), security staffing needs, medical supplies, medication costs, and laboratory services.

The populations that would benefit most from evening and weekends are people who work during the day, students, and young people. The extended hours could also help decrease visits to the emergency room for sexual health related issues and better support District residents with harm reduction and health education resources.

8. **We discussed adding behavioral health staff to the DC Health and Wellness Center. How many positions are needed to meet the need? Please describe their potential scope of work.**

DC Health believes that two Licensed Independent Clinical Social Worker (LICSWs) would be needed. Their scope of work would include counseling and treatment adherence support for people newly diagnosed with HIV, syphilis or another STI, as well as for those taking PrEP. The behavioral health staff would also facilitate groups sessions for those lost to care and ready to reengage, support groups for those taking PrEP, and readiness assessments and support for rapid initiation of Antiretroviral Therapy (ART).

Health Systems and Preparedness Administration (HSPA)

9. **DC Health mentioned that it would have liked to prorate licensure applications during this transition to the staggered renewal system, but statute prohibited it. Please refer the Committee to the relevant part of the Code that prohibits pro-rating and provide suggested language on how to amend that part of the Code.**

DC Health's desire to prorate licensure applications during the transition to a staggered renewal system was primarily constrained by DC Official Code § 3-1204.09(b)(1), specifically concerning physician licenses. It states:

> ***(b) (1)*** *The fee for the issuance of a medical license shall be set by the Board of Medicine; provided that the fee shall be no less than $500 and shall be sufficient to fund the programmatic needs of the Board.*

This section mandates that the Board of Medicine sets the fee for medical licenses, with a minimum of $500, and requires that the fee covers the Board's programmatic needs. The language does not explicitly allow for or provide a mechanism for prorating these fees, creating an exception to the general fee-setting authority granted to the Mayor in subsection (a) and the proration flexibility available in Chapter 35 regulations for other license types.

DC Health continues to evaluate whether a pro-rated fee structure would be budgetarily feasible. Should it not adversely harm DC Health's ability to fund health professional licensure operations, DC Health will follow up with the Committee to provide suggested language.

10. **Please confirm how many training providers have applied to provide MA-C credential training programs. If there have been applicants, please describe the delay in credentialing these training programs.**

The Board of Nursing has not received any applications from training providers seeking to offer MA-C credential training programs. Since no training providers have applied, there have been no delays in credentialing such training programs.

11. **As we discussed at the hearing, the Giant in Ward 8 was fined $2,000 in FY 2024 for "Failure to report thefts, suspected diversions, significant losses of drug inventory or the inability to account for such inventory, to the Director within forty-eight (48) hours after discovery." What amount of drugs were lost? What corrective action plan was put in place along with the fine?**

The pharmacy failed to report a theft to DC Health within 48 hours as required (Title 22 DCMR Chapter 19 Pharmacies § 1901.8) which resulted in a standard fine. In this instance the theft of 1 tablet of a controlled substance was not reported for 10 days. The Pharmaceutical Control Division did not require a corrective action plan as this was an isolated incident.

12. **The Medical Society of DC submitted written testimony to the Committee regarding "fitness for duty" questions during licensing and renewals. What consideration has DC Health given to limiting questions to only current impairment to practice safely, and not past impairment and wellness treatment?**

DC Health adjusted screening questions to limit the time period of inquiries and ensure Americans with Disabilities Act (ADA) compliance approximately six years ago. DC Health will conduct a comprehensive review of all screening questions this fiscal year to ensure continued compliance and refine the questions to focus on current and recent impairment to practice safely. Evaluating

impairment that recently occurred is an important component of the application process as it ensures providers have the resources they need to provide safe and competent care in the District.

Environmental Health Administration (EHA)

13. As we discussed at the hearing, the responses show that for restaurants, DC Health conducted 3,251 inspections for 2,677 restaurants. Does that mean every restaurant was inspected at least once, or did some get inspected multiple times and others zero times?

In Fiscal Year 2024, some restaurants had one inspection, others had multiple, and some had none. Priority inspections, such as those triggered by complaints and incidents, can rapidly divert resources from routine inspections. Additionally, other priority assignments such as mobile vending and cannabis taskforces, and school and summer feeding program inspections require resources to be diverted to ensure DC Health can meet those commitments. DC Health also responded to the North Atlantic Treaty Organization Summit and the Presidential Inauguration to plan and provide food safety and defense coverage and food sample collection. These competing priorities affect the overall number of restaurants inspected at least once during the fiscal year, which for Fiscal Year 2024 totaled 2,677 restaurants.

14. In your responses, you report that 4 businesses have applied for their microenterprise home kitchen certification from DC Health and only 1 has been approved. What criteria did the other applicants not meet?

There were several reasons why the other three applicants were not approved for a Microenterprise Home Kitchen certification:

- One applicant mistakenly applied, as they were not interested in a Microenterprise Home Kitchen certification.
- One applicant was approved by DC Health and needed to schedule an inspection with the Department of Licensing and Consumer Protection (DLCP). However, that applicant did not follow up with DC Health regarding the status of their DLCP approval. DC Health has since reached out to the applicant to inquire about this status but has yet to hear back.
- One applicant was sent a request for follow-up information on their application; however, they have not responded.

DC Health will continue to work with the community to promote access to the Microenterprise Home Kitchen certification.