Q28: Please provide an update on funding allocated to Howard University's Center of Excellence in FY 2024. Please describe any final deliverables that the COEs accomplished in the final year of funding.

Response:

In 2020, Howard University (HU) was initially awarded $30.8 million for the Centers of Excellence (COE) through FY 2026. In FY 2022, unexpended funds transitioned to a non-lapsing account. As of FY24, the total award amount was adjusted to $23.4 million and encompassed non-lapsing funds only. The FY24 grant award was issued in April 2024, after Council budget approval. No local funds have been allocated for the COE's in FY 2025, however, DC Health is collaborating with Howard University to support education and outreach for the launch of the Sickle Cell Day Hospital. The following table is a financial snapshot of funding allocated to HU COE over the project period:

	Amount Awarded	**Expended Funds**	**Expended Funds**
Total Award FY21-FY24	*$23,412,351.26*		
Year 1 (FY21)	$4,199,601	$0	0%
Year 2 (FY22)	$4,200,000	$3,801,778	91%
Year 3 (FY23)	$12,558,517	$6,067,008	48%
Year 4 (FY24)	$2,454,233.26	$2,454,233.26	100%

Progress:
In FY24, the Howard COEs prioritized activities based on feasibility of completion and sustainability after FY24 funding ended. Highlights of final deliverables that the COE's accomplished in FY24, the final year of funding, include:

COE	**FY24 Final Deliverables and Accomplishments**
Behavioral Health	• 540 patients evaluated in the Open Access Behavioral Health Clinic (target: 288). • 209 patients with substance use disorders received Addiction Consult services (target: 180). • 305 participants received education on substance use disorder, behavioral health, and trauma disorder education efforts (target: 200).
Oral Health	• 3,100 Medicaid managed care patients received oral health services (target: 200). • 317 patients with special needs received oral health services as a result of the expansion of access to urgent oral health services for vulnerable and underserved populations (target: 110). • 3,900 patient visits were facilitated through the Senior Oral Health Care Initiative (target:1,900).

Sickle Cell Disease	• 1,094 patients were seen in the Sickle Cell Disease clinic (target: 934). • 262 patients received disease modifying therapy (target: 74). • Continued renovations to fully implement the Sickle Cell Disease Day Hospital with five infusion chairs, five infusion pumps, and five PCA pumps. Anticipated full launch date March 2025.
Trauma and Violence Prevention	• 422 community residents engaged in outreach initiatives (target: 200). • Convened over 20 community partners from organizations including Life Deeds DC, The Trigger Project and Johns Hopkins Center for Gun Violence Solutions for the 2024 Violence Prevention Leadership Summit. The Summit concluded with a draft roadmap and next steps to develop a strategic plan/framework that uses a public health approach to violence prevention including identification of high-risk youth, enhancing data collection and promotion of available resources.
Women's Health	• Partnered with other HU programs to host and participate in seven events during the 2024 Black Maternal Health Week. Approximately 80 individuals attended the events collectively.

Q29: In DC Health's FY 2023 Performance Oversight responses, the agency reported that it would publish a formal update on the Framework for Improving Community Health and progress toward 2026 targets in Q3 FY24. Please provide that update, and any more recent data available on the District's progress to meet the 2026 Targets.

Response:

The agency's decision to revise its reporting processes has impacted the timeline for publishing a formal update on the Framework for Improving Community Health and progress toward 2026 targets. Under the new direction, all DC Health reports are being developed to align with updated standards for clarity, consistency, and stakeholder engagement. As a result, the original plan for a Q3 FY24 update has been reevaluated to ensure it reflects these priorities and has projected a Q2 FY25 publication.

CHA Framework Objective Updates (last revised 12/2024)

<u>Access to health services</u>

Objectives	**Data Source**	**Baseline Data** (Year)	**Most Recent Data** (Year)	**2026 Target**	**Movement towards Target**
Increase percentage of District residents age 40 - 64 who reported a primary care visit within the previous 12 months • Overall • Black or African American Males	Department of Healthcare Finance (DHCF)	2021 (52%) 2021 (44%)	2023 (61%) 2023 (52%)	66% 58%	Yes
Increase the percentage of adults who visited the dentist or dental clinic within the past 12 months • Overall • Black or African American Adults	Behavioral Risk Factor Surveillance System (BRFSS)	2018 (74%) 2018 (65%)	2022 (70%) 2022 (64%)	78% 71%	No
Reduce the use of emergency department by District residents for preventable dental emergencies (/100,000 residents)	Hospital Discharge Data	2019-2020/834	2022/389	666	Yes, target exceeded

Clinical preventive services for adults

Objectives	Data Source	Baseline Data	Most Recent Data	2026 Target	Movement towards Target
Increase the percent of residents with hypertension who have achieved blood pressure control	Million Hearts database	2021 (57%)	2023 (65%)	66%	Yes
Black or African-American Residents		2021 (56%)	2023 (64%)	65%	Yes
Hispanic/Latino Residents		2021 (56%)	2023 (66%)	66%	Yes, met target
Patients in FQHCs	UDS Data	2021 (52%)	2023 (62%)	62%	Yes, met target
Reduce the proportion of adults with diabetes who have an A1c value above 9 percent	Million Hearts database	2021 (38%)	2023 (36%)	28%	Yes
Patients in FQHCs	UDS Data	2021 (36%)	2023 (32%)	27%	Yes
Increase the percent of residents with high blood cholesterol who are on (prescribed) statin therapy	Million Hearts database	2021 (70%)	2023 (81%)	79%	Yes, exceeded target
Patients in FQHCs	UDS Data	2021 (73%)	2023 (77%)	81%	Yes
Increase percent of adults receiving colorectal screening as recommended	Behavioral Risk Factor Surveillance System (BRFSS)	2020 (79%)	2022/71% **rate reflects expanded eligible age group (45-75yrs)*	86%	No, target not met
Black or African-American Males	BRFSS	2020 (71%)	2022/71% * *rate reflects expanded eligible age group (45-75yrs)*	79%	No, target not met
Patients in FQHCs	UDS Data	2021 (41%)	2022/37% * *rate reflects expanded eligible age group (45-75yrs)*	51%	No, target not met
Reduce diagnosis of colorectal cancer at distant-stage	DC Cancer Registry	2011-2015 (26%)	2020 (30.6%)	18%	No, target not met
Reduce diagnosis of breast cancer at distant-stage	DC Cancer Registry	2011-2015 (8%)	2020 (4.7%)	3%	Yes
Black or African-American Residents	DC Cancer Registry	2011-2015 (9%)	2020/* *data suppressed due to small number*	4%	Currently unknown
Increase the percent of residents 18 or older who have received an immunization against influenza	Behavioral Risk Factor Surveillance System (FluVaxView)	2020-2021 (56%)	May 2023 (60%)	65%	Yes
Black or African-American (6 months+)		2020-21 (46%)	May 2023 (49%)	58%	Yes

Maternal and reproductive health services

Objectives	Data Source	Baseline Data	Most Recent Data	2026 Target	Movement towards Target
Increase the percent of women age 18-44 who have had a preventative health visit in the past 12 months	DHCF	2021 (54%)	2022 (61%)	70%	Yes
Increase the percent of pregnant women who initiate prenatal care in the 1st trimester	Vital Statistics				
Overall		2019-2020 (68%)	2023 (68.61%)	75%	Yes
Black or African American Pregnant Women		2019-2020 (55%)	2023 (25.80%)	62%	No, target not met
Reduce severe maternal morbidity (/10,000 deliveries)	Vital Statistics				
Overall		2019 (259.2)	2023 (415.758)	233	No, target not met
Black or African American Birthing Persons		2019 (323.3)	2023 (500.360)	290	No, target not met
Reduce preterm births	Vital Statistics				
Overall		2020 (9.8%)	2023 (10.74%)	9.4%	No, target not met
Black or African American Birthing Persons		2020 (12.4%)	2023 (6.20%)	11.4%	Yes, target exceeded
Reduce births to teens age 15-19 (/1,000)	Vital Statistics				
Overall		2020 (15.6)	2023 (12.2647)	10.4	Yes
Black or African American Teens		2020 (23.3)	2023 (19.4216)	15.5	Yes
Hispanic/Latino Teens		2020 (31.7)	2023 (19.6865)	21.1	Yes, target exceeded
Reduce the percent of births that are unintended	PRAMS				
Overall		2020 (36%)	2022 (40.4%)	28%	No, target not met
Black or African American Birthing Persons		2020 (53%)	2022 (40.7%)	40%	Yes

Care of young children

Objectives	Data Source	Baseline Data	Most Recent Data	2026 Target	Movement towards Target
Increase the percent of mothers breastfeeding infants at 8 weeks of age	PRAMS				
Overall		2020 (78%)	2022 (80.0%)	85%	Yes

Black or African American Mothers		2020 (63%)	2022 (68.0%)	75%	Yes
Increase the percent of children under age 3 who are screened for development using standardized tools	DC Health's Data Collection and Reporting System (DCRS)	2019-2020 (32%)	2023 (83%)	85% (45% district-wide)	Yes
Increase the number of at-risk families with children under the age of 5 enrolled in home visiting or home visiting support services	DCRS	2023 300 families	2023 300 families	145 families	No, target not met

Preventive services for children and adolescents

Objectives	Data Source	Baseline Data	Most Recent Data	2026 Target	Movement towards Target
Reduce the number of emergency department visits for asthma in children(/ 100,000)	Hospital Discharge Data	2019 (2,452)	2022 (1,949)	1962	Yes
Increase the percent of children with up-to-date vaccinations at 2 years of age	NIS (ChildVaxView)	2020 (70%)	2022 (70%)	80%	No, has remained consistent
Increase the percent of children enrolled in Kindergarten who have received two doses of MMR vaccine	DOCIIS (Immunization Registry)	2021 (79%)	2023 (88%)	95%	Yes
Increase the percent of children age 6 months – 17 years who are vaccinated against influenza	NIS (FluVaxView)	2020-2021 (69%)	2022-23 (77%)	78%	Yes
Increase the percent of adolescents age 10-18 who have had a primary care visit in the previous 12 months	DHCF	2021 (52%)	2022 (50%)	63%	No
Reduce the percent of high school students who reported seriously considering attempting suicide	Youth Risk Behavior Surveillance System	2019 (19%)	2023 (20.4%)	15%	No

Tobacco and marijuana use

Objectives	Data Source	Baseline Data	Most Recent Data	2026 Target	Movement towards Target
Reduce smoking prevalence among adults	Behavioral Risk Factor Surveillance System	2019 (13%)	2023 (10%)	6%	Yes
Black or African-American Adults		2019 (20%)	2023 (16%)	11%	Yes
Reduce prevalence of smoking or use of smokeless tobacco among high school students	Youth Risk Behavior Surveillance System	2019 (10%)	2023 (6%)	6%	Yes, met target

Reduce prevalence of marijuana use among high school students	Youth Risk Behavior Surveillance System	2019 (29%)	2023 (21%)	23%	Yes, exceeded target

Nutrition, physical activity, and weight status

Objectives	**Data Source**	**Baseline Data**	**Most Recent Data**	**2026 Target**	**Movement towards Target**
Increase percent of adult residents who report eating vegetables at least one time per day	Behavioral Risk Factor Surveillance System	2019 (84%)	2021 (83%)	87%	No, below target
Black or African-American Adults		2017 (82%)	2021 (77%)	83%	No, target not met
Hispanic/Latino Adults		2017 (84%)	2021 (79%)	82%	No, target not met
Reduce the percent of high school students consuming soda or pop drinks one or more times per day	Youth Risk Behavior Surveillance System	2017 (17%)	2023 (16%)	10%	Yes
Black or African-American High School Students		2017 (18%)	2023 (17%)	10%	Yes
Hispanic/Latino High School Students		2017 (14%)	2023 (16%)	10%	No, target not met
Stop the increase in obesity in adults	Behavioral Risk Factor Surveillance System	2018 (25%)	2023 (24%)	25%	Yes
Black or African-American Adults		2018 (40%)	2023 (36%)	40%	Yes
Hispanic/Latino Adults		2018 (30%)	2023 (24%)	30%	Yes
Reduce prevalence of obesity in adolescents in high school	Youth Risk Behavior Surveillance System	2017 (17%)	2023 (19%)	14.5%	No, target not met
Increase participation rate of eligible pregnant women, infants, new WIC Program mothers, and children in WIC	USDA	2018 (45%)	2022 (47%)	60%	Yes
Reduce the prevalence of obesity in 2- to 4-year olds participating	USDA	2018 (13%)	2022 (13%)	10%	No, has remained consistent

Q30: Please provide an overview of DC Health's efforts to address chronic disease disparities in the District in FY 2024 and FY 2025, to date.

Response:

In the District, chronic diseases (heart disease and stroke, diabetes, cancer, chronic lung disease, and others) are a significant contributor to many of the leading causes of death and account for a majority of healthcare spending. Trends in chronic disease disproportionately impact residents with lower income and marginalized racial and ethnic communities. Through collaboration with multi-sector partners, agency initiatives focus on planning, implementing, and evaluating policy, systems, and environmental changes to prevent new cases of chronic disease; improve disease control; and address the social determinants of health that contribute to disparities.

In FY24, administrations led agency-wide efforts across four strategy areas:

(1) Epidemiology and Surveillance: collect, monitor, and report on chronic disease indicators through surveillance systems including Vital Records birth and death data, Behavioral Risk Factor Surveillance System (BRFSS) data, Emergency Medical Service (EMS) encounter and hospital discharge data, and health system chronic disease management data. FY24 activities included:
- DC Health produced heat maps, identifying 16 census tracts with a high blood pressure prevalence greater than 53% in Black residents age 40+.
- DC Health designed an internal Chronic Disease Data Dashboard with a set of key indicators of chronic disease and their risk factors including diabetes, hypertension, heart disease, stroke, obesity, asthma, and subjective cognitive decline to identify high risk populations, monitor disease trends, and assess progress and guide programming and policy decision-making.
- DC Health published an updated set of Cancer Fact sheets with the latest incidence and mortality data from 2020 across breast, cervical, colorectal, lung, pancreatic, and prostate cancer.

(2) Health Care System Interventions: lead health systems and clinic-level continuous quality improvement to improve identification and treatment of patients with and at risk for chronic disease. FY24 activities included:
- DC Health led a monthly Heart Disease and Stroke Learning Collaborative with DCPCA and eight (8) health center partners and designed a data quality report card which will be used in FY25 to guide technical assistance and peer-learning during collaborative sessions.
- DC Health administered and analyzed electronic health record (EHR) assessments across 8 heart disease and stroke grantee health centers to establish a baseline of gaps in technological capacity to optimize use of EHRs analytical and population health management functions to 1) streamline team-based care and 2) identify and monitor patients at risk for- or living- with multiple chronic conditions. Results will be used in FY25 to provide tailored technical assistance to each health center partner.

- DC Health also administered a Diabetes Landscape Assessment across 11 diabetes prevention and management program providers to understand barriers to access and high-quality service delivery. DC Health used results to inform program strategic planning and provide technical assistance to improve program operations and billing, marketing and referral processes, and cultural responsiveness of programming.

(3) Community & Clinical Linkages: build and sustain referral systems to link community-based health promotion and disease self-management resources to health systems and providers. FY24 activities included:
- DC Health began development of a 4-year Strategic Plan for the Heart Disease and Stroke Learning Collaborative to guide strategies implemented by 37 health system and community partners across 1) collaboration between clinical and community-based organizations to strengthen referral making, 2) improving data sharing across care providers and tracking patient progress throughout the continuum of care, and 3) strengthening primary care and social need provider workforce. DC Health aims to finalize the Strategic Plan in spring 2025.
- DC Health supported all eight heart disease and stroke program grantees to adopt LinkU from external use of the platform to integration with health center electronic health records (EHR). Through LinkU, providers can make closed-loop referrals to social needs services and chronic-disease self-management programs.

(4) Improving Health Literacy: enhance organizational and individual ability to find, understand, and use health information. FY24 activities included:
- DC Health developed a multimedia Go-Go DC campaign promoting healthy eating, physical activity, healthy sleep, smoking cessation and regular health care check-ups. Campaign ads featured local actors and Go-Go, a genre of funk music with roots in the District. Messaging directs viewers to Livingwell.dc.gov. The campaign launched in winter 2024.
- DC Health began planning to update content on Livingwell.dc.gov, a health promotion website for residents, community organizations, and health care providers to easily access actionable health promotion information, tips, and resources to support healthy living and chronic disease prevention. DC Health's Community Health Administration, Office of Communications and Community Relations, and Office of Health Equity collaborated to update content to include actionable information for residents looking to adopt healthier habits across healthy eating, exercising, quitting smoking, going to the doctor, and healthy sleep.

In FY25, the agency will focus on:

- Finalizing an update and publish a Chronic Disease Data dashboard along with a set of chronic disease fact sheets across diabetes, heart disease, stroke, obesity, asthma, chronic lung disease, and Alzheimer's disease and dementia.

- Leading an agency strategic initiative to improve hypertension control among the group with poorest outcomes through enhanced data surveillance, targeted community outreach, and enhanced clinical care.
- Establishing a Pharmacy Wellness Hub to expand access to diabetes, heart disease, and stroke prevention and management services in independent pharmacy settings.
- Leading a pilot to integrate hypertension management services into colorectal cancer screening and navigation at two health centers to expand navigation services and provide social resources and clinical adherence support to colorectal cancer screening-eligible patients with persistent uncontrolled hypertension.

Q31: Please provide an overview of DC Health's efforts to implement the Cancer Action Plan in FY 2024 and FY 2025, to date, including any updated metrics indicating progress on the 2026 goals.

Response:

Cancer is the second leading cause of death in the District and significantly impacts the social and economic well-being of communities. Disparities persist with the burden of cancer disproportionately impacting communities with lower income and marginalized racial and ethnic communities. The Cancer Control Plan is developed every five years to address disparities in cancer screening, incidence, and mortality. In FY24, DC Health prioritized elements of the plan relating to clinical care best practices, evidence-based community interventions, and modifiable risk factors including healthy eating, physical activity, alcohol and tobacco. An overview of the goals for which DC Health focused its efforts in FY24 and FY25 (to date) is included below. Comments and strategies to address trends that are not moving in the desired direction are also included.

GOAL 1: Improve Nutrition & Physical Activity among all DC Residents

		Baseline (2019)	Current	Target (2026)	Moving toward target (Y/N)
1.1	Increase fruit consumption among adults to one or more times per day	64.4%	67.2% (2021)	68.7%	**Y**
1.2	Increase vegetable consumption among adults to one or more times per day	83.5%	83.4% (2021)	87.5%	**N, target not met**
	Comment: Most recent data available reflect 2021 during the COVID-19 pandemic when household dietary patterns were significantly impacted due to economic and food supply chain factors and may have contributed to a slight decrease in self-reported vegetable consumption. **Strategy**: Q34, 35, 36, and 37 share strategies being led by DC Health and partners to increase access and consumption of vegetables across communities.				
1.4	Stop the increase in the proportion of adults who are considered obese	24%	24% (2023)	24%	**Y, target met**
1.5	Increase the percentage of adults reporting physical activity within the previous 30 days other than their regular job	81%	84.8% (2023)	85.6%	**Y**
1.6	Decrease percentage of high schoolers who are obese	17.1%	18.8% (2023)	13.5%	**N, target not met**

		Baseline (2019)	Current	Target (2026)	Moving toward target (Y/N)
	Strategy: DC Health's SNAP-Ed team is working to expand programming across high schools with DC Public Schools and DC Public Charter Schools.				
1.7	Increase the percentage of high schoolers who report physical activity at least 60 minutes per day on five or more of the past seven days	27.9%	34.6% (2023)	32.6%	**Y, exceeded target**

GOAL 2: Reduce Tobacco Use Prevalence and Consumption

		Baseline (2019)	Current	Target (2026)	Moving toward target (Y/N)
2.1	Decrease the percentage of adults who are current smokers.	12.7%	9.8% (2023)	8.3%	**Y**
2.2.1	Decrease percentage of Black/African American adults who smoke	20.4%	15.6% (2023)	14.3	**Y**
2.2.2	Decrease percentage of Hispanic adults who smoke	7.8%	11.1 (2022)	5%	**N, target not met**
2.3	Decrease percentage of current smokers among middle schoolers	2.5%	1.3% (2021)	1.5%	**Y, exceeded target**
2.4	Decrease the percentage of middle school students who report current use of "e-cigarettes" (vaping)	5.3%	6.2% (2023)	3%	**N, target not met**
	Strategy: -DC Health is utilizing JUUL settlement funding to supplement federal and local funds and lead a portfolio of initiatives to reduce access and use of vaping products among youth in the District. - DC Health is collaborating with DCPS to support health education initiatives in schools to prevent and empower youth to quit vaping. -DC Health will launch a counter marketing campaign including social media and featuring DC youth influencers to prevent and empower youth to quit vaping. -DC Health is collaborating with Department of Behavioral Health and Department of Licensing and Consumer Protection to increase retail enforcement of the Tobacco 21 and Flavors laws.				
2.5	Decrease the percentage of high school students who report use of "e-cigarettes" (vaping)	13%	9.6% (2023)	9.8%	**Y, exceeded target**

GOAL 4: Prevent HPV Infections

		Baseline (2019)	Current (2021)	Target (2026)	Moving toward

					target (Y/N)
4	Increase up-to-date vaccination coverage for the human papillomavirus (HPV) of adolescents aged 13 to 17 years				
	Female	73%	81%	77.3%	**Y exceeded target**
	Male	78%	78%	81.8%	**N, target not met**
	Comment: In 2020, HPV vaccine coverage among male adolescents dropped to 71% and increased to 78% in 2021, mirroring national trends. **Strategy**: - DC Health is leading education campaigns paired with adolescent trainings to increase community demand and enhance access to vaccination services. - DC Health is providing technical assistance to providers to increase utilization of assessment and feedback (IQIP) interventions to identify missed opportunities for vaccination. - DC Health is providing technical assistance to providers to utilize practice-focused strategies, including clinic-based client education, client reminder and recall systems, provider reminders, and standing orders, to increase HPV vaccination rates. - DC Health is collaborating with school-based health centers and DC Health Youth Advisory Council to promote vaccinations.				

GOAL 6. Reduce Late-Stage Diagnosis of Cancer for Which Screening is Available

		Baseline (2018)	Current	Target (2026)	Moving toward target (Y/N)
6.1	Increase the percentage of women aged 50-74 who have had a mammogram within the past two years	79.9%	77.4% (2022)	84.8%	**N, target not met**
	Comment: Health care delivery was significantly disrupted and cancer screening services decreased nationwide and in the District during the COVID-19 pandemic. Health systems continue to be affected by workforce shortage (radiologists, technicians, medical assistants etc.). **Strategy**: -DC Health is providing funds to cover the cost of screening and diagnostic tests for uninsured and underinsured residents. - DC Health is supporting funding for patient navigators to help patients complete screening and follow-up tests by addressing social determinant of health barriers. - DC Health is working with health system partners to enhance clinical workflows and electronic medical record (EMR) systems to effectively identify and refer those due or overdue for breast cancer screening. - DC Health is collaborating with health system partners to provide educational webinars for clinical staff on screening guidelines and best practices.				
6.2	Decrease the proportion of breast cancer cases diagnosed at distant stage among Black/African American women Female	9.5%	Data suppressed as few cases, and following	8.4%	**Y**

		Baseline (2018)		Current	Target (2026)	Moving toward target (Y/N)
				CDC/NCI suppression rules		
6.3	Increase the percentage of women aged 21-65 who have had a Pap test in the past three years	81.3%		79.2% (2020)	82.9%	Due to trend break, will need additional years to determine
	Comments: Health care delivery was significantly disrupted and cancer screening services decreased nationwide and in the District during the COVID-19 pandemic. Health systems continue to be affected by workforce shortage (radiologists, technicians, medical assistants etc.). **Strategy**: -DC Health is providing funds for uninsured and underinsured residents to complete cervical cancer screening and diagnostic tests, increasing access to screening and eliminating the burden of financial cost. - DC Health is working with health care partners to enhance clinical workflows and EMR systems to effectively identify those due or overdue for cervical cancer screening and offer PAP tests at the time of their medical visit. -DC Health is working with health care partners to lead educational webinars for clinical staff on screening guidelines and best practices.					
6.5	Increase percentage of adults eligible for colorectal cancer screening who have met the USPSTF recommendation for colorectal cancer (CRC) screening.	73.8 (2018)	(78.6% (2020)	73.8* (2022) *(screening age 50-75)*	82.9% (Target)	**N, Below Target**
	Comments: *The U.S. Preventive Services Task Force issued a new recommendation that colorectal cancer screening for people at average risk should be screened starting at 45 years – expanding the screening eligibility from 50-75 to 45-75 years. The CRC screening rate for 2022 is based on adults aged **50 to 75** years. Using the updated guidelines for adults to be screened between ages 45 to 75 years, 70.3% were screening for colorectal cancer screening in 2022. The increase in CRC screening rate in 2020 may be attributed to health centers and hospitals using innovative strategies, such as leveraging COVID vaccination appointments and events to provide CRC stool-based test kits to patients. In 2022, the decrease in CRC screening rate may be attributed to the significant disruption in health care delivery and cancer screening services due to ongoing workforce shortages (radiologists, technicians, medical assistants etc.). In addition, the new U.S. Preventive Services Task Force recommendation that colorectal cancer screening for people at average risk should be screened starting at 45 years expanded screening eligibility from 50-75 to 45-75 years. **Strategy**: -DC Health is providing funds for uninsured and underinsured residents to complete colonoscopy tests. -DC Health is providing training to clinical staff to educate and create awareness on the new guidelines. -DC Health is partnering with community organizations on outreach and awareness campaigns to educate the public on new guidelines. - DC Health is working with health systems to enhance clinical workflows and EMR systems to effectively identify and refer those due or overdue for breast cancer screening. - DC Health is providing funds to health care partners for patient navigators to help patients complete screening and follow-up tests by addressing SDOH barriers and linking to resources. -DC Health is providing chaperone rides to address transportation barriers to complete colonoscopies.					

		Baseline (2018)	Current	Target (2026)	Moving toward target (Y/N)
6.6	Decrease the proportion of colorectal cancer cases diagnosed at distant stage	25.8%	30.6% (2020)	21.6%	**N, target not met**
	Comment: Year to year cancer case trends fluctuate especially for a small population like the District. We need assess more years to observe more accurate trend changes. COVID-19 pandemic biased diagnosis toward distant stage. Colonoscopy services were restricted to patients who have symptoms during the pandemic. This could have led to increased detection and reporting of distant stage diagnosis. **Strategy:** -DC Health is providing funds for uninsured and underinsured residents to complete colonoscopy tests. -DC Health is providing training to clinical staff to educate and create awareness on the new guidelines. -DC Health is partnering with community organizations on outreach and awareness campaigns to educate the public on new guidelines. - DC Health is working with health systems to enhance clinical workflows and EMR systems to effectively identify and refer those due or overdue for breast cancer screening. - DC Health is providing funds to health care partners for patient navigators to help patients complete screening and follow-up tests by addressing SDOH barriers and linking to resources. -DC Health is providing chaperone rides to address barrier of transportation to complete colonoscopies.				
6.7	Increase percentage of adults age 50-80 who meet the eligibility requirements for screening and have been screened for Lung Cancer	6.9% (2022)	Crude prevalence numbers are low to report, Changed recommended age from 55-80 to 50-80.	7.6%	Will determine with additional years of data
	Comment: The recommended age for lung cancer screening was lowered from 55 to 50 years old in March 2021 by the U.S. Preventative Services Taskforce (USPSTF), thus 2022 data are used as the new baseline. More recent data is not available at this time.				
6.8	Decrease the proportion of lung cancer cases diagnosed at distant stage	45.5 %	49.2% (2022)	40.6%	**N, target not met**
	Comment: Year to year cancer case trends fluctuate, especially for a small population like the District. We will need to address more years to observe more accurate trend changes. In addition, the COVID-19 pandemic biased diagnosis toward distant stage. Screening and low-dose computed tomography (CT) screening services were restricted to patients who were showing symptoms during the pandemic. This could have led to increased detection and reporting of distant stage diagnosis. **Strategy**: - DC Health is partnering with health systems to enhance the EMR to systematically screen for smoking history that will enable clinicians identify eligible patients and refer them to lung cancer screening. -DC Health is collaborating with health care partners to educate clinicians on new guidelines through a series of webinars through a partnership with MedStar Georgetown Cancer Institute at Washington Hospital Center. - DC Health is collaborating with health care partners to educate the community on lung cancer screening guidelines by partnering with national organizations.				
6.9	Decrease the rate (per 100,0000) prostate cancer cases	135.4	111.8 (2020)	121.9	**Y, exceed target**

Q32: Please provide the recommendations DC Health submitted to DHCF regarding the Medicaid 1115 Waiver to address health-related social needs and structural determinants of health for District residents enrolled in Medicaid.

Response:

The following recommendations were developed and presented to DHCF for review and consideration:

1. **Home delivered groceries for residents with Type II Diabetes**.
   In the District, residents with low incomes are disproportionately impacted by high-cost, diet-related diseases such as diabetes and obesity. Addressing socioeconomic and transportation barriers to purchasing healthy foods is essential to promoting health equity and connecting residents with healthy, affordable foods to support diabetes self-management. DC Health proposed providing a $75 monthly incentive to residents with type 2 diabetes to purchase healthy, diabetes-friendly foods on a custom-built online grocery platform such as Instacart for home delivery or store pick-up.

2. **Food access to support residents re-entering the community**.
   In the District, approximately 5,000-6,000 persons are incarcerated annually. These incarcerated persons are disproportionately Black residents (89% incarcerated persons versus 44% of the general DC population are Black). Formerly incarcerated persons have a much higher rate of chronic and diet related diseases than the general public, even when adjusted for sociodemographic factors. DC Health proposed the creation of a screening tool to match persons leaving incarceration to nutrition and food assistance programs, and then connect returning citizens to a community health worker to help navigate enrollment processes. DC Health also recommended providing returning citizens with $40 monthly for six months following release to spend on fresh fruits and vegetables at grocery stores, and providing home delivered meals and groceries to returning citizens to reduce the burden of preparing meals during their time of reentry.

3. **Loan repayment for healthcare workers to address the workforce shortage**.
   DC Health administers the state Health Professional Loan Repayment Program (HPLRP), providing loan repayment to healthcare providers serving in Health Professional Shortage Areas and serving high volumes of residents who are uninsured or Medicaid beneficiaries. HPLRP is federally and locally funded, so DC Health proposed using local funds in a 30/70 match to contract primary and behavioral health care providers as each represent the greatest shortage and a critical public health need.

4. **Farmers market benefits for residents with chronic diseases**.
   Increasing access to healthy food can lead to improved health outcomes for persons with high-cost chronic diseases. Produce Plus is a *locally* funded fruit and vegetable incentive program that provides participants with $40 each month from June through November to spend on local produce at farmers' markets. Produce Plus is open to District residents who

are eligible for one or more of the following programs: Medicaid, TANF, SNAP, WIC, SSI Disability, and/or Grocery Plus (CSFP). In FY23, more than half of participants identified as participating in Medicaid. Produce Plus is a proven method to increase food access to healthy, affordable, and fresh produce with 93% of enrolled participants redeeming benefits and spending an average of over $160 per season during the 2022 season (June 2022-November 2022). DC Health proposed to leverage the local investment to expand the Produce Plus program to include all DC Medicaid participants, with an emphasis on persons with Type II Diabetes and heart disease.

5. **Reimbursement of National Diabetes Prevention Program (DPP) services**.
DC Health provides awareness, technical support and funding for DPP programs across the District to implement evidence-based lifestyle change programs focusing on screening, enrollment, retention, and sustainability to prevent the onset of diabetes, especially in vulnerable populations. The program has proven effective health outcomes for participants, as studies showed participants were one third less likely to develop type 2 diabetes a decade later. DC Health proposed to allow all District Managed Care Organizations to cover the cost of DPP, for all eligible beneficiaries to allow increased opportunities for beneficiaries to utilize the program.

6. **Reimbursement of Diabetes Self-Management Education and Services (DSMES**).
DC Health provides awareness, technical support and funding for DSMES programs across the District to implement evidence-based programs that support persons with diabetes navigate their treatment goals and decisions and improve health outcomes. DC Health proposed to allow all District Managed Care Organizations to cover the cost of DSMES for beneficiaries to increase access.

7. **Increase Value Based Payments.**
Building off of existing contract requirements with MCOs that require greater percentage of payments to be value based, DC Health proposed an expansion of milestones for incentive/value-based payments, with requirements to cover key settings not traditionally targeted to transition from process measurement towards outcome measurement over a 5 year period (e.g. outpatient primary care, inpatient, outpatient specialty).

8. **Develop healthcare provider-led Accountable Care Entities (AEs) to coordinate whole person care**.
DC Health proposed provider-led Accountable Care Entities (AE) (similar to ACOs) , which would have to register with DHCF to contract with MCOs. AEs coordinate teams of providers and other professionals who address whole person care (including health related social needs), including screening and referral for social needs, and developing/leveraging community partnerships to address needs. AEs accept more downside risk as the years progress but also receive a greater share of incentive/savings dollars as years progress.

9. **Community paramedicine and mobile integrated healthcare expansion**.

DC Health proposed to enable community paramedicine (EMS clinicians only) and mobile integrated health (combination of EMS clinicians and other licensed healthcare professionals) activities within the city for eligible Medicaid enrollees, utilizing the existing EMS infrastructure. These teams would have the capacity to avert 911 activations, respond to calls for routine service, assist with one-time home visits, initiate medication for opioid use disorder (MOUD), and connect people to care. Similar models have been implemented in other states to support these efforts.

10. **Fund data systems serving Medicaid beneficiaries**.
The Immunization Registry, DOCIIS 2.0, serves all residents of the District, including Medicaid beneficiaries—it is key to population health and disease prevention. The data system serves healthcare providers, managed care organizations, schools, and other stakeholders. The data system itself is costly and includes annual maintenance fees and staff support. The cost per resident is $2.14. DC Health proposed cost-sharing with Medicaid at $2 per enrollee for approximately 300,000 Medicaid enrollees per year, totaling $600,000 per year to support sustainability. Similarly, by supporting DOCIIS, other data systems such as School Health Management and Immunization Compliance Portal would benefit in terms of sustainability.

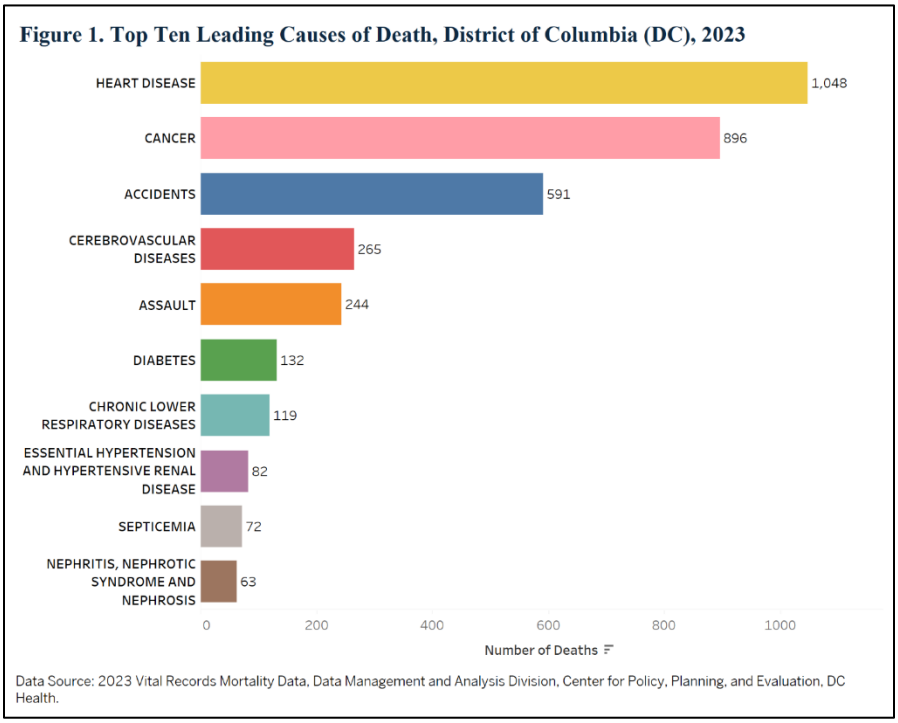
11. **Registered Dietitians as an eligible provider type for Medical Nutrition Therapy**.
Registered Dietitian Nutritionists are nutrition professionals with nationally recognized credentials obtained after meeting certain educational and experiential standards who provide medical nutrition therapy and nutrition counseling. Medical Nutrition Therapy is an unrestricted, covered benefit by DC Medicaid therefore any Medicaid provider can be reimbursed for the service. RDNs are not DC Medicaid providers, therefore they are unable to be reimbursed for providing medical nutrition therapy. Medical Nutrition Therapy has been proven to improve health outcomes, especially for people with chronic diseases. DC Health proposed that Registered Dietitians should be approved as Medicaid Providers to increase access to medical nutrition therapy among beneficiaries.

12. **Community Health Workers as an eligible provider type for existing billable coordination services.**
Community Health Workers (CHW) is an umbrella term for a frontline public health worker who is a trusted member of and/or has a unique understanding of the community they serve. DC Health currently provides grant funding to support community-based organizations who utilize CHWs to improve health outcomes among people with HIV. DC Health proposed an expansion of Medicaid reimbursements to include CHW services for people living with one or more chronic diseases or with significant need (e.g. inpatient discharge and vulnerable). Research has shown that including CHWs in wrap-around services for clients improves health outcomes and reduces long-term (Medicaid) healthcare costs associated with disease management, particularly in underserved communities. The expansion of reimbursable CHW services would allow an increase in care coordination for those with urgent, short-term needs. Additionally, it would be a cost-effective strategy in a more comprehensive and patient-centered approach to healthcare.

13. **Reimbursement for Durable Medical Equipment**.
Some of the District's most at-risk populations are those who are living with electricity-dependent durable medical equipment. While DC Health and the District works extensively to encourage readiness behaviors among this population, they are often limited by fiscal resources and capacity to do so. DC Health proposed to support beneficiaries with electricity-dependent durable medical equipment to secure portable, rechargeable power stations (battery packs) that would be sufficient to run their medical equipment for up to 24 or 48 hours in the event of an emergency. This would give them additional time on top of any pre-existing preparedness activities and give our utilities organizations additional time to restore power to affected persons.

Q33: Provide the most up-to-date top ten causes of death in the District, including number of deaths and deaths per 100,000 people. Please describe any disparities in causes of death related to race, ethnicity, gender, or LGBTQ status.

Response:



For the first time since the onset of the COVID-19 pandemic in 2020, COVID-19 did not rank among the top 10 causes of death in the District, ranking at #11 in 2023. A total of 4,922 deaths were recorded among District residents in 2023, with heart disease, cancer, and accidents accounting for nearly 62% of these deaths (see Table 1). Heart disease was the leading cause of death for the fifth consecutive year (2019-2023), contributing to 25.5% of resident deaths in 2023. Cancer remained the second leading cause over this five-year period, accounting for 21.8% of resident deaths. Accidents (unintentional injuries) ranked third, accounting for 14.4% of resident deaths. For the first time since the pandemic began, Nephritis, Nephrotic Syndrome, and Nephrosis entered the top 10 leading causes, ranking 10th and contributing to 1.5% of deaths among District residents.

Table 1. Top Ten Leading Causes of Death in the District of Columbia and United States

DC (2023)					US (2023)			
Rank	**Cause of death[1]**	**# of Deaths**	**Crude Rate**	**% of all deaths**	**Cause of death**	**# of Deaths**	**Crude Rate**	**% of all deaths**
1	Diseases of heart	1,048	154.4	25.5	Diseases of heart	680,981	203.3	22.0
2	Malignant neoplasms	896	132.0	21.8	Malignant neoplasms	613,352	183.1	19.8
3	Accidents (unintentional injuries)	591	87.0	14.4	Accidents (unintentional injuries)	222,698	66.5	7.2
4	Cerebrovascular diseases	265	39.0	6.5	Cerebrovascular diseases	162,639	48.6	5.3
5	Assault (homicide)	244	35.9	5.9	Chronic lower respiratory diseases	145,357	43.4	4.7
6	Diabetes mellitus	132	19.4	3.2	Alzheimer disease	114,034	34.0	3.7
7	Chronic lower respiratory diseases	119	17.5	2.9	Diabetes mellitus	95,190	28.4	3.1
8	Essential hypertension and hypertensive renal disease	82	12.1	2.0	Nephritis, nephrotic syndrome and nephrosis	55,253	16.5	1.8
9	Septicemia	72	10.6	1.8	Chronic liver disease and cirrhosis	52,222	15.6	1.7
10	Nephritis, nephrotic syndrome, and nephrosis	63	9.3	1.5	COVID-19	49,316	14.9	1.6

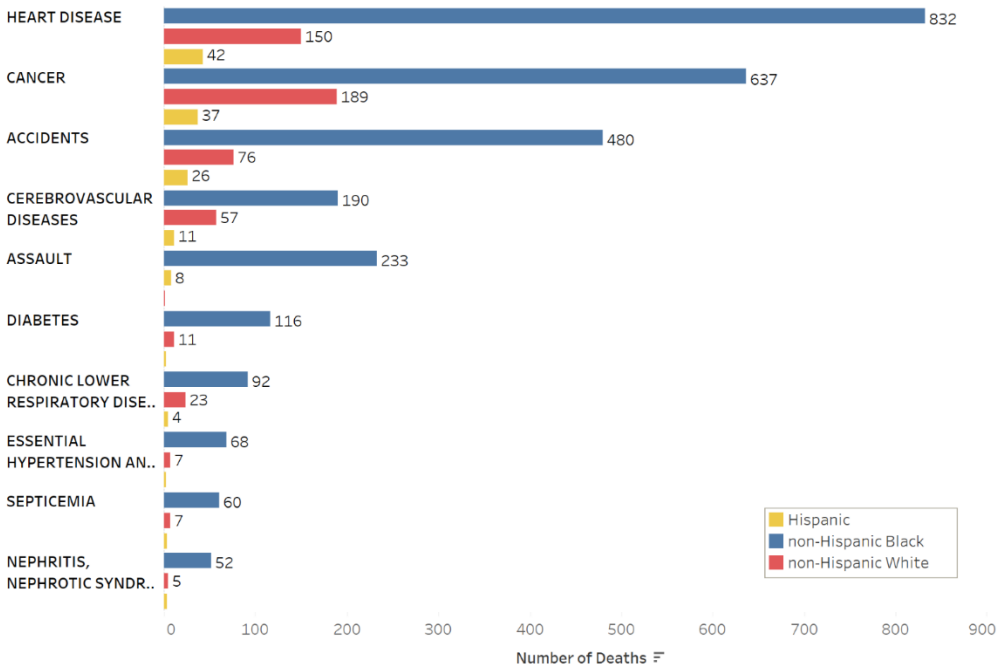
Data Sources: 2023 DC Mortality File, Vital Records Division, Center for Policy, Planning and Evaluation, D.C. Department of Health; Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 2018-2022 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[1] ICD-10 codes for causes: Diseases of heart (heart disease) (I00-I09,I11,I13,I20-I51); Malignant neoplasms (cancer) (C00-C97); Accidents (unintentional injuries) (V01-X59,Y85-Y86); Cerebrovascular diseases (stroke) (I60-I69); Diabetes mellitus (diabetes) (E10-E14); Chronic lower respiratory diseases (J40-J47); Alzheimer's disease (G30); Assault (homicide) (X85-Y09,Y87.1,U01-U02); Influenza and pneumonia (J09-J18); Essential hypertension and hypertensive renal disease (hypertension) (I10,I12,I15); Nephritis, nephrotic syndrome and nephrosis (kidney disease) (N00-N07,N17-N19,N25-N27); COVID-19 (U07.1).

[2] *Per 100,000 population based on populations enumerated as of July 1 of the following year.*
[3] *Per 100,000 U.S. standard population.*

In 2023, there were significant disparities in heart disease deaths by race and ethnicity (Figure 2). Heart disease deaths among non-Hispanic Black residents were 5.5 times higher than among non-Hispanic White residents. Cancer deaths among non-Hispanic Black residents were 3.4 times higher than among non-Hispanic White and 17.2 times higher than Hispanic residents. Accidents among non-Hispanic Black residents were 6.3 times higher than among non-Hispanic Whites and 18.5 times higher than Hispanic peers.

Figure 2. Top Ten Leading Causes of Death by Race and Ethnicity, District of Columbia, 2023

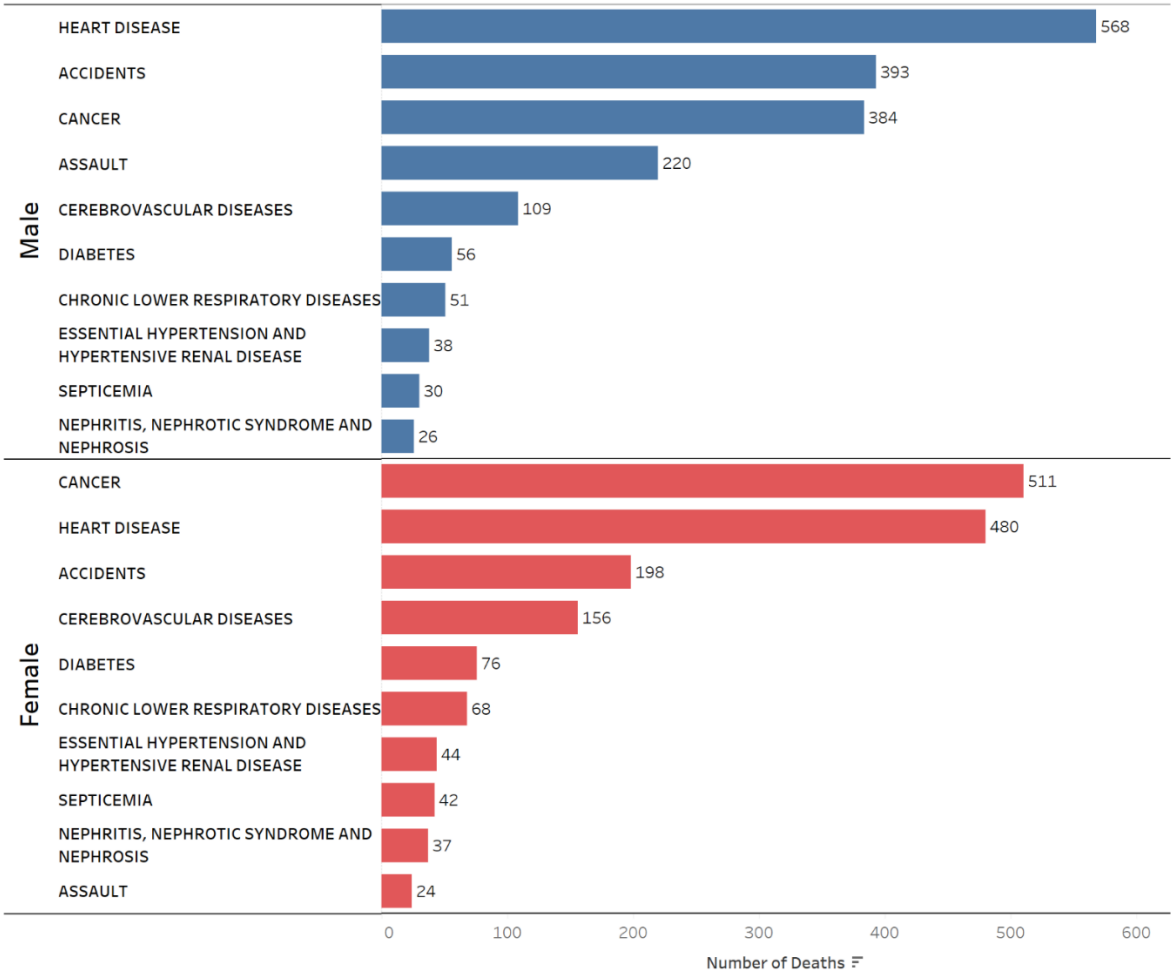


Data Source: 2023 Vital Records Mortality Data, Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Health.

In 2023, the leading causes of death for males in the District of Columbia were Heart Disease, Accidents, and Cancer, while for females, the top causes were Cancer, Heart Disease, and Accidents (Figure 3). Heart disease was the leading cause of death among males, responsible for 26.1% of male resident deaths. For females, heart disease ranked second, accounting for 24.9% of female resident deaths. Accidents were the second leading cause of death among males, making up 18.0% of male resident deaths, while they ranked third for females, accounting for 10.3% of female deaths. Cancer was the primary cause of death among females, responsible for 26.5% of female resident deaths, whereas it ranked third for males, contributing to 17.3% of male resident deaths. Assaults ranked as the fourth leading cause of death for men (10.1% male

resident deaths), but it was much lower for women (1.2% female resident deaths), ranking at 10th among the top causes of death across the District.

Figure 3. DC Top Ten Leading Causes of Death Disaggregated by Sex, District of Columbia, 2023



Data Source: 2023 Vital Records Mortality Data, Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Health.

Q34: Please provide the following information for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC):

a. **An updated list of all certified WIC Program Sites, broken down by Ward;**
b. **An updated list and map of all certified retailers that accept DC WIC, broken down by Ward, indicating any stores added or removed in FY 2024 and FY 2025, to date;**
c. **The number and percentage of eligible District residents, including adults and children, who were enrolled and participating in WIC in FYs 2022, 2023, and 2024;**
d. **What has DC Health observed as barriers to WIC enrollment in the District? What are additional strategies the District could take to increase enrollment?**

Response:

In FY 2024, the DC WIC program expanded services in Ward 8 to help meet the needs of DC residents. With support from a USDA WIC Infrastructure Grant, the DC WIC Program supported Community of Hope WIC to open a 3rd clinic at Stanton Commons in Ward 8 and Children's National Hospital WIC open a 4th clinic at THEARC. In addition, the other grantees (Mary's Center and Unity Health Care) increased their operating hours to include weekends to support school-aged children and working families to access WIC services.

a. Updated List of All Certified WIC Program Sites By Ward

Ward 1		
Children's at Shaw 641 S Street, NW Washington, DC 202-476-5594 Mon.-Fri. 8:00 a.m.-4:30 p.m.	**Unity Health Care Upper Cardozo** 3020 14th St., NW Washington, DC 20009 202-938-3688 Mon.-Fri. 8:30 a.m.-5:00 p.m.	**Mary's Center at Ontario Rd.** 2333 Ontario Rd. NW Washington, DC 20009 202-232-6679 Mon.-Fri. 8:30 a.m.-5:00 p.m.
Ward 2 and 3		
n/a		
Ward 4		
Mary's Center at Georgia Avenue 3912 Georgia Avenue, NW Washington, DC 20011 202-232-6679 Mon.-Fri. 8:30 a.m.-5:00 p.m.		
Ward 5		
Mary's Center at Brentwood 1060 Brentwood Road, NE 20018 Washington, DC 20018 202-232-6679 Thurs. 8:30 a.m.-5:00 p.m.	**Mary's Center at Ft. Totten** 100 Gallatin St. NE 20018 Washington, DC 20018 202-232-6679 Tues. and Thurs. 8:30 a.m.-5:00 p.m.	**Community of Hope Family Health and Birth Center** 2120 Bladensburg Rd. NE Washington, DC. 20018 202-470-3074 Mon.-Fri. 8:30 a.m.-4:30 p.m.

Ward 6	
n/a	
Ward 7	
Unity Health Care Parkside 765 Kenilworth Terrace, NE Washington, DC 20019 202-938-3688 Mon.-Fri. 8:30 a.m.-5:00 p.m.	**Unity Health Care East of the River** 123 45th St. NE, 20019 Washington, DC 20019 202-938-3688 Mon.-Fri. 8:30 a.m.-5:00 p.m.
Ward 8	
Unity Health Care Anacostia Satellite 1500 Galen Street, SE Washington DC 20020 202-938-3688 Mon.-Fri. 8:30 a.m.-5:00 p.m.	**Children's at THEARC** 1801 Mississippi Ave SE Washington, DC 20020 202-791-1617 Fridays 8:00am-4:30pm
Children's at Martin Luther King Jr. Avenue, SE "The Big Chair" 2101 MLK, Jr. Avenue, SE 20020 Washington, DC 20020 202-476-6994 Mon.-Fri. 8:00 a.m.-4:30 p.m.	**Community of Hope at Conway** 4 Atlantic St. SW Washington, DC 20032 202.470.3074 Mondays 8:30 am to 4:30 pm
Community of Hope at Stanton Commons 2375 Elvans Road SE Washington DC 20020. 202-470-3074 Wednesdays 8:30 am to 4:30 pm	

b. Updated list and map of all certified retailers in the district that accept WIC, broken down by Ward, indicating which new stores were added in FY 2024.

In FY 2024, DC did not approve any new vendors. All vendors operate under a three-year agreement cycle, with FY 2023 starting the current period. In FY 2024, no vendors were removed from the program. In FY 2025, one vendor, Newton Food Mart was removed at the end of Q1. DC Health provided extensive technical assistance, but Newton Food Mart was not able to meet requirements to remain authorized.
Currently there are 53 authorized vendors in DC, categorized as follows:

- 9 Small Vendors (<10,000 square feet, at least $5,000 in WIC sales)
- 9 Medium Vendors (10-20,000 square feet, at least $20,000 in WIC sales)
- 32 Large Vendors (>20,000 square feet, at least $100,000 in WIC sales)
- 3 Independent Pharmacies (at least $1,000 in WIC sales)

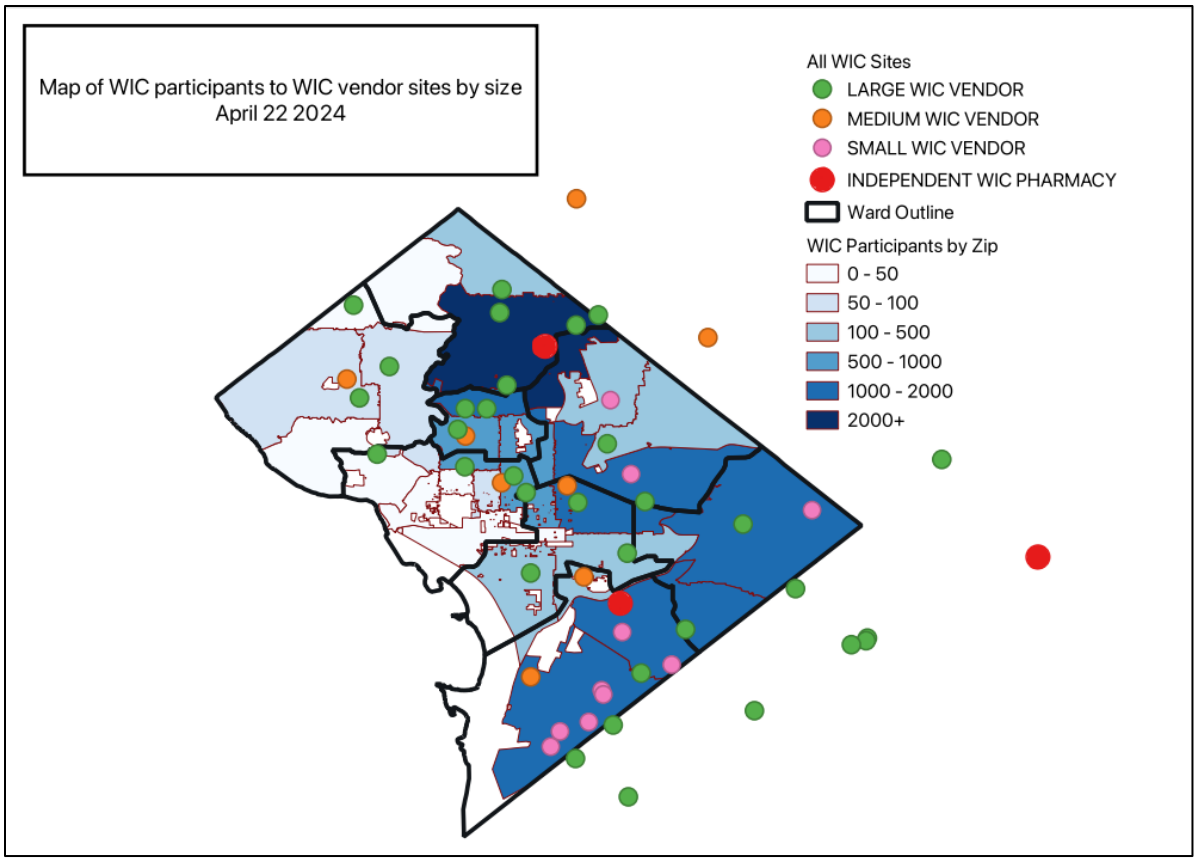
Northeast DC		
Store Name	**Address**	**Ward**
A-1 Grocery	615 Division Avenue NE	7

Circle 7	1211 Mount Olivet Road NE	5
Safeway	1601 Maryland Avenue NE	5
	322 40th Street NE	7
Giant Foods	1050 Brentwood Road NE	5
	300 H Street NE	6
Harris Teeter	1201 First Street NE	6
Wal-Mart Supercenters	310 Riggs Road NE	4
Northwest DC		
Store Name	**Address**	**Ward**
Wegmans	41 Ridge Square NW	3
Safeway	1701 Corcoran Street NW	2
	1747 Columbia Road NW	1
	3830 Georgia Avenue NW	4
	6500 Piney Branch Road NW	4
	5545 Connecticut Avenue NW	3
	1855 Wisconsin Avenue NW	2
	490 L Street NW	6
Giant Foods	1345 Park Road NW	1
	4303 Connecticut Avenue NW	3
	1400 7th Street NW	2
	3336 Wisconsin Avenue NW	3
Harris Teeter	1631 Kalorama Road NW	1
New Hampshire Medical Supply *Provides home delivery*	5005 New Hampshire Avenue NW	4
Wal-Mart Supercenters	5929 Georgia Avenue NW	4
Capitol Super Market	1231 11th Street NW	2
Bestworld Super Market	3178 Mount Pleasant Street NW	1

Southwest DC		
Store Name	**Address**	**Ward**
Elmira Market	4401 S Capitol Street SW	8
Safeway	1101 4th Street SW	6
Southeast DC		
Store Name	**Address**	**Ward**
Bolling Air Force Base ***Military Families Only***	185 Chappie James Boulevard SE	8

Chesapeake Big Market	601 Chesapeake Street SE	8
Fort Drum Market	4686 Martin Luther King Jr Avenue SE	8
Giant Foods	1535 Alabama Avenue SE	8
Grubbs SE Pharmacy & Mini-Mart	1800 Martin Luther King Jr Avenue SE	8
Harris Teeter	401 M Street SE	8
Holiday Market	3509 Wheeler Road SE	8
Safeway	2845 Alabama Avenue SE	7
	415 14th Street SE	6
Stanton Supermarket	1453 Howard Road SE	8
Shipley Super Market	2283 Savannah St SE	8
Wheeler Market	4133 Wheeler Rd SE	8

Maryland	
Store Name	**Address**
Bestway	8540 Piney Branch Road, Silver Spring
	3511 Hamilton Street, West Hyattsville.
Compare Foods	3831 Bladensburg Road, Colmar Manor
Giant Foods	5815 Eastern Avenue, Hyattsville
	20 Audrey Lane, Oxon Hill
	5500 Silver Hill Road, District Heights
Safeway	6235 Oxon Hill Road Oxon Hill
Shopper's Food Warehouse	5820 Silver Hill Road, Forestville
	7051 Marith Luther King Jr. Hwy, Landover
	4801 Marlboro Pike, Capitol Heights
Tiger Market	823 Southern Avenue, Oxon Hill
	5800 Silver Hill Road, District Height
Tricare Medical Health & Supplies *Provides Home Delivery*	505 Hampton Park Boulevard, Capitol Heights

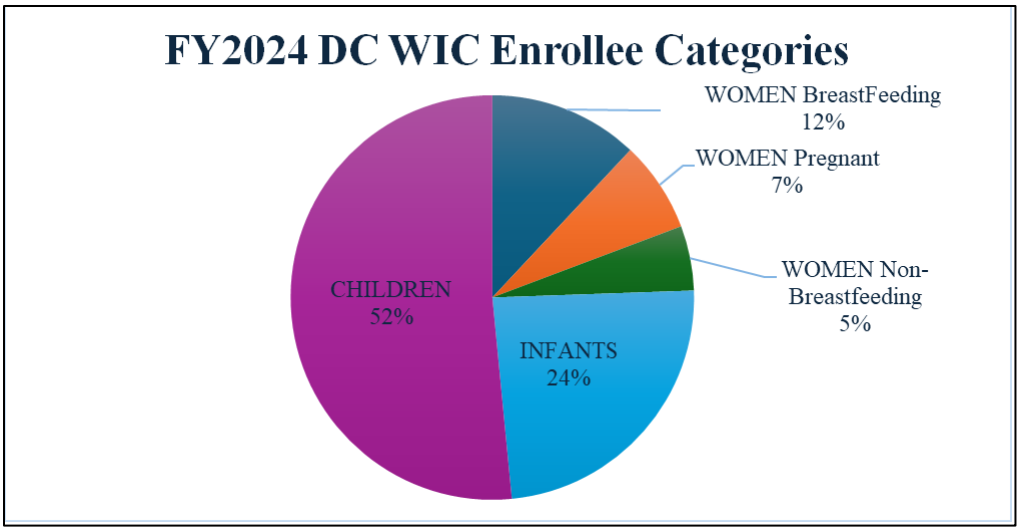


c. The number and percentage of eligible district residents, including adults and children, who were enrolled and participating in WIC in FY 2022, 2023, and 2024.

Eligibility: In FY2024, DC Health collaborated with DC Department of Health Care Finance (DHCF) to carry out a one-time data dump of 2020 WIC and DHCF beneficiary data. DHCF estimated that 32,400 beneficiaries enrolled in Medicaid, DC Healthcare Alliance, and the Immigrant Children's Program may have been eligible for WIC. 13,100 WIC participants could be matched to a DHCF beneficiary, implying a 40% WIC coverage rate.

In FY 2024, the DC WIC program increased enrollment across all categories. Enrollment in the program increased by 7% from FY 2023 and FY 2024 as a result of several strategies implemented to improve program access, customer service and staff retention.

	DC WIC - Average Monthly Enrollment	Infants	Children	Women (Pregnant)	Women (Breastfeeding)	Women (Non Breastfeeding)
FY2022	13,349	3,141	7,189	885	1424	710
FY2023	13189	3,292	6,631	990	1503	737
FY2024	14,098	3,384	7,267	1,026	1,691	730



d. What has DC Health observed as barriers to WIC enrollment in the District? What are broader strategies the District Government can implement?

- ***Streamlined Enrollment:***
  Barrier: The annual enrollment process is a consistent barrier described by current and past WIC families, based on annual surveys and feedback sessions. Paperwork burden is frequently reported, and families describe the desire to streamline the application process across multiple federal assistance programs.
  Broader Strategies:
  - **Cross-Agency Data Sharing and Outreach**: In FY2024, DC WIC was one of five states awarded a MORE WIC! (Matching, Outreach, Referrals for Enrollment in WIC) grant from John Hopkins University to identify and reach out to eligible families using information from other federal assistance programs. DC Health and DC Department of Health Care Finance are working to revise their current data sharing agreement to facilitate ongoing Medicaid and WIC data sharing. With support from the grant, DC Health and Department of Health Care Finance will work to identify a multi-pronged approach to reduce paperwork burden and streamline the application process for WIC families. DHCF and DC WIC are in the planning phase to provide WIC clinic staff modified access to the District of Columbia Access System (DCAS) to verify income eligibility of families. Over the three-year grant period, DHCF and DC WIC will identify and implement a sustainable solution to streamline the application process across Medicaid, SNAP, TANF, and WIC.

- ***Remote Services:***
  Barrier: Transportation is a persistent barrier described by current and past WIC families to attending in-person WIC appointments.
  Broader Strategies:

- **Federal Waivers**: DC WIC maintains federal waivers to provide remote services via video-conference and telephone and reduce the number of annual in-person appointments from approximately four to two. In-person appointments for annual enrollment allow for a comprehensive nutrition assessment that involves taking weight and height measurements and blood screening.
- **High Quality Remote Services**: Improving the quality of remote services is key to ensuring delivery of high-quality WIC services. DC Health works with WIC grantees to leverage access to health center and hospital electronic health record systems to gather patient information for WIC appointments and support efficient remote services.
- **Technology**: DC WIC also leverages technology to continually improve its online presence and reach younger residents. DC WIC maintains a robust online nutrition education platform that allows participants to access many WIC-related nutrition education resources on topics such as healthy eating, breastfeeding, iron, starting solid foods, and feeding picky eaters. DC WIC also continually enhances its public-facing website: dcwic.org. In FY24, DC WIC revised the "Request an Appointment" webpage with a new dropdown feature to more easily navigate and select a WIC clinic in the District based on quadrant (NE, SE, NW, SW): dcwic.org/dc-wic-appointment-request. In addition, DC WIC revised the "Family Health Resources" webpage to include a fuller coverage of immunization information and resources for DC WIC participants: dcwic.org/wic-family-health-resources and mobile.

- ***Staff Recruitment and Retention:***
  Barrier**:** Nationwide, states are experiencing challenges recruiting and retaining WIC staff, similar to challenges experienced in the healthcare sector. Within DC WIC, there was a major improvement in position vacancy rates across grantees in FY 2024. However, DC WIC continued to experience challenges recruiting for key positions including nutritionists.
  Broader Strategies**:**
  - **Innovative Workforce Development**: To improve staff recruitment and retention, DC WIC was one of eight awarded projects for a 5-year WIC Workforce Development grant from USDA. DC WIC will create education and career pathways as a strategy to build upward mobility and increase diversity and cultural awareness in the WIC workforce. DC WIC has created a workforce development framework that supports professional development geared to existing WIC staff through tuition assistance and training to support advancement within the WIC program. The framework also supports the recruitment of future WIC staff through outreach and paid dietetic and public health internships.

- ***Shopping Experience***:
  Barrier: The WIC shopping experience is also a key determinant of long-term WIC retention to ensure families remain engaged until a child reaches 5 years of age. Providing a high-quality shopping experience is critical to eliminate stigma and empower WIC families to redeem benefits. Through annual surveys and feedback sessions, families voice the importance of choice, variety, and culturally diverse foods.
  Broader Strategies:

- **Expanding Food Choice**: In FY24, DC WIC drafted policies and procedures and prepared for implementation of USDA's Final Food Rule in FY25. Changes include adding more varieties and package sizes of plant based dairy products, yogurts, and whole grain foods. All children will receive canned fish, and nuts and seed butters will be added as a substitute for peanut butter. The changes are intended to provide WIC participants with a wider variety of foods that align with the latest nutritional science; provide WIC state agencies with greater flexibility to tailor food packages that accommodate participants' special dietary needs and cultural food preferences; and address key nutritional needs to support healthy dietary patterns.
- **Online Retail Shopping**: In addition, in FY24, DC WIC successfully applied for and received a WIC Online Shopping Sub-Grant from the Center for Nutrition and Health Impact. DC WIC will lead an online planning project in FY25 and conduct a comprehensive evaluation of logistical, technological, operational, and regulatory aspects involved in bringing online shopping to DC WIC. The assessment will include thorough landscape research, stakeholder consultations, and feasibility analysis to ensure the proposed online shopping solution aligns with the unique needs and requirements of small, medium, and large retail stores and WIC participants in the District. Subsequently, DC WIC will create a plan and prepare for bringing online shopping to DC WIC, working closely with WIC participants, WIC local agencies, authorized vendors, technology partners, DC Health, and other District agency partners to lay the foundation for online shopping while ensuring compliance with all regulatory guidelines and program standards.

Q35: Please provide the following information for FY 2024 and FY 2025, to date, for each of the Equitable Food Access Programs:

a. Description of program, including goals and target audience;
b. Current grantee organization(s);
c. Amount of grant award and grant term;
d. Number of residents served;
e. Average amount of funding or food received by each resident served;
f. Describe any excess demand or unmet need for each program; and
g. Any available data or information on outcomes of program.

Response:

USDA Commodity Supplemental Food Program (Grocery Plus)

a. **Description of program, including goals and target audience;**
The Commodity Supplemental Food Program (CSFP) is designed to improve the health of people with low-income who are at least 60 years of age, by supplementing their diets with nutritious USDA Foods. CSFP is locally known in DC as Grocery Plus, a food access program that provides eligible residents with monthly, shelf-stable boxes of healthy foods. Participants can pick-up boxes at over 70 distribution sites across DC.

b. **Current grantee organization;** Program is managed by the Capital Area Food Bank (CAFB) a nonprofit organization working with partners across the food system, providing more than 45 million meals to people in communities across D.C., Maryland, and Virginia. Their food assistance network includes faith-based organizations, food pantries, soup kitchens, emergency shelters, senior programs, daycare centers, and other nonprofits that provide food directly to the people. Their mission is to help communities by creating more equitable access to food and opportunity through community partnerships.

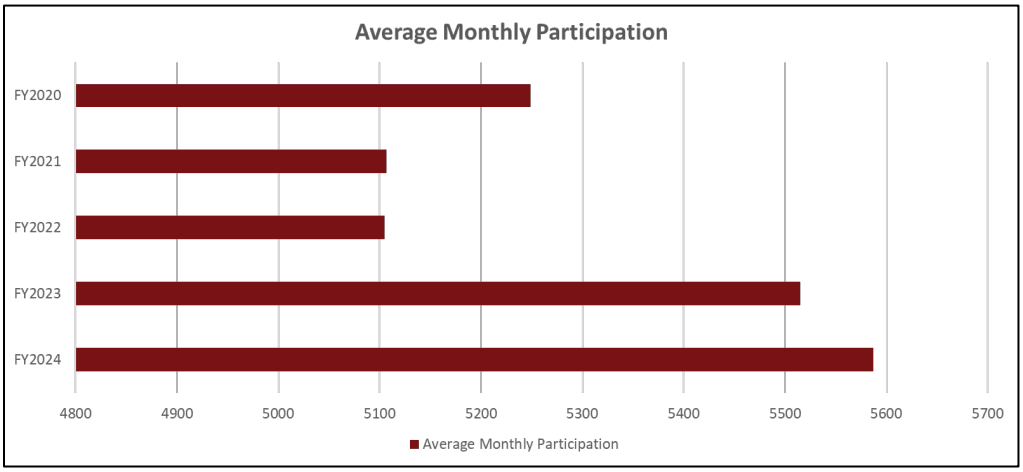
c. **Grant award amount, Grant Term, and Residents Served**

	FY24	**FY25**
Total Amount of Grant Award ***Congress has not released final appropriations, so FY25 federal award amount may change***	$971,775	$945,000
Grant Term	October 1, 2023 to September 30, 2024	October 1, 2024 to September 30, 2025
Number of Residents Served ***Maximum caseload that states are able to serve is set by the USDA based on participation***	5570	5730

d. **Average amount of funding or food received by each resident served;** Boxes contain shelf-stable milk, plant-based proteins such as dry or canned beans and lentils, grains, cheese,

canned fruits, and vegetables, and juice. Food items are set by the USDA. Boxes are valued at approximately $50-$60 per month.

e. **Describe any excess demand or unmet need for each program; and Any available data or information on outcomes of program.**
   - Grocery Plus has a *current waitlist of 1,431 residents*



   - *Monthly Participation* has increased over the last two fiscal years resulting in the USDA increasing the caseload (the amount of monthly participants served) from 5411 in FY22 to 5570 in FY23 to 5730 in FY24.
   - *Supporting Local Agriculture:* Grocery Plus leveraged funding through the USDA's Local Food Purchasing Agreement to partner with Dreaming Out Loud and provide fresh, local fruits and vegetables to participants enrolled in Grocery Plus thru FY26.

<u>The Emergency Food Assistance Program (TEFAP)</u>

a. **Description of program, including goals and target audience;**
   TEFAP is a federal program that helps supplement the diets of people with low income by providing them with emergency food assistance at no cost. The USDA purchases a variety of nutritious, high-quality USDA Foods, and makes those foods available to state distributing agencies. DC Health is the State Agency for DC and provides the food to Capital Area Food Bank, who serves as the Local Agency. CAFB distributes the food to local organizations, such as soup kitchens and food pantries that directly serve DC residents.

b. **Current grantee organization;**
   Program is managed by the Capital Area Food Bank (CAFB) a nonprofit organization that stores and distributes food to partners across the food system in D.C., Maryland, and Virginia. Their food assistance network includes faith-based organizations, food pantries, soup kitchens, emergency shelters, senior programs, daycare centers, and other nonprofits that provide food directly to the people.

c. **Grant award amount, Grant Term, and Residents Served**

	FY24	**FY25**
Total Amount of Administrative Funding	$193,907	*Award information not yet available from USDA.*
Grant Term	October 1, 2023 to September 30, 2024	October 1, 2024 to September 30, 2025
Number of Residents Served **count may be duplicated*	330,070*	82,510 (Oct to Dec 2024)

d. **Average amount of funding or food received by each resident served;**
USDA Foods include fresh, frozen and canned meats, vegetables, and fruits, juices, beans, cereals, grains and nuts. Distribution varies by sites with pre-packaged bags at some locations, market style distributions at others. TEFAP also supports congregate meal sites with foods for meal preparation.

e. **Describe any excess demand or unmet need for each program;**
Through TEFAP, the USDA authorizes each state with a "state share". The state share determines how much food a state is able to order through USDA. Typically, DC orders the full allotment of the state share, indicating a need for the food.

Medically Tailored Home Delivered Meals

a. **Description of program, including goals and target audience**: The Medically Tailored Home Delivered Meals program provides home delivered meals, groceries, and medical nutrition therapy to DC residents and their caregivers living with serious illnesses like cancer, diabetes, and heart disease, who cannot shop or prepare food for themselves due to their illness. All meals and services are free-of-charge to the client.

b. **Current grantee organization(s):** Food and Friends

c. **Amount of grant award and number of residents served:**

	FY24	**FY25 (Oct thru Dec 2024)**
Total Amount of Grant Award	$1,335,000	$1,335,000
Grant Term	October 1, 2023 to September 30, 2024	October 1, 2024 to September 30, 2025
Number of Residents Served	2,530	1310

d. **Average amount of funding or food received by each resident served:** Residents receive up to 18 meals per week depending on client type. Approximately 293 meals were received annually per resident participating in the program.

e. **Describe any excess demand or unmet need for each program and any available data or information on outcomes of program.**

- In FY24 Food & Friends expanded capacity to serve more clients as the post-COVID increase in new, more advanced disease diagnosis continued. With advanced diagnoses, coupled with continued impacts of inflation on household budgets, Food and Friends continues to see a steady increase in client referrals year over year.
- *Referrals*: Food and Friends increased their number of referral providers which resulted in increased referrals. Food and Friends delivered 4% more meals in FY24 than FY23.
- *Food Security*: Food and Friends continues to see an increase in reported food security of new clients.
  - Per the FY24 Food and Friends Client Survey, Food and Friends is the only source of food for 39% of clients.
  - 65% of clients have a household income of less than $1,500 per month.
- *FY24 Client Satisfaction Survey Results:*
  - 86% of respondents agree that receiving services helped improve health outcomes.
  - 93% of respondents reported they were Very Satisfied or Satisfied with Food and Friends Services overall.

Healthy Corner Stores

a. **Description of program, including goals and target audience:** DC Central Kitchen's (DCCK) Healthy Corner Store Program (HCSP) delivers fresh produce and minimally processed healthy food at or below cost to small independent stores Wards 1, 4, 5, 6, 7, 8, with an emphasis on 5, 7, 8. The partnership provides technical assistance on food storage, display and capital equipment such as small refrigeration units. In addition, DC Central Kitchen received the Gus Schumacher Nutrition Incentive Program grant through the USDA to provide incentive matching for SNAP customers through their $5 for $5 program in 33 of their stores.

b. **Current grantee organization(s)**: DC Central Kitchen

c. **Amount of grant award:**

	FY24	**FY25**
Total Amount of Grant Award	$750,000	$750,000
Grant Term	October 1, 2023 to September 30, 2024	October 1, 2024 to September 30, 2025

d. **Number of residents served**: 56 corner stores participate in the program. Approximately 22,210 unique SNAP customers shopped at the SNAP Match locations in FY24 – an increase of 46% compared to FY23.

	FY24	**FY25 (Oct thru Dec 2024)**
Number of Healthy Corner Stores	56	56
Number of SNAP Match Stores	33	36
Number of SNAP Match Customers	22,210	Data not available due to grantee reporting cadence

e. **Average amount of funding or food received by each resident served:** N/A

f. **Describe any excess demand or unmet need for each program and any available data or information on outcomes of program.**
   - *Sales*: In FY24, DC Central Kitchen saw a 16.4% increase in sales of healthy food across participating Healthy Corner Stores. DC Central Kitchen also saw a marked increase in unique visitors throughout FY24, going from 3,855 in Q1 to 7,513 in Q4 of FY24 which aligns with corresponding increases in sales and coupon redemption throughout the year. The timing aligns with implementation of the temporary "Give SNAP a Raise" program, which passed into law in January and was in effect from March to September 2024, giving SNAP customers additional funds.
   - *WIC*: In FY24, 11 Healthy Corner Stores were authorized to accept WIC benefits.

Joyful Food Markets

a. **Description of program, including goals:** Joyful Food Market are pop-up, monthly markets in 56 Elementary, Middle, and High School schools in Ward 7 and 8. The program has focused on the following strategies: 1) School-based and summer community markets to increase healthy food access; 2) Nutrition education through interactive cooking demonstrations and healthy recipes based on USDA's MyPlate and SNAP-Ed curricula; 3) Community engagement to improve the food environment through multi-sector partnerships, volunteers, and supporters of the program.

b. **Current grantee organization(s):** Martha's Table

c. **Amount of grant award:**

	FY24	**FY25**
Total Amount of Grant Award	$1,825,000	$1,825,000
Grant Term	October 1, 2023 to September 30, 2024	October 1, 2024 to September 30, 2025

d. **Number of residents served**:

	FY24	**FY25 (Oct thru Dec 2024)**
# Unique First Time Shoppers	6,988	5,219

e. **Average amount of funding or food received by each resident served:** Each participant receives a monthly bag of approximately 11pounds of produce and healthy, shelf stable grocery items. The average value of each grocery bag was $11.95.

f. **Describe any excess demand or unmet need for each program; and any available data or information on outcomes of programs.**
   - *Participation*:

	FY24	FY25 (Oct thru Dec 2024)
# of Markets	373	139
# of Grocery Bags Distributed	48,832	13,800
# of Meals Distributed	475,720	140,183

- *Client feedback:*
  - 100% of clients agree or strongly agree that "The JFM program is making a contribution to the greater good of my school's community"
  - 100% of clients agree or strongly agree that "Produce (fruits and vegetables) offered at the market are high-quality."

Produce Plus

a. **Description of program, including goals and target audience**:
Produce Plus is a nutrition incentive program that provides eligible residents with $40 per month to spend on local produce with 60 farmers across over 50 DC farmers markets from June through November. Produce Plus increases access to fresh fruits and vegetables and generates income for local farmers, many of which are first-generation and BIPOC farmers.

Target Audience: District resident 16 years or older, eligible for one or more of the following programs: Medicaid, TANF, SNAP, WIC, SSI Disability, Commodity Supplemental Food Program, and Senior Farmers Market Nutrition Program

b. **Current grantee organization(s):** FRESHFARM

c. **Amount of grant award and grant term:**

	FY24	FY25
Total Amount of Grant Award	$1,500,000	$2,100,000
Grant Term	October 1, 2023 to September 30, 2024	October 1, 2024 to September 30, 2025

d. **Number of residents served:**

	FY24	FY25
Number of Residents Redeeming Benefits	6,084	*Data not yet available as market season hasn't started.*

e. **Average amount of funding or food received by each resident served:** Participants received $40 monthly allotments from June through November for a total of $240. Participants were enrolled into the program on a rolling basis as funding allowed.

f. **Describe any excess demand or unmet need:**
12,718 participants submitted an application and were eligible to participate in the program. 8,001 of these participants were enrolled and issued benefits. 4,717 were waitlisted representing a 37% gap.

g. **Any available data or information on outcomes of program.**

- *FY2024 Redemption Results:*
  - 96% of Produce Plus participants that activated their Produce Pass card made purchases.
  - 76% of Produce Plus participants spent over half of their monthly benefit each month.

- *FY2024 End of Season Survey Results:*
  - 98% of participants agree that they eat more fruits and vegetables because they participate in Produce Plus.
  - 98% of participants agree that they buy more local fruits and vegetables because they participate in Produce Plus.

- *FY2024 Participant Feedback:*
  - Many survey respondents shared specific health gains that they or their clinicians observed:
    - "Each year I have been able to participate my blood pressure goes down. Being able to eat fresh and in season produce is a wonderful opportunity for my health."
    - "The Produce Plus program was instrumental in assisting me in using healthy eating to address many of my health concerns."
  - When asked, "What do you like best about the Produce Plus program?" participants mentioned many factors including produce, cost savings, health benefits, convenience, ability to choose what they want and where to shop, and the people/community:
    - "Farm fresh produce & fruit, community atmosphere, helpful, knowledgeable & friendly merchants in program. It's such a sensible and cost-effective approach."
    - "I am on a fixed income, and I am delighted to be able to purchase fresh vegetables in and out of season it has helped with my budget and especially saving money on the purchases. All of the Vendors are polite and extremely helpful always with a smile. I love the program and I have shared the information with other seniors that were not informed about this exceptional program. Thank you so much."
    - "My first season participating in PP [Produce Plus]; whenever I called the office I was treated with patience and respect. Excellent customer service getting assistance in-person with PP staff and vendors. Thank you very much for this wonderful resourceful program. Yes, I'm eating fresh fruit and veggies."

- **FY2024 Produce Plus Participant Demographic Data** **Data below is self-reported.*

FY2024 Produce Plus Enrollment by Ward of Residence		
Ward 1	707	9%
Ward 2	599	7%
Ward 3	568	7%
Ward 4	552	7%
Ward 5	2,045	26%
Ward 6	636	8%
Ward 7	1,639	20%
Ward 8	1,255	16%

FY2024 Produce Plus Enrollment by Age Range		
16-18	84	1%
19-25	294	4%
26-35	1,245	16%
36-45	1,234	15%
46-59	1,223	15%
60 and above	3,921	49%

FY2024 Produce Plus Enrollment by Qualifying Program		
EBT/ SNAP	3,595	45%
Medicaid	3,942	49%
Grocery Plus/ CSFP	1,391	17%
Supplemental Security Income or SSDI	1,955	24%
TANF	435	5%
WIC/ WIC FMNP	1,131	14%

FY2024 Produce Plus Enrollment by Racial/Ethnic Background		
American Indian/ Alaska Native	118	1%
Asian	390	5%
Black/ African American	5,565	70%
Hispanic/ Latino/ Spanish	931	12%
Native Hawaiian	4	0%
Other Pacific Islander	29	0%
White	297	4%
Don't know/ not sure	56	1%
Prefer not to answer	363	5%

FY2024 Produce Plus Participant Self-Reported Chronic Conditions		
Alzheimer's Related Dementia	85	1%
Arthritis	2,317	29%
Cancer/ Cancer Survivor	540	7%
Diabetes (High Blood Sugar)	1,712	21%
High Cholesterol	2,123	27%
Heart Disease	665	8%
Hypertension	2,931	37%
Obesity	1,347	17%
None of the above	2,321	29%
Prefer not to answer	0	0%

USDA Senior Farmers Market Nutrition Program (SFMNP)

a. **Description of program, including goals and target audience:** The Senior Farmers Market Nutrition Program (SFMNP) is a USDA funded farmers' market incentive program for seniors over the age of 60 with low incomes that provides eligible DC residents with $50 to purchase fresh fruits and vegetables at authorized farmers markets in DC from June through November. In FY23, DC Health received additional funding for two years through the American Rescue Plan Act (ARPA) to expand program reach and transition to a digital benefit solution

b. **Current grantee organization(s):** DC Health, FRESHFARM, Capital Area Food Bank

c. **Amount of grant award and grant term:**

Program	FY24 Award	FY25 Award	Grant Term
SFMNP	$179,042	*Award information not yet available from USDA.*	October 1, 2023 – September 30, 2024

SFMNP-ARPA	$244,909	*No cost extension to spend remaining grant funds.*	October 1, 2022 – September 30, 2025

d. **Number of residents served:** 6,980

Program	**FY24 Number of Residents redeeming benefits**
SFMNP	3,222
SFMNP-ARPA	3,758

e. **Average amount of funding or food received by each resident served:** $50 per season

f. **Describe any excess demand or unmet need for each program:**
Through American Rescue Plan (ARPA) funding from the USDA, DC Health reached an additional 4,545 residents in FY23 and 3,758 in FY24. Through a no-cost extension, DC Health will continue to provide additional seniors with SFMNP ARPA during FY25.

Program	FY24 Federal Food Funds	FY24 Total Redeemed	% Redeemed of Federal Funds
SFMNP	$161,138	$169,231.16	105%
SFMNP ARPA	$147,200	$52,622.80	36%*

*Unredeemed SFMNP ARPA food funds will be issued to residents in FY25.

g. **Any available data or information on outcomes of program.**
- In FY24, for the second year in a row, 100% of federally allocated SFMNP funds were redeemed by program participants. Unmet SFMNP federal funds were covered with SFMNP ARPA funds.
- FY24 was the second year of digital incentives, with participants and farmers becoming more comfortable with the technology. Increased familiarity supported increased engagement, with farmers finding the system easy to use and participants feeling more confident accessing their benefit.

USDA Women, Infants, and Children (WIC) Farmers Market Nutrition Program (FMNP)

a. **Description of program, including goals and target audience:**
The WIC Farmers Market Nutrition Program (FMNP) is a USDA funded farmers' market incentive program associated with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Eligible WIC participants receive $30 to purchase fresh fruits and vegetables at authorized farmers' markets in DC from June through November.

b. **Current grantee organization(s):** Program is managed by DC Health's WIC Program

c. **Amount of grant award and grant term:**

Program	**FY24 Award**	**FY25 Award**	**Grant Term**

WIC FMNP	$322,003	*Award information not yet available from USDA.*	October 1, 2023 – September 30, 2024

d. **Number of residents served:** 11,299

e. **Average amount of funding or food received by each resident served:** $50.00 per person

f. **Describe any excess demand or unmet need for each program:**
For the first time since 2020, FMNP participants redeemed over 50% of federal FMNP funds. Through a USDA-authorized temporary waiver, DC WIC was able to increase the FMNP benefit from $30.00 to $50.00.

Program	FY24 Federal Food Funds	FY24 Total Redeemed	% Redeemed of Federal Funds
FMNP	$260,822	$149,776.20	57%

g. **Any available data or information on outcomes of program:**
- In FY24, FMNP benefit redemption increased 72% compared to FY2023.
- DC Health continued their partnership with Dreaming Out Loud to offer Home Delivery to FMNP participants. During the 2024 FMNP Home Delivery program, over 750 orders were placed with a delivery success rate of over 90%.

Q36: Please provide the following information on the SNAP-Ed Program:

a. Current grantee organizations and description of each program;
b. Amount of grant awards and grant term;
c. Participation by Ward in FYs 2023, 2024, and 2025 broken down separately by ward, age, race, and gender; and
d. The number of SNAP-Ed participants who have received free grocery delivery through the Grocery Access Pilot Program funded by the Committee in the FY 2025 budget; and the number that will be served by the end of FY 2025.

Response:

The Supplemental Nutrition Assistance Program Education (SNAP-Ed) is funded through the United States Department of Agriculture (USDA), Food and Nutrition Services (FNS). SNAP-Ed is designed to improve the likelihood that persons eligible for SNAP make healthy food choices within a limited budget and choose a physically active lifestyle consistent with the 2020-2025 Dietary Guidelines for Americans and USDA food guidance. The District of Columbia (DC) Department of Human Services (DHS), Economic Security Administration (ESA), serves as the State Agency (SA) for the SNAP-Ed Program. DC Health's Community Health Administration serves as the State Implementing Agency (SIA). DC Health oversees the implementation of SNAP-Ed programming and services by providing strategic direction, technical assistance and guidance to grantees, and implementing policy, systems, and environmental approaches to improve food and physical activity environments in the District. In FY24, DC Health provided funding support to five organizations to implement SNAP-Ed programming across all eight wards. DC SNAP-Ed released a request for applications in April 2024 to fund nine grantees for the project period 2025-2030.

DC SNAP-Ed set the following state level goals in alignment with USDA's SNAP-Ed Evaluation Framework and DC Health's *Framework for Improving Community Health:*

- Increase consumption of healthy foods and beverages and decrease consumption of unhealthy foods and beverages.
- Increase access to affordable foods that promote well-being and prevent disease for all residents.
- Increase physical activity and reduce sedentary behavior.
- Implement policies, systems, and environmental approaches to improve food environments.
- Leverage multi-sector partnerships to increase capacity of DC SNAP-Ed to implement direct education and policy, systems, and environmental change.

To meet these goals, DC SNAP-Ed implements the following activities:

- **Direct Education**: Engaging, evidence-based behavior focused nutrition education and/or physical activity intervention conducted at the individual and interpersonal level.
- **Indirect Education**: Health education materials or supports that are shared with SNAP-eligible residents to supplement direct education.

- **Policy, Systems, and Environmental Approaches:** Changes made in writing or practice to expand access or improve the appeal of sites where people can make choices about food and beverages and engage in physical activity.

FY24 DC SNAP-Ed Grantees: (Grant Term: October 1, 2023 – September 30, 2024)

Organization	Amount of Grant Award	Description of Program
University of the District of Columbia (UDC)	$460,000	UDC SNAP-Ed targets toddlers, school-age children, parents/caregivers, teachers, and staff by leading monthly nutrition education workshops and healthy food demonstrations at childcare centers and elementary schools. UDC also delivers series-based and one-time direct education events to families, adults and seniors in public housing and homeless shelters, adult education and job training sites, supermarkets and Healthy Corner Stores, public recreation centers, schools, healthcare centers, farmers' markets, faith-based organizations, senior wellness centers and apartments. Policy, systems, and environmental interventions include strategies to enhance food environments at childcare centers, schools, and corner stores.
American University	$150,0000	AU provides point-of-purchase nutrition education in grocery stores with high SNAP redemption to change shoppers' food knowledge, skills, and purchasing behaviors. AU also leads series-based nutrition education in community locations informed by resulting data in the point-of-purchase education and the SNAP-Ed Toolkit. AU also conducted a food retail assessment across the District to assess disparities in healthy food access. The assessment measured availability, quality, and price of selected food items in small food/corner stores, convenience stores, grocery stores, supermarkets, and superstores. Results will be used to inform future food access strategies and initiatives.
FRESHFARM	$293,000	FRESHFARM SNAP-Ed provides direct nutrition education in early childcare and education centers, elementary schools, and farmer's markets. FRESHFARM's curriculum, FoodPrints, integrates gardening, cooking, and nutrition education through hands-on lessons and garden-based education. FRESHFARM partners with DC Health to implement the Food Navigator program, which provides training to community-based organizations, SNAP-Ed educators, community health workers, and farmers market managers on how to connect residents and improve access to local and federal nutrition assistance programs.

Washington Youth Garden (WYG)	$125,000	WYG SNAP-Ed leads a Summer Institute for Garden Based Learning where teachers learn how to deliver outdoor lessons, build gardening skills, and plan their garden programs for the school year. Throughout the academic year, school teams work with WYG staff to set goals for their garden programs and receive technical assistance with the goal of increasing the number of students per school who receive 10+ hours per year of garden-based education.
YMCA of Metropolitan Washington (YMCA)	$154,990	YMCA provides series-based nutrition education and culinary instruction to adults and seniors using the Simple Cooking with Heart curriculum. In addition, YMCA focuses on developing community-clinical linkages to increase referrals and enrollment in SNAP-Ed programs by partnering with health centers and managed care organizations.

Additional FY24 Highlights:
In FY24, DC Health's SNAP-Ed program released two competitive requests for applications to fund organizations to implement 1) direct nutrition and physical activity education programming, and 2) policy, systems, and environmental (PSE) approaches to improve the food and built environments across the District. To inform development of the RFAs, DC Health held listening sessions with residents, community-based organizations, healthcare partners, and other government agencies to determine the needs of the community.

In FY25, DC SNAP-Ed increased the number of grantees from five organizations to nine. Seven organizations are implementing direct education: American University, DC Greens, FRESHFARM, Friends of the National Arboretum, Sorogi, University of the District of Columbia, and YMCA. Direct education grantees will focus on implementing nutrition and physical activity education across the lifespan in five project areas: Schools, Healthcare, Food Retail, Place-based, and Physical Activity and the Built Environment.

Three organizations are implementing Policy, System, and Environmental initiatives: District of Columbia Hospital Association, the YMCA of Metropolitan Washington, and the Washington Area Bicyclists Association. Policy, System, and Environmental (PSE) initiatives focus on 1) implementing policies and initiatives that connect pedestrian, bicycle, or transit transportation networks (e.g. active-friendly routes) to everyday destinations, 2) promoting foodservice and nutrition guidelines associated with healthy food procurement in facilities, programs, or organizations where food is sold, served, and distributed, and 3) coordinating expansion and increased utilization of existing fruit and vegetable incentive and produce prescription programs.

DC SNAP-Ed Participation
**Numbers may differ from totals as some SNAP-Ed participants did not report ethnicity and/or race, or gender.*

DC SNAP-Ed Direct Education Participation by Ward FY23 - FY25			
Ward	**FY23**	**FY24**	**FY25**
1	454	695	Data not available due to federal reporting cadence
2	166	297	
3	270	396	
4	449	892	
5	2,643	2,381	
6	775	595	
7	2,446	2,480	
8	2,886	3,247	

DC SNAP-Ed Direct Education Participation by Reported Race and Ethnicity FY23-FY25				
		FY23	**FY24**	**FY25**
Ethnicity	Hispanic	1,843	1,292	Data not available due to federal reporting cadence
	Non-Hispanic	6,694	6,528	
Race	American Indian or Alaska Native	16	9	
	Asian	280	259	
	Black or African American	8,292	7,825	
	Native Hawaiian or Pacific Islander	0	157	
	White	1,718	1,246	

DC SNAP-Ed Direct Education Participation by Age FY23-FY25			
	FY23	**FY24**	**FY25**
Less than 5 years	907	1,014	Data not available due to federal reporting cadence
5-17 years	2,383	2,475	
18-59 years	1,978	2,693	
60 years and older	3,383	2,840	
Total*	8,651	9,022	

DC SNAP-Ed Direct Education Participation by Gender FY23-FY25 **FY25 Data not available due to grantee reporting cadence*									
	Female			**Male**			**Total**		
	FY23	**FY24**	**FY25**	**FY23**	**FY24**	**FY25**	**FY23**	**FY24**	**FY25**
Total	5,268	5,691	*	2,760	2,749	*	8,028	8,440	*

d. **The number of SNAP-Ed participants who have received free grocery delivery through the Grocery Access Pilot Program funded by the Committee in the FY 2025 budget; and the number that will be served by the end of FY 2025.**
   - *Number SNAP-Ed participants who have received grocery delivery*: 0
   - *Number who will be served by the end of FY 2025*: 1,000

Q37: Please provide for the Healthy Hospital grant for FY 2024 and FY 2025, to date:
a. Deliverables required under the grant;
b. Outcomes on those deliverables; and
c. Budget breakdown for grant allotment.

Response:

a. Deliverables required under the grant:
The DC Hospital Association (DCHA) partners with 13 member hospitals to implement the Healthy Hospital Initiative, aiming to reduce availability and consumption of sugar sweetened beverages and promote healthier choices in District Hospitals. Participating hospital CEO's sign a pledge to promote healthy choices within their hospital. The intended deliverables for this grant include:

1. At least 80% of participating hospitals adhere to the 60/20/20 guideline for sugar for serving sugar-sweetened beverages. (See Table 1).
2. At least 80% of participating hospitals adhere to the 60/20/20 guideline for sodium content in meals, entrees and sides. (See Table 2).
3. At least 80% of participating hospitals in the District initiate the process for collecting and reporting data on the saturated fat content of menu items.

Table 1. HHI Nutrition Standard Categories - Beverages

Green Beverage	Yellow Beverage	Red Beverage
Percentage of beverages under 25 calories per 12 fluid ounces; skim/low fat milk is considered Green. *Goal=60%*	Percentage of beverages between 26-100 calories per 12 fluid ounces: 100% juice is considered Yellow. *Goal=20%*	Percentage of beverages over 100 calories per 12 fluid ounces is considered Red. *Goal=20%*

Table 2: HHI Nutrition Standard Categories-Sodium

Goals	Entrée Per Serving	Side Per Serving	Meal Per Serving
Average 60%	Percentage of food items less than 600mg	Percentage of food items less than 230mg	Percentage of food items less than 800 mg
Average 20%	Percentage of food items between 600-800mg	Percentage of food items between 230-400mg	Percentage of food items between 800-1000mg
Average 20%	Percentage of food items over 800mg	Percentage of food items over 400mg	Percentage of food items over 1000mg

b. **Outcomes on deliverables:**
- As of 2024, 100% of hospital CEOs committed to the *pledge* to promote healthy choices within their hospital by:
  - Educating employees about healthy eating and promote healthier choices.

  - Providing more fruits, vegetables and fiber-rich whole grain foods to patients and employees.
  - Reducing and ultimately eliminating sugar-sweetened beverages, chips, candy and other less-nutritious, high-sugar foods.
  - Reducing sodium, added sugars, saturated fat and trans-fat in foods and beverages.
- Policies to promote *healthy food procurement* were measured during FY 2024, with the following findings:
  - Of the 12 Healthy Hospital Initiative member hospitals, 71% have at least one ***policy in place*** for healthy food procurement and 43% have ***plans to develop a policy*** for healthy food procurement.
- *Nutrition standard outcomes* met during FY 2024 include:
  - **Sugar:** The percentage of low sugar beverages served at 10 hospitals increased by 8% from 52% to 60%.
  - **Sodium:** The percentage of low sodium products served at 11 hospitals remained stable at 68%.
- *Community engagement outcomes* during FY 2024 include:
  - **Wellness Walk:** To increase engagement from hospital staff in the Healthy Hospital Initiative, DCHA held a step challenge. In total, 166 hospital staff across 12 hospitals were engaged in the Wellness Walk.
  - **Pop Up Farmers Markets:** Five member hospitals partnered with Arcadia Market to host pop-up farmers markets at their hospital locations.
  - **Cooking Competition:** DCHA held their annual cooking competition to build community awareness of local hospital efforts to serve as role models and deliver nutritious hospital food service. Seven hospitals competed in the challenge, which focused on creating low sodium, low-sugar, and plant-based dishes.

c. **Budget breakdown for grant allotment:**

	FY24	**FY25**
Personnel	$42,345.24	$35,679.72
Occupancy	$2,199.96	$2,208.00
Travel	$244.89	$451.27
Communication	$306.48	$0.00
Supplies & Other Direct	$9,919.99	$16,207.00
Indirect	$5,501.67	$5,454.01
Total Grant Award	**$60,518.23**	**$60,000.00**

Q38: DC Health indicated in its FY 2023 Performance Oversight responses that it had hired a staff person to focus on population health strategies to increase physical activity and data surveillance. What physical activity related projects did CHA work on in FY 2024 and FY 2025, to date? Please provide any available deliverables.

Response:

DC Health worked on the following projects in FY24 and FY25 to date:

Online Built Environment Mapping Tool
DC Health collaborated with the Department of Energy and Environment, Office of Planning and Office of the Chief Technology Officer to develop the Built Environment Indicators and Health Interactive Mapping Tool. As part of the update to Sustainable DC 2.0, the online mapping tool can serve as a surveillance resource as well as a tool to identify strategy priorities and resource allocation. The tool uses the concept of the "15-minute" city to highlight how close (in walking distance) DC neighborhoods are to various neighborhood amenities spanning nine key drivers of health – education, employment, financial institutions, housing, transportation, food environment, medical care, outdoor environment and community safety. Together, the team mapped 41 separate data measures. The tool leverages publicly available datasets, primarily gathered through Open Data DC to identify physical characteristics of DC's built environment. The tool is available on Open Data DC:
https://opendata.dc.gov/apps/ce560db830634fff90933dc5664d4ebf/explore

Social Marketing Campaign
DC Health was awarded a grant through the DC Department of Transportation, Office of Highway Safety to utilize resident centered data collection and inform a social marketing campaign promoting safe forms of active transportation. DC Health is partnering with Washington Area Bicyclists Association to implement Walk Audits in high priority areas in the city with a focus on neighborhoods in Wards 7 and 8. Walk Audits are assessments of walkability or pedestrian access of an external environment. The walk audits are set to begin in February 2025 and will be conducted by resident champions who reside in the areas in which they are auditing. Data collected from the audits will be used by DC Health to develop and disseminate a social marketing campaign intended to promote walking, and other forms of low-impact physical activity.

Physical Activity and Data Surveillance Framework
In FY 2025, DC Health will develop a physical activity and data surveillance framework to monitor and coordinate physical activity indicators across the District. DC Health will collect feedback from community members, community-based organizations, and sister agencies. Specifically, community feedback will be collected through walk audits and feedback sessions hosted by the Washington Area Bicyclists Association. DC Health will also convene relevant sister agencies, such as the Department of Parks and Recreation, Department of Energy and the Environment, DC Department of Transportation, and Office of Planning to identify data surveillance sources. Once developed, the framework will support monitoring physical activity

trends in the District over time, setting District goals and objectives regarding physical activity, and understanding which populations are most at risk because of low physical activity levels and related health outcomes. The framework will also include a comprehensive set of initiatives and policies led by DC Health and sister agencies that support physical activity across the District.

Q39: For the DC Healthy Start Program, please provide:

a. **The target and actual number of residents served per Ward in FY 2024 and FY 2025, to date;**
b. **The names of grantee(s) and amount of awards for each grantee;**
c. **Any changes to federal funding over the past 3 fiscal years; and**
d. **Data showing outcomes of this program during this time period.**

Response:

The DC Healthy Start Program (DCHS) is funded by the Health Resources and Services Administration (HRSA). HRSA has set a goal for DCHS to serve a total of 700 participants per year, of which 300 are prenatal women, 300 are infants/children up to 18 months, preconception women and interconception women combined, and 100 are fathers/male partners affiliated with the women/infants/children participating in services.

In FY24, DCHS served a total of 878 participants. These numbers were comprised of 178 pregnant women, 373 infants (0-11 months), 13 children (12-18 months), 283 women in either preconception, postpartum, or interconception stages, and 31 fathers/male partners. Approximately 76.8% of participants were African American. Participants resided primarily in Ward 5 (270), Ward 7 (195), and Ward 8 (325) (Table 2).

In FY25-to-date, DCHS served 476 participants. These numbers were comprised of 21 pregnant women, 212 infants (0-11 months), 6 children (12-18 months), 223 women in either preconception, postpartum, or interconception stages, and 14 fathers/male partners. Approximately 92.5% of participants were African American. Participants resided primarily in Ward 5 (80), Ward 7 (99), and Ward 8 (220) (Table 3).

Due to limitations of HRSA's database, we are unable to longitudinally track changes in ward level data when an address changes to an ineligible ward. Clients counted in unidentified wards were originally in Ward 5, 7, or 8 but have since moved.

Residents Served

Table 1: Target v Actual Number Served

	FY24	FY25-to-Date
Number Served	878	476
Target Served	700	350*
Difference	+178	+126

a. **The target and actual number of residents served per Ward in FY 2024 and FY 2025, to date**

Table 2: FY24 DC Healthy Start Participants by Wards Served

Participant Type	Ward 5	Ward 7	Ward 8	Undefined Ward	Total
Pregnant Women	54	44	58	20	**176**

Infants (0-11 months)	116	95	134	25	**370**
Children (12-18 months)	2	2	7	2	**13**
Non-Pregnant Women	87	50	116	24	**277**
Fathers	11	4	10	6	**31**
Total	**270**	**195**	**325**	**77**	**867**

Table 3: FY25-to-Date DC Healthy Start Participants by Wards Served

Participant Type*	Ward 5	Ward 7	Ward 8	Undefined Ward	Total
Pregnant Women	4	5	6	0	**15**
Infants (0-11 months)	40	50	94	23	**207**
Children (12-18 months)	0	1	3	2	**6**
Non-Pregnant Women	34	41	110	37	**222**
Fathers	2	2	7	3	**14**
Total	**80**	**99**	**220**	**65**	**464**

Data source: CAREWare, pulled 11/5/2024
**DCHS grantees were reduced to one (1) from two (2) as of FY25. The target served value is half of FY24's value.*

b. The names of grantee(s) and amount of awards for each grantee

Awardees	**FY21-FY22** April 2021-March 2022	**FY22-FY23** April 2022-March 2023	**FY23- FY24** April 2023-March 2024	**FY24-FY25** DC Health was not awarded Healthy Start Funding
Mary's Center	$472,950	$472,950	$472,950	N/A
Community of Hope	$418,000	$418,000	$418,000	$215,562.16
Georgetown University (Evaluation)	$100,000	$100,000	$100,000	N/A
Total Amount	$990,950	$990,950	$990,950	$215,562.16

c. Changes to federal funding over the past three fiscal years

Over the past three fiscal years, the DC Healthy Start Program has consistently received federal funding to support its grantees and evaluation activities. The funding levels remained steady from FY21 to FY23, with a total of $990,950 awarded annually. Mary's Center received $472,950 per fiscal year, Community of Hope was awarded $418,000 per fiscal year, and Georgetown University received $100,000 per fiscal year for program evaluation. However, in FY24-25, DC Health was not awarded federal funding for the Healthy Start Program. Notably,

Community of Hope received a reduced allocation of $215,562.16 during the transitional period in FY23-24, marking a shift in funding continuity for the program.

d. Data showing outcomes of this program during this time period

FY2024 outcome highlights include:

- 434 out of 449 (96.66%) Healthy Start women participants receiving intimate partner violence screening.
- 367 out of 393 (93.38%) Healthy Start child participants have received a well-care visit in the reporting year
- 438 out of 459 (95.42%) Healthy Start women participants report being insured
- 152 out of 186 (81.72%) mothers of Healthy Start child participants report supportive father and/or partner involvement.

Status and DC Health Program Conclusion

Due to the lack of federal funding for FY24-25, DC Health's involvement in the Healthy Start Program will conclude in its entirety by April 2025. Mary's Center and Georgetown University have already closed out their involvement as grantees for FY24-25, while Community of Hope remains the sole grantee continuing operations under DC Health until the program's conclusion. However, it is important to note that Healthy Start services will continue independently through Mary's Center. DC Health requested an extension from the Health Resources and Services Administration (HRSA) to spend the remaining funds which were approved. Additionally, HRSA provided supplemental funding to ensure that ongoing program activities could be sustained until DC Health's conclusion of its program involvement. DC Health remains committed to transitioning participants and resources, and continuing to address maternal and child health needs through other initiatives and partnerships.

Q40: Please provide the following information for the Preterm Birth Reduction Initiative grants in FY 2024 and FY 2025, to date:

a. The organizations awarded grants, amount of each grant, and expenditures for each grant;
b. Description of grant project;
c. Number of patients served by each grantee; and
d. For each grantee, provide the following information:
- **# of pregnant women classified as high risk for pre-term birth**
- **# of women that received a specific intervention (i.e., preterm birth-specific education, enhanced monitoring regime, etc.)**
- **# of women receiving intervention that delivered preterm (< 37 weeks)**
- **# of women that did not receive intervention and delivered preterm (< 37 weeks)**

Response:

The Preterm Birth Reduction Initiative supports the implementation of evidence-based strategies to reduce maternal risk factors and the occurrence of preterm births among high-risk District residents. DC Health is funding partners to implement quality improvement initiatives to reduce preterm birth, with a focus on institutionalizing best practices in screening and referral processes, medication therapy, management of risk factors, and coordination of support services. In FY24 $1,399,960.34 was distributed to grantees to implement services to prevent preterm births. Current partners include Community of Hope, Howard University Hospital, MedStar Washington Hospital Center, and Unity Healthcare. Target populations served through the grant are pregnant women and birthing persons at risk for preterm birth, prioritizing women with Medicaid insurance and residing in Wards 5, 7 and 8.

Services provided through the Preterm Birth Reduction Grant include: Early preterm birth high-risk screening, educational material and target interventions; CenteringPregnancy; perinatal navigation and coordination services; midwife support; parental and care); behavioral improved connectivity using designated Connectivity Coordinators and use of applications such as Mahmee and BabyScripts; referral to high-risk specialty care (Maternal Fetal Medicine); behavioral health and substance use screenings and referrals; social determinant of health screening and assessment and referral (i.e., WIC, housing, transportation), and postpartum resources. Training and education on delivery of care, screening and assessment, service coordination, and quality improvement are also provided to providers and staff.

- Every month, grantees identify women who are at high risk for preterm deliveries and enroll them into appropriate services to help reduce the risk of poor outcomes. The services include Centering Programs, referrals to Maternal Fetal Medicine Clinics, providing educational material, or pharmaceutical therapy when applicable. Over 2,500 women have utilized the services.
- Additional funds are being utilized to improve connectivity and address data capacity to improve data reporting, such as patient-level outcomes (i.e., interventions to delivered to high-risk patients, number of women who delivered preterm, and referral tracking).

- The Maternal Health Learning Collaborative provides an opportunity for grantees to receive collective technical assistance and support, including training opportunities and sharing of progress and lessons learned to improve collaboration.

Community of Hope (COH)

- **Primary Target Population Served:** Wards 4, 5, 7 and 8
- **Grant Awards:**
  - **FY24**: $350,000 (FY24 Expenditures: $344,130.47)
  - **FY25:** $350,000
- **Performance Metrics**:
  - In FY24 **374** patients delivered and had an OB high risk assessment completed
    - In FY24 **154** (41%) patients entered prenatal care within the first trimester
    - In FY24 **374** (100%) patients received Preterm Birth Education and glucose monitoring
    - In FY24 **50** patients received referral to Maternal Fetal Medicine
    - In FY24 **10** patients received blood pressure monitoring (at home or other)
    - In FY24 **45** (12%) patients delivered preterm (< 37 weeks).
  - In FY24 **307** (82%) delivered patients were classified as *high risk* for preterm birth
    - In FY24 **133** (43%) high-risk for preterm birth entered prenatal care with the first trimester
    - In FY24 **35** *high-risk patients* receiving intervention delivered preterm (<37 weeks)
    - In FY24 **65** *high-risk patients* receiving intervention delivered early term (≥ 37 weeks to < 39 weeks)
    - In FY24 **199** *high-risk patients* receiving intervention delivered full-term (≥ 39 weeks)
  - In FY25 to date = October 2024 and November 2024(December 2024 data is due January 15th, 2025):
    - In FY25 to date **61** patients entered care, received their first prenatal appointment, and had their OB high risk assessment completed.
    - Delivery data is received quarterly given the nature of birth and 9-month pregnancy term.
- ***Programmatic Highlights***:
  - Community of Hope provides exceptional data to support the Preterm Birth Reduction Initiative and is a role model in implementing Centering Pregnancy. In FY24 **374** patients delivered during this grant year and **21%** were enrolled in Centering Pregnancy. **56%** of prenatal patients referred to Centering Pregnancy this year were enrolled and **47%** of enrolled patients remained in group prenatal care. 100% of CenteringPregnancy patients

received information and/or referrals to additional health promotion and wellness resources and services.
- Community of Hope (COH) utilizes BabyScripts for patients as part of its efforts to improve and facilitate coordination to care and services. BabyScripts provides perinatal education, remote patient monitoring, and mental health assessments. In FY24 COH developed perinatal education packet and uploaded materials to Babyscripts app. Designed promotional materials for app and scheduled a training for MCH staff.
- COH Perinatal navigators screen for postpartum depression at first prenatal visit using PHQ-2 and providers screen multiple times during perinatal period using EPDS. In FY24 72% were screened via EPDS during perinatal period.

Howard University Hospital

- **Primary Target Population Served:** DC Resident minority women Wards 4, 5, 7 and 8
- **Grant Awards:**
  - **FY24**: $350,000 (FY24 Expenditures: $253,583.43)
  - **FY25**: $350,000
  - Note: Reduced spending due to staff transition and capacity. This also impacted the ability to implement proposed activities, such as Centering Pregnancy.
- **Performance Metrics**:
  - In FY24 **1,048** patients delivered at Howard University Hospital.
  - In FY24 **130** (12%) patients delivered preterm (<37 weeks).
  - In FY24 **98** patients received prenatal care at the Women's Wellness Clinic and delivered at Howard University Hospital.
  - In FY24 **49** patients enrolled in Mahmee.
  - In FY25 to date = October 2024 and November 2024(December 224 data is due January 15th, 2025):
    - Delivery data is received quarterly given the nature of birth and 9-month pregnancy term.
- ***Programmatic Highlights***:

  - Howard's Preterm Birth team convenes a Community Health Advisory Board. Providers from Community of Hope, Unity, La Clinica and Mamatoto Village meet to discuss challenges and successes.
  - Howard partners with the Mahmee platform to provide patients with access to a broad array of virtual services, including care navigation, online classes and education, lactation and doula support, mental health and nutrition coaching, and remote monitoring.
  - In FY24, Howard hosted a series of educational events, including Doula 101, a Community Baby Shower, and Postpartum Depression patient education webinars. Community engagement events were employed to

prevent preterm birth by raising awareness through workshops, ensuring cultural sensitivity, and providing practical support services, addressing social determinants of health. Additionally, feedback from community members will inform program adjustments, fostering a collaborative approach toward reducing preterm birth risks.
  - While there have been delays in implementation of CenteringPregnancy, Howard has received licensing and identified additional staff and will aim to begin recruitment in FY25.
- **Challenges:**
  - Ongoing challenges have included staff turnover, capacity, spending, and data indicator reporting challenges. In addition, there have been delays in submission of monthly and annual reports. Additional challenges have also been due to Howard's internal financial systems and procedures that have also often delayed approvals of contracts. The DC Health team has provided continued and ongoing technical assistance, including clear strategies for addressing challenges. This has included approaches for utilization of funds to implement relevant activities that align with the grants' overall goals and objectives; as well as strategies for addressing staffing capacity, such as working and collaborating with schools of social work, public health, nursing and medical school, as well as working with the Centers of Excellence. DC Health is planning to meet with Howard to further discuss data collection and reporting challenges. A corrective action plan will be implemented.

MedStar Washington Hospital Center

- **Primary Target Population Served:** Pregnant Individuals
- **Grant Awards:**
  - **FY24**: $349,562.00 (FY24 Expenditures: $289,126.17)
  - **FY25:** $350,000.00
- **Performance Metrics**:
  - In FY24 **388** patients had an OB high risk assessment completed
    - In FY24 **47** (12%) patients delivered preterm (< 37 weeks).
    - In FY24 **340** (88%) patients entered prenatal care within the first trimester
  - In FY24 **203** (52%) patients were classified as *high-risk* for preterm birth
    - *High-risk* for preterm birth risk factors
      - Diabetes Risk Factor – **50** patients
      - Hypertension Risk Factor – **78** patients
      - Pre-eclampsia Risk Factor – **74** patients
      - Spontaneous PTB Risk Factor - **23** patients
      - Fetal Growth Restriction Risk Factor – **28** patients
      - Substance Use in Pregnancy Risk Factor – **24** patients
      - Multiple Risk Factors – **125** patients
    - In FY24 **91%** (184) high-risk for preterm birth patients entered prenatal care within the first trimester

- In FY24 **203** *high-risk* patients received Preterm Birth Education and blood pressure monitoring (at home or other)
- In FY24 **66** high-risk patients received referral to Maternal Fetal Medicine
- In FY24 **50** patients received glucose monitoring
  - In FY24 **44** *high-risk patients* receiving intervention delivered preterm (<37 weeks)
  - In FY24 **68** *high-risk patients* receiving intervention delivered early term (≥ 37 weeks to < 39 weeks)
  - In FY24 **91** *high-risk patients* receiving intervention delivered full-term (≥ 39 weeks)

- In FY25 to date = October 2024 and November 2024(December 224 data is due January 15th, 2025):
  - In FY25 to date **69** patients entered care, received their first prenatal appointment, and had their OB high risk assessment completed.
  - In FY25 to date **32** pregnant women were classified as high-risk for preterm birth.
  - Delivery data is received quarterly given the nature of birth and 9-month pregnancy term.

- ***Programmatic Highlights***:
  - Medstar Washington Hospital Center provides exceptional data to support the Preterm Birth Reduction Initiative.
  - In FY24 **100%** of patients (388) were screened for perinatal mental health (depression), substance use, and social determinants of health.
  - In FY24 **187** patients engaged in Nurse Navigation services. Medstar utilizes Nurse Navigation services for patients who are risk high risk for preterm birth. The navigation services involve weekly follow-up and more intense tracking/surveillance.
  - In FY24 **221** patients were enrolled in Mahmee's MomHEART postpartum hypertension surveillance program. This program provides high risk patients with education, support and remote blood pressure monitoring.
  - MedStar will be piloting the utilization of PreTRM®, which is a clinically validated commercially available blood test that helps to provide an early individual risk assessment for spontaneous preterm birth (in asymptomatic, singleton pregnancies).
- ***Challenges*:**
  - Spending challenges: Centering Pregnancy was not rolled out in FY24 due to conflicts with the Midwives schedules and the vacant Centering Pregnancy Program Coordinator position. However, in FY24 Q4 a Centering Pregnancy Program Coordinator was hired and Medstar is on track begin Centering Pregnancy in FY25, which will improve spending.

Unity Healthcare, Inc.

- **Primary Target Population:** Pregnant patients
- **Grant Awards:**
  - **FY24**: $349,960.80 (FY24 Expenditures: $335,528.47)
  - **FY25**: $349,960.80
- **Performance Metrics**:
  - In FY24 there was **2,135** active pregnancies
    - In FY24 **100%** of pregnant women received specific intervention (i.e., preterm birth-specific education, enhanced monitoring regime, etc.)
    - In FY4 over **100** pregnant patients received at home blood pressure monitoring.
  - In FY24 the OB RN Coordinator conducted **1,253** initial intake visits.
  - In FY24 there were **732** Centering Pregnancy participants.
  - In FY25 to date = October 2024 and November 2024(December 224 data is due January 15th, 2025):
    - In FY25 In FY25 to date **223** patients had their OB initial intake visit.
    - Delivery data is received quarterly given the nature of birth and 9-month pregnancy term.
- ***Programmatic Highlights***:
  - Unity Healthcare utilizes an Obstetric Register Nurse Coordinator to conduct initial intake visits and triage all pregnant women to appropriate care. This would allow the nurse to focus solely on the intake of all pregnant women following a positive pregnancy test result and would then allow providers schedules to open for higher level patient needs as they occur. Unity's OB Intake Nurse conducts the PRAPARE tool during the official OB Intake with pregnant patients and makes relevant referrals as well as triage patients to the correct provider type.
  - The addition of the coordinator has improved the time to entry into prenatal care from **13** days to **3-4** days. The rate of women who started prenatal care during their first trimester was **77.5%** in FY24.
  - In FY24 an agreement was established to retrieve insurance application assistance counts directly from the Director of Social Services monthly based on the services that staff were performing with pregnant patients.
  - In FY24 ~79% pregnant women attended their postpartum visit, due to the work of the OB care Coordinators. The OB Care Coordinators schedule patients for their prenatal and postpartum appointments. They conduct outreach to follow-up with patients who have missed their appointments and require rescheduling as well as contact patients who are lost to care utilizing their appointment tracking spreadsheets.
- ***Challenges***:

- During FY24 Unity Healthcare underwent extensive organization-wide layoffs and restructuring, causing programmatic and data indicator reporting challenges.

Q41: Please provide the following information on the Perinatal Quality Collaborative in FY 2024 and FY 2025, to date:

a. Funding allocated by DC Health to DC Hospital Association for this program;
b. Rates of hypertension, pre-eclampsia, and maternal morbidity and mortality for every hospital participating in the PQC for FY 2023, 2024, and 2025, to date;
c. Description of programs administered through the collaborative and number of healthcare professionals reached by each one;
d. Other program outcomes of the PQC in FY 2024 and planned activities in FY 2025; and
e. Overview of PQC participants.

Response:

a. **Funding allocated by DC Health to DC Hospital Association for this program;**

DC Health awarded $387,348.57 to the DC Hospital Association for this program in FY24.

b. Rates of hypertension, pre-eclampsia, and maternal morbidity and mortality for every hospital participating in the PQC for FY 2023, 2024, and 2025, to date;

Overall, birth admissions decreased by 1.24% from Fiscal Year 2023 (FY23) to Fiscal Year 2024 (FY24) based on hospital discharge data. In contrast, the rates of gestational hypertension increased by 1.26% during the same period. The rate of preeclampsia saw a rise of 11.14% from FY23 to FY24. Additionally, the severe hypertension rate increased by 7.87% between these two fiscal years. However, severe maternal morbidity showed a decrease of 10.99% from FY23 to FY24. Efforts to improve identification of complications during pregnancy including a focus on hypertension, preeclampsia, eclampsia, and related complications were underway through the Perinatal Quality Collaborative over the past several years. The decline in birth admissions coupled with initiatives to improve identification of comorbidities were a factor in the increased rates noted above. As a result of these focused efforts, timely treatment of hypertension during birth admissions increased from 35.2% at the beginning of FY23 to 84.2% during FY24. This improvement in treatment has been sustained since the 3rd quarter of FY23. (Please note, final deadlines for 2024 discharge data reporting occur in March of this year. Updates to reported data points for 2024 may occur at that time.)

Severe Maternal Morbidity:
The Alliance for Innovation on Maternal Health (AIM) severe maternal morbidity (SMM) rate in the District of Columbia shows an increase for calendar year 2023 following three years or relatively steady performance from 2020 – 2022. The rate also increased from the 2019 rate with the 2023 AIM SMM rate of 213 per 10,000 deliveries compared to 137 per 10,000 in 2019. This rise in SMM rates has been observed across all racial categories. Disparities persist, with black

mothers consistently experiencing the highest rates of SMM. During2019, the number of black women affected by SMM was double that of their white counterparts. This disparity increased to three times the rate of white women from 2023. Notably, a contributing factor to this change may be that the work of the District of Columbia Perinatal Quality Collaborative (DC PQC) from 2020 – 2023 focused in part on improving identification of severe maternal morbidities with particular attention to black birthing women given the disparities in maternal morbidity and mortality observed at the start of the PQC. This increase in SMM rates and in the apparent disparity may be, at least in part, a reflection of more accurate identification. Efforts to identify and address these disparities remain critical, as black mothers continue to bear a disproportionate burden of severe maternal morbidity in the District.

Severe Maternal Morbidity (per 10,000 deliveries), by Year & Race/Ethnicity

Year	Race	SMM	Births	Rate
2021	Overall	233	7417	314.143
	Black/African American	128	3094	413.704
Year	**Race**	**SMM**	**Births**	**Rate**
2022	Overall	254	7026	361.514
	Black/African American	131	2941	445.427
Year	**Race**	**SMM**	**Births**	**Rate**
2023	Overall	286	6879	415.758
	Black/African American	139	2778	500.360

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.

Summary of SMM by Ward, 2021

Wards	SMM(N)	Birth(N)	SMM Rate(per 10,000 births)
Ward1	20	840	**238.10**
Ward2	12	442	**271.49**
Ward3	9	533	**168.86**
Ward4	36	1226	**293.64**
Ward5	35	1040	**336.54**
Ward6	25	987	**253.29**
Ward7	50	897	**557.41**
Ward8	33	938	**351.81**

Missing	13	523	
Total	**233**	**7426**	

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

Maternal mortality:
The District maternal mortality rate (MMR) is the number of DC-resident maternal deaths during calendar years 2019-2023 divided by the total number of live births to residents in the District of Columbia. The value is multiplied by 100,000 to present a rate per 100,000 live births. There were 10 maternal deaths, and the five-year DC maternal mortality rate was 23.5 per 100,000 live births for 2019-2023.

The DC pregnancy-related mortality rate is the number of DC-resident pregnancy-related deaths in calendar years 2019-2023 divided by the total number of live births to residents in the District of Columbia during these years. The value is multiplied by 100,000 to present a rate per 100,000 live births. There were 11 pregnancy-related deaths, and the DC pregnancy-related mortality rate was 25.8 per 100,000 live births between 2019-2023.

Table 2. Maternal and pregnancy-related mortality, District of Columbia, 2017-2021		
Characteristic	N	Rate (per 100,000 live births)
Maternal mortality	10	23.5
Pregnancy related mortality	11	25.8
Data Source: Birth and Death data, Vital Records Division, DC Health, 2019-2023.		

c. **Description of programs administered through the collaborative and number of healthcare professionals reached by each one;**

Severe Hypertension Sustainability:
DC PQC has transitioned into a sustainability phase for the AIM Severe Hypertension Bundle, focus has shifted to ensuring that improvements are not only maintained but also deeply integrated into routine clinical practice. Sustainability efforts emphasize ongoing data tracking, continuous provider education, and robust patient engagement. All District birthing hospitals (MedStar Georgetown University Hospital, George Washington University Hospital, Sibley Memorial, Howard University Hospital, and MedStar Washington Hospital Center) completed a hypertension sustainability plan to establish metrics that will continue to be monitored.

Blood Pressure Cuff Distribution:

All five birthing hospitals successfully implemented a BP cuff distribution program, with Howard University Hospital launching a new initiative. This program allows the hospital to distribute blood pressure cuffs to its patients at discharge, contributing to improved patient care and better postpartum hypertension management.

FY2023 Severe Hypertension (HTN) Measures (Alliance for Innovation on Maternal Health)

Severe Hypertension (HTN) Measures	**Q2 (2023)**	**Q3 (2023)**	**Q4 (2023)**	**Q1 (2024)**	**Q2 (2024)**	**Q3 (2024)**
SHTN P3 Provider Education on Severe Hypertension and Preeclampsia	85.0%	87.5%	95.0%	95.0%	95.0%	95.0%
SHTN P4 Nursing Education on Severe Hypertension and Preeclampsia	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

As part of the transition to hypertension sustainability, the DC PQC conducted a focused training session for District birthing hospitals to discuss their blood pressure (BP) cuff distribution programs for patients and exchange best practices. Prior to this training, four out of five hospitals had established programs in place, excluding Howard University Hospital. Following the session, all five birthing hospitals successfully implemented a BP cuff distribution program, with Howard University Hospital launched a new initiative. Howard University Hospital has since demonstrated exceptional commitment by maintaining and consistently reporting on their program throughout the year to the PQC by submitting an excel sheet to track distribution by race and ethnicity. This program allows the hospital to distribute blood pressure cuffs to its patients at discharge, contributing to improved patient care and better postpartum hypertension management.

Obstetric Hemorrhage Patient Safety Bundle:
The DC PQC Advisory Board made the strategic decision to prioritize the implementation of the Alliance for Innovation on Maternal Health (AIM) Obstetric Hemorrhage Patient Safety Bundle across birthing hospitals in the District in January 2024. The DC PQC adopted a Community of Learning (COL) approach, fostering collaboration among multidisciplinary teams from participating hospitals. This model encourages the exchange of knowledge, shared problem-solving, and continuous improvement by leveraging insights and best practices across institutions. In addition, hospital team training and technical assistance are provided monthly to all birthing hospital clinical teams across the District of Columbia. This ensures that 100% of birthing hospitals receive tailored support, ongoing training, and targeted resources to address their specific needs and advance quality improvement projects.

The initiative began with a series of three structured kick-off sessions. The first session provided an overview of the clinical implementation of the hemorrhage bundle and the second session focused on data collection and reporting for the hemorrhage bundle. Lastly, hospitals completed a gap analysis to identify opportunities for improvement relative to hemorrhage best practices.

FY2024 Obstetric Hemorrhage Measures (Alliance for Innovation on Maternal Health) *

Hemorrhage Measures	**Q3 (2023)**	**Q4 (2023)**	**Q1 (2024)**	**Q2 (2024)**	**Q3 (2024)**
ALL P1. Provider Education on Respectful and Equitable Care	N/A	77.5%	63.0%	77.5%	79.0%
ALL P2. Nursing Education on Respectful and Equitable Care	N/A	83.0%	77.0%	83.0%	83.0%
ALL PS. Unit Drills- Number of Drills	N/A	4.4	1.0	5.0	3.0
HEM S2. Unit Policies & Procedures	0.0%	60.0%	60.0%	80.0%	60.0%

**Note: Metrics indicated with an S# are structure measures that are instituted prior to implementation of a recommended process. Metrics indicated with a P# are measures of process implementation.*

Under the guidance of the DC PQC Full Committee and birthing hospital teams, the DC PQC initiated a focused quality improvement sprint on improving the measurement and performance of Quantitative Blood Loss (QBL), a critical metric for managing obstetric hemorrhage. This targeted effort promotes rapid-cycle learning, testing of interventions, and measurable improvements in care quality. To support improvements in Quantitative Blood Loss (QBL) practices, sessions were designed to enhance understanding and implementation. Sessions included hands-on training, expert-led discussions, and collaborative workshops aimed at sharing best practices, addressing challenges, and refining measurement techniques. Dr. Veronica Gillispie-Bell, a national subject matter expert presented on the QBL process, offering valuable insights and evidence-based strategies to further elevate the DC PQC's practices. The DC PQC provided in FY24 diverse learning opportunities in an effort to ensure hospital teams are well equipped with the knowledge and tools necessary to drive prevention and improvements in obstetric hemorrhage management.

As the implementation of the Obstetric Hemorrhage Bundle progresses, focus has expanded to include trauma-informed care and improving provider-patient communication following hemorrhage events. This dual focus not only supports the emotional and physical recovery of patients but also equips care teams to address the clinical and psychological impacts of hemorrhage with an emphasis on equitable and respectful care. By prioritizing trauma-informed practices, the DC PQC acknowledges and validates patients' experiences, fostering an environment of trust and dignity. This approach enhances the recovery experience by empowering patients to feel heard, respected, and supported throughout their care journey. Planned activities in FY25 will include participation of birthing hospitals, as well as community, primary care and postpartum care providers.

An essential part of addressing trauma is the integration of the patient voice, which continues to play a central role in all DC PQC initiatives. The DC PQC is committed to ensuring that patients, particularly those who have experienced traumatic events like obstetric hemorrhage, are not only recipients of care but active participants in shaping the care they receive. In effort to create a holistic, person-centered approach to care, patient and family representatives continue to be woven into all ongoing projects and activities. This collaborative model ensures that the voices of birthing people inform policies, practices, and interventions, fostering a care environment that is truly responsive to the diverse needs of the community. These diverse perspectives are used to guide improvements and ensure clinically effective and culturally attuned.

In FY24, the DC PQC hosted a Subject Matter Expert (SME) from a maternal-child health education organization dedicated to empowering black women to replace silence with storytelling around pregnancy and infant loss and infertility. The SME shared valuable insights on enhancing communication to better meet patient needs and improve care quality. Additionally, the SME presented on the importance and process of patient event debriefs, highlighting how these debriefs can support both the clinical and emotional needs of patients and care teams. This comprehensive approach ensures that the physical, psychological, and emotional aspects of hemorrhage care are addressed in a holistic and supportive manner.

Additional Training in FY24:
Hospitals continued to maintain respectful care training programs within their own health systems in alignment with AIM bundle recommendations and metrics. These ongoing training efforts for providers and nursing staff demonstrated significant improvements compared to FY23. Participation rates increased from the first-quarter FY23 baselines of 58% for providers and 65% for nursing staff to 79% for providers and 83% for nursing staff in the first quarter of FY24. Quality improvement methodology training efforts also expanded in FY24.

Building on the success of the FY23 Certified Professional in Healthcare Quality (CPHQ) Certification Training pilot, new CPHQ training opportunities were introduced. These included a two-day in-person training event followed by a series of participant-led virtual sessions. Designed to deepen participants' understanding and application of quality improvement principles, these sessions fostered greater engagement and impact in quality improvement initiatives. The FY23 pilot featured on-demand content, book resources, practice exams, and weekly sessions, which continued to serve as a foundation for these efforts.

d. **Other program outcomes of the PQC in FY 2024 and planned activities in FY 2025;**

Timely Treatment for Severe Hypertension:

a. Among the birthing hospitals, 36% of women, compared to 19% in FY23 received timely treatment for severe hypertension as defined by AIM in FY24
b. Implementation of process improvement activities led to an improvement to 85%, with sustained results ranging between 85% and 89%.
c. The disparity in the delivery of timely treatment for severe hypertension in DC has also significantly decreased. At baseline in the first quarter of 2021, white non-Hispanic

women received timely treatment at a rate 48% higher than Black non-Hispanic women. This gap had been reduced to 6.3%, reflecting substantial progress in addressing disparities. Despite these improvements, Black non-Hispanic women's rates of timely treatment still lag-behind those of white non-Hispanic women, underscoring the ongoing need for targeted efforts to achieve equity in timely care.

Funding:

a. In FY24, the DC PQC received Health Resources Services Administration (HRSA) funding for a five-year project period to support expanded AIM capacity. The grant is intended to support expanded capacity bundle implementation leveraging the community of learning (COL) model. The DC PQC has identified areas to address including Perinatal Mental Health, Postpartum Discharge (a new AIM Patient Safety Bundle), Substance Use and Cardiac Care. This postpartum group will join birthing hospital teams in focusing on improvements in respectful care and communication post hemorrhage event. Additionally, based on available data and recommendations from a maternal health subcommittee through the Department of Healthcare Finance, planning to implement the maternal mental health bundle is underway with a planned launch in 2025. Through additional HRSA funding, the DCPQC has also taken a proactive approach to enhancing hypertension management by equipping hospitals with blood pressure cuff kits These kits are distributed to patients at discharge, empowering them with the tools needed to monitor their blood pressure at home.

Data Enhancements:
One of the primary initiatives has been improving the functionality of CRISP DC's alert system to better support care continuity. Enhancements include refining alerts and notifications for follow-up appointments, ensuring timely tracking of patient attendance, and flagging critical health conditions that providers need to address during postpartum visits. The development of these notifications and subsequent piloting of the new features is planned for 2025. These updates aim to streamline care coordination and ensure that patients receive the attention and resources they need during this crucial period.

The DC PQC has developed and begun leveraging a DC PQC dashboard to visualize hospital maternal health data, disaggregated by race, ethnicity, and other key areas to support our quality improvement efforts. This tool enables tracking key metrics and identifying disparities in maternal health outcomes, allowing for targeted interventions. To further enhance a data-driven approach, a Data Workgroup was created that works closely with the dashboard to analyze these insights and inform actionable strategies.

Hemorrhage Community of Learning:
In FY25, the postpartum and perinatal mental health workgroups will be integrated with the Hemorrhage Community of Learning to align improvement efforts with postpartum hemorrhage care. This integration will focus on enhancing provider-patient communication, particularly for individuals who have experienced a hemorrhage and associated trauma. The workgroups will

explore strategies to improve communication, address emotional and psychological needs, and ensure access to appropriate resources for recovery.

Patient Family Action Network:
In FY24, patient and family engagement remained a priority. Significant progress was achieved in expanding the Patient and Family Action Network (PFAN), increasing representation from one partner to a total of four partners and three advocates, culminating in seven active representatives.

Two focus groups were conducted in FY24 with individuals with lived experience, which included a session focused on postpartum care experiences. This session aimed to gather insights on patient experiences during the postpartum period, focusing on key aspects of follow-up care.

a. In FY2025, the DC PQC will continue to engage the PFAN representatives into the DC PQC quality improvement activities to enhance and strengthen the work of the collaborative and other DC Health programs.
b. In FY24, the DC PQC participated in the DC Black Mammas Wellness Day community activities. Patient education materials on signs and symptoms were distributed and participating aided in increasing partnerships within the community.

DC Health and DC Hospital Association (DCHA) Educational Collaboration:
In FY24, DCHA/DC PQC in collaboration with DC Health began planning a joint District symposium focused on maternal health and aimed at informing strategic planning and advancing care improvements across the District. The target audience for the Symposium, which took place in FY25, included clinicians, patient and family representatives, community-based organizations, payors and other relevant stakeholders.

DC PQC Social Media & Communications:
In FY24, DC PQC has enhanced its digital presence through the launch and development of social media platforms where we decimated 50 posts across all platforms (Instagram, Facebook and LinkedIn), a more comprehensive website, and a regular newsletter. These initiatives aim to broaden outreach and improve communication. The DC PQC's social media platforms were able to reach more than fifty thousand people over the past months due to boosting and gained 157 followers across the new platforms.

In FY24, The DC PQC also worked on updating and improving the website and began disseminating a quarterly newsletter. The newsletter highlights key activities, successes, and important developments in the DC PQC and maternal health. The DC PQC continues to engage with stakeholders and the community through focus groups, educational initiatives, and collaborations to ensure projects align with community needs.

In FY25, the DC PQC is looking to expand social media print by creating interactive videos and starting a podcast to share insights and educational topics with the community.

Planned Activities in FY25

Collaborate with Clinical Implementation Workgroups to drive data-driven quality improvement efforts. This includes implementing Communities of Learning focused on using data insights to improve AIM Patient Safety Bundle-specific measures.

Expand resource accessibility by utilizing diverse platforms such as social media, podcasts, and short videos. These tools will share critical maternal health information, highlight best practices, and engage a broader audience effectively.

Leverage its dashboard to enhance data analytics capacity, enabling deeper insights into maternal health outcomes and disparities. This advanced analytical capability will help identify emerging trends, measure intervention impacts, and inform data-driven strategies, supporting the DC PQC's expanding scope.

We will work with Count the Kicks to implement a stillbirth prevention initiative across the hospitals in the District, with local funds of $74,600 allocated to the District of Columbia Hospital Association for this effort.

Overview of PQC participants

The District of Columbia Perinatal Quality Collaborative (DCPQC) is comprised of 60 members, some of whom serve on the Advisory Board and others on the Full Committee. The PQC brings together a diverse group of stakeholders, including payors, hospitals, Federally Qualified Health Centers (FQHCs), community-based organizations who provide perinatal services, patient and family representatives, and government agencies such as DC Health, Department of Healthcare Finance, and the Department of Behavioral Health. This collaboration ensures a wide range of perspectives to guide the PQC's initiatives.

The DCPQC values patient and family engagement through its Patient and Family Advisory Network (PFAN). PFAN representatives contribute critical insights to quality improvement efforts and ensure that care aligns with patient needs and priorities. Efforts to strengthen patient participation include targeted recruitment and onboarding strategies, partnerships with community organizations, and the inclusion of diverse voices, such as fathers.

Q42: Please provide the following information for Help Me Grow DC's activities in FY 2024 and FY 2025, to date:

a. **DC Health has improved the Help Me Grow program in FY 2024 and FY 2025, to date, including integrating it with home visiting programs;**
b. **The number of individuals served in FY 2024 and FY 2025, to date, including the number of children receiving a developmental screening through this program;**
c. **The current service capacity of the program and whether there is a waitlist for the program; and**
d. **The amount budgeted and actually spent on the program. Please include a breakdown of the amount of local, federal, private, and special revenue funding.**

Response:

In 2024, DC Health continued to explore platforms to enhance the Help Me Grow (HMG) centralized access line and advanced efforts toward developing a centralized intake (C-Intake) system aligned with the District's population-health approach. The primary goal is to guide programmatic decision-making and implementation while ensuring successful linkages to services for all DC residents. The data system aims to increase enrollment and utilization of both the HMG and home visiting programs, facilitate timely referrals, and connect at-risk families and children to community-based social, health care, behavioral health, and other support services. DC Health examined alternative options for system development through Salesforce, researched centralized systems used by other states and jurisdictions, and engaged with program staff to enhance and modify internal data management systems. A partnership with DC Child and Family Services (CFSA) was proposed, including the use of CFSA's 211 warmline. DC Health plans to finalize a Memorandum of Agreement (MOA) with CFSA in FY 2025 to coordinate referrals to services for District residents.

The HMG team explored using LinkU as an alternative to its current database. However, it was determined that LinkU was not a viable option due to its inability to link children and caregiver profiles, limited case management capabilities, and lack of required functions for HMG DC Care Coordinators. The team also considered enhancing QuickBase, the platform currently used by agency-funded home visiting programs for data entry and management. Following a discovery process, all necessary information to design and build the database was presented to the DC Health IT Team. Visit Tracker, a home visiting database with a centralized intake component, was explored. However, concerns about interoperability and its ability to meet specific DC Health requirements remained unresolved. In FY 2025, DC Health, in collaboration with a contracted vendor, initiated a series of IT assessment and discovery sessions to gain a comprehensive understanding of:

- **People**: Key personnel and their roles in managing and interacting with IT systems.
- **Processes**: Current workflows and business processes and how they interact with IT systems.
- **Technology**: Existing systems and tools, including infrastructure, software, and integrations.

The first IT assessment and discovery session focusing on the centralized intake system was held in December 2024. Help Me Grow DC served 425 children and 388 families in FY 2024. To date in FY 2025, Help Me Grow has served 101 children and 90 families. A total of 31 families received developmental screenings in FY 2024, while 15 families have received screenings to date in FY 2025, all administered by HMG Care Coordinators. Help Me Grow DC has capacity to serve additional families and currently has no waitlist.

Funding Entity	FY24 Award	FY24 Expenditures	FY25 Award	FY25 Expenditures (To Date)
Department of Health Care Finance (DHCF)	$485,744.92	$204,449.00*	$473,799.68	$62,494.71
Maternal and Child Health Title V	$475,930.62	$249,943.22*	$579,088.50	$76,382.42
Connecticut Children's Medical Center	$60,000.00	$60,000	$0.00	$0.00
Total	$1,021,675.54	$514,442.22	$1,052,888.18	$138,877.13

*Due to staff vacancies: Program Manager, Program Coordinator, and Public Health Analyst. Program Coordinator and Public Health Analyst position has been filed for FY 2025. Interviews for Program Manager pending. An additional Public Health Analyst position pending start date (1/20/2025).

Q43: Please provide the following information for home visiting in FY 2024 and FY 2025, including:

a. The amount of local and federal funding awarded to each grantee;
b. The average salary each grantee pays home visitors;
c. The number of residents served by each grantee, including the average number of visits per resident;
d. The metrics and outcomes showing efficacy of each grantees' program;
e. An update on the rollout of the centralized intake initiative for home visiting scheduled to begin in FY 2024; and
f. Any other updates to DC Health's home visiting strategy in FY 2024 and FY 2025, to date, including plans to spend the new MIECHV federal funding.

Response:

a. The amount of local and federal funding awarded to each grantee.

Grantee	FY24 Award	FY 24 Expenditures	FY 25 Award	FY 25 Expenditures (To Date)
Locally Funded				
Community of Hope (PAT)	$283,005.00	$271,675.63	$299,999.20	$55,110.92
Georgetown Parent Support Program (PSP)	$299,999.06	$281,767.60	$299,999.62	$0.00*
Mamatoto's Village Evaluation Programs	$460,000.00	$459,282.85	$310,000.00	$56,033.03
Mary's Center Healthy Families America (HFA) MIECHV	$304,058.00	$66,493.79	$300,000.00	$50.128.59
Mary's Center Parents As Teachers	$0.00	$0.00		

(PAT) MIECHV				
Federally Funded				
Mary's Center Healthy Families America (HFA) MIECHV	$653,028.95	$653,028.95	$1,231,824.28	$108,406.65
Mary's Center Parents As Teachers (PAT) MIECHV	$557,213.00	$557,213.00	$587,927.00	$66,659.34
DC Health (Safe Care Augmented)**	-	-	$767,409.21	$0.00
Community of Hope (PAT)***	-	-	$300,000.00	$0.00
Mamatoto Village (Training)****	-	-	$159,494.00	$0.00
Georgetown Evaluation	$154,652.51	$127,859.53	$154,653.69	$0.00*

* Invoices submitted quarterly (will be submitted January 15, 2025)

**DC MIECHV will provide direct services through the implementation of the SafeCare evidence-based home visiting model. SafeCare is a home-based program that promotes parent skill acquisition in the family's natural environment (in the home) and to capitalize on natural opportunities for learning. It is designed to be completed in 18 sessions (6 sessions per each of the 3 modules). The actual length of the program for each family will depend on the parent's initial skills and rate of skill acquisition; it may be shorter or longer. Each session typically lasts 50 to 90 minutes, depending on the session focus. Sessions are typically conducted weekly and scheduled when assessment and training is most applicable (e.g., nap time, bath time). SafeCare delivery is no more than twice a week and no less than every two weeks to optimize skill acquisition and retention. SafeCare can be conducted by itself or with other services.

*** Funds will be used to expand home visiting services implemented by Community of Hope using the PAT model.

**** DC Health will contract with Mamatoto Village to provide annual training for 50 home visitors. Mamatoto Village offers trainings and professional development for maternal and child health, human services, and public health professionals. Mamatoto facilitates trainings that will provide home visiting staff with the knowledge and skill set to provide culturally congruent care to meet the needs of families in the District. Mamatoto provides trainings to include Perinatal Health Worker and Lactation Specialist Trainings and an array of culturally resonant trainings to professionals of all levels of expertise and backgrounds via the Mamatoto Village Academy (MVA).

b. **The average salary each grantee pays home visitors.**

Grantee	Average Salary
Community of Hope (PAT)	**$56,012.67**
Georgetown Parent Support Program (PSP)	**$57,325.50**
Mamatoto's Village Evaluation Programs	**N/A**
Mary's Center, Healthy Families America (HFA) MIECHV (Local and Federal)	**$47,000**
Mary's Center, Parent's as Teachers (PAT) MIECHV (Local and Federal)	**$47,000**

Please note that the District cannot dictate salaries that a grantee pays its personnel, we can only provide guidance.

c. The number of residents served by each grantee, including the average number of visits per resident.

Grantee	Number of Residents Served		Average Number of Visits Per Resident	
	FY 24	FY25 (YTD)	FY24	FY25 (YTD)
Community of Hope (PAT)	**49 caregivers 59 children**	**43 caregivers**	**11 visits per family**	**4 Visits per family**
Georgetown Parent Support Program (PSP)	**24 caregivers 34 children**	**15 caregivers**	**11 visits per family**	**3 Visits per family**
Mamatoto's Village Evaluation Programs	**30 individuals trained**	**0**	**N/A**	**N/A**
Mary's Center, Healthy Families America (HFA) MIECHV	**72 (caregivers and children)**	**68 (caregivers and children)**	**23 (average number of visits per resident)**	**5 (average number of visits per resident)**

Mary's Center, Parent's as Teachers (PAT) MIECHV	**51 (caregivers and children)**	**35 (caregivers and children)**	**34 (average number of visits per resident)**	**2 (average number of visits per resident)**

d. The metrics and outcomes grantees must report to DC Health through required grant reporting;

The federal and local home visiting programs must collect and report data on the performance of eligible families participating in the program under the legislatively mandated benchmark areas. The following table lists the benchmarks and the corresponding performance measures:

Benchmark Area	**Performance Measure**
Maternal and Newborn Health	Percent of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment.
	Percent of infants (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at 6 months of age.
	Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally).
	Percent of children enrolled in home visiting who received the last recommended visit based on the American Academy of Pediatrics (AAP) schedule.
	Percent of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery.
	Percent of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment.

Child Injuries, Abuse, Neglect, Maltreatment and Emergency Department Visits	Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bed-sharing or soft bedding.
	Rate of injury-related visits to the Emergency Department (ED) during the reporting period among children enrolled in home visiting.
	Percent of children enrolled in home visiting with at least 1 investigated case of maltreatment following enrollment within the reporting period.
School Readiness and Achievement	Percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool.
	Percent of children enrolled in home visiting with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily, every day.
	Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool.
	Percent of home visits where primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning
Crime and Domestic Violence	Percent of primary caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within 6 months of enrollment using a validated tool
	Percent of primary caregivers who enrolled in home visiting without a high school degree or equivalent who subsequently enrolled in or maintained continuous enrollment in middle school or high school, or completed high school or equivalent during their participation in home visiting.

Family Economic Self-Sufficiency	Percent of primary caregivers enrolled in home visiting for at least 6 months who had continuous health insurance coverage for the most recent 6 consecutive months.
Coordination And Referrals for Other Community Resources And Supports	Percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts.
	Percent of children enrolled in home visiting with positive screens for developmental delays (measured using a validated tool) who receive services in a timely manner.
	Percent of primary caregivers enrolled in home visiting with positive screens for IPV (measured using a validated tool) who receive referral information to an IPV resource.

Mary's Center

- ***Outcomes per Household***
  - 81.6% of households served by the Mary's Center home visiting program are low-income households below 100% of federal poverty guidelines
  - 13.6% of households served had a history of child abuse and neglect
  - 8.8% of households served had a history of substance abuse or needed substance abuse treatment
  - 13.6% of households served had a child who had attained a low-student achievement
  - 17.6% of the households served had a child with developmental delays or disability.
- ***Health Insurance and Medical Care***
  - 94.2% of children had a usual source of medical care
  - 92.2% of children had 6+ months of continuous health insurance coverage
  - 62.5% of women who gave birth to a baby in FY24 received postpartum care within 56 days of delivery
- ***Caregiver Screenings and Service Linkages***
  - 66.7% of female caregivers received screening for intimate partner violence (IPV)
  - 100% of female caregivers who screened positive for IPV were given referrals to services addressing IPV
  - 66.7% of women in the home visiting program received timely screening for depression
  - 42.9% of women screening positive for depression were successfully linked to services
- ***Education***

  - 6.7% of caregivers who enrolled in home visiting with less than a high school level of education re-enrolled in a GED/high school program after enrollment in the home visiting program
- ***Child Health and Development***
  - 71.4% of children received well-child visits (Note: Families had a difficult time getting appointments for well-child visits due to long wait-times to see a doctor/physician.)
  - 60% of children were breastfed any amount at 6 months of age
  - 58.1% of parents with children less than 12 months old were always used infant safe sleep practices
  - 39.6% of children had a timely screening for developmental delay within the American Association of Pediatrics (AAP) recommended guidelines of screening at 9-months, 18 months, and 24 or 30 months of age.
  - 100% of children who screened positive for developmental delay and were referred for additional supports and services were successfully linked to services
  - 82% of households in home visiting engaged in early language and literacy activities with their children.

Community of Hope Parents as Teacher's

- ***Caregiver Screenings and Referrals***
  - 88% of caregivers participating in home visiting were screened for depression
  - 32% of caregivers screened had a positive screen for depression
  - 100% of caregivers who screened positive for depression were referred for services
  - % of primary caregivers referred to services for a positive screen for depression receive one or more service contacts
- ***Maternal and Child Health***
  - 100% of mothers enrolled in home visiting prenatally or within 30 days of giving birth who received postpartum visit with health provider within 8 weeks (56 days) following birth.
  - 0% of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) were born preterm following program enrollment
  - 48% of parents with infants enrolled in home visiting always used infant safe sleep practices
- ***Developmental Screenings and Referral***
  - 90% of children enrolled in home visiting were screen for developmental delays using the ASQ-3
  - 5% of children screened had a positive ("refer") ASQ-3
  - 100% of children enrolled in home visiting who screened positive were referred for follow-up evaluation and intervention as indicated by developmental screening with ASQ-3.
  - 87% of children enrolled in home visiting were screen for developmental delays using the ASQ-SE

  - 4% of children screened had a positive ("refer") ASQ-SE
  - 100% of children enrolled in home visiting who screened positive were referred for follow-up evaluation and intervention as indicated by developmental screening with ASQ-SE.
- ***Pediatric Preventive Health Care***
  - 48% of children enrolled in home visiting received their last/most current recommended visit based on AAP Bright Futures schedule
- ***Tobacco Use and Referral***
  - **N/A** % of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment were referred to tobacco cessation counseling or services within 3 months of enrollment.
- ***Breastfeeding***
  - 67% of infants (among mothers who enrolled in home visiting prenatally) were breastfed any amount at 6 months of age

Mamatoto Village

- Mamatoto Village trained 30 women across 2 training pathways (90-hour Lactation Specialist, and Community Birth Worker)
- Provided 30 scholarships
- Mamatoto has completed a mixed methods evaluation of the MRHV program. This evaluation resulted in the creation and publication of scholarly articles regarding Mamatoto's MRHV program.
- Mothers Rising program served 333 clients

Georgetown Parenting Support Program

- 2 parents with depression and anxiety disorders accepted referrals for services
- 0 Preterm Births
- 2 parents to be referred to DC Health for Safe Sleep training
- 4 children received developmental screenings
- 1 child with a positive screening was referred to Strong Start

Q44: Please provide an update on the Newborn Screening Program, including the registry, database, and data system enhancements, in FY 2024 and FY 2025, to date.

Response:

The DC Newborn Screening (DC NBS) Program aims to ensure early identification of health conditions that can adversely impact an infant's health and development. DC NBS is made up of three screening programs, including:

- DC Early Hearing Detection and Intervention (newborn hearing screening) Program (DC EHDI) - Ensure All deaf or hard of hearing (DHH) infants and children up to age 3 are identified in a timely manner and patient-centered, culturally-tailored follow-up services are received to optimize language, literacy, cognitive, social, and emotional development.
- DC Newborn Metabolic Screening Program (DC NMS) - Ensure all newborns born in the District are screened at birth for 45 inherited metabolic and genetic disorders that are treatable by diet, vitamins and/or medication, or by anticipatory measures to prevent attacks.
- DC Newborn Critical Congenital Heart Disease Screening Program (DC CCHD) - Ensure all newborns born in the District are screened at birth for CCHD and any infants with abnormal results receive timely and appropriate follow-up and services.

The DC Newborn Screening Database (Revvity OZ eScreener Plus)currently receives and helps track newborn hearing screening results and follow-up information. Soon the database will also do the same for metabolic/genetic (dried blood spot) and critical congenital heart disease (CCHD) screenings.

In FY24, system enhancements focused on adding in new features to assist with EHDI data sharing and utilization among DC's five birthing hospitals, one children's hospital and one birthing center, called Telepathy EHDI. The majority of the implementation has been completed, and the rest will be completed in FY25.

In FY25, the next phase of database expansion is for the Dried Blood Spot (DBS)/metabolic and Critical Congenital Heart Disease (CCHD) screening components. The database is currently running final testing and internal implementation for the DBS component. Once ready, we will work with each of the hospitals and birthing facility, as well as out contracted newborn screening laboratory to implement the DBS component. DC NMS is also supporting each facility to conduct a new e-filter paper process, which will create a single, streamlined profile for each baby, including all newborn screening results and follow up information (for newborn hearing, metabolic/genetic and heart screenings).

Additionally, DC Health anticipates publication of Hospital Discharge Regulations which would enhance the procedures that birthing hospitals and facilities must follow to ensure compliance with comprehensive newborn screening and hospital discharge requirements. The new regulations aim to improve the quality of care for newborns delivered or cared for in hospitals

and facilities across the District of Columbia. The team is working with General Council on final edits. Once completed, the regulations will be posted as a rulemaking before finalizing the regulations. An updated version was submitted to DC Health legal in December 2024.

Q45: In January 2024, DC Health told the Committee it was developing a Maternal Health Task Force that will begin evaluating and streamlining the consolidation of eleven maternal health subcommittees. What is the status of the Task Force? What are its recommendations for streamlining subcommittees?

Response:

DC Health, as part of the State Maternal Health Innovation (SMHI) program funding through the Health Resources and Service Administration, was tasked with developing a Maternal Health Taskforce. As a result, DC Health began to assess how best integrate existing District-wide maternal health working groups, programs, task forces, and committees. DC Health began identifying key stakeholders and partners and initiated engagement. This included meeting with the DC Perinatal Quality Collaborative (DC PQC), Title V, Department of Healthcare Finance (DHCF), and DC Primary Care Association (DCPCA) to discuss collaboration and support of the State Maternal Health Innovation Grant, including the Maternal Health Taskforce.

DC Health has developed an MHI Maternal Health Taskforce formal application. The application has been sent out to identified/potential stakeholders and agency partners. The application is being used to gather initial information regarding current engagement and involvement and work in maternal health in the District. The form also collects information regarding existing strategic plans and work plans addressing maternal health. In addition, it will help to guide development of subcommittees, assess initial potential areas of interest/priority areas that will be used to guide the development of the strategic plan, and guide scheduling of initial meetings. The form was drafted and sent for additional review and feedback, including from external partners from the agency. Once approved, the form began to be distributed.

The Maternal Health Taskforce is tasked with the development of a District Maternal Health Strategic Plan. DC Health is also reviewing publicly available reports and recommendations from key maternal health stakeholders and organizations in an effort to streamline and reduce duplication of efforts in the development of the state Maternal Health strategic plan. DC Health has partnered with the George Washington University and its Centers of Excellence on Maternal Health to utilize public health fellows and student interns to assist with this opportunity. The initial Maternal Health Taskforce kick-off meeting was held at the end of FY2024. A follow-up meeting was held in which DC Health shared the draft strategic plan for feedback.
DC Health also partnered with internal and external partners to host a District maternal health symposium at the top of FY25. The symposium was set to serve as the central meeting for the Maternal Health Taskforce and included partners and other maternal and child health related working groups, advisory boards, committees, and taskforces across the District. The in-depth strategic planning session gathered key stakeholders and community partners who will further support the development of the state strategic plan.

Regarding the consolidation of committees, a proposal has been submitted to have the DC Maternal and Child Health (MCH) Advisory Council serve as the steering committee to oversee, manage, and support the strategic alignment of existing perinatal and infant health structures in

the District. The MCH Advisory Council, overseen by Title V, provides the DC Title V program and others within the Community Health Administration (CHA), guidance on improving the health of families in the District, specifically maternal and child health populations. Title V would act as the steering committee to ensure synergy and cohesion of maternal and child health efforts in the District. DC Health plans to revisit the MCH Advisory Council by-laws and review and update stakeholder's positions on the Council. Additionally, through the State Maternal Health Innovation program, DC Health will leverage and engage health systems, health associations, academia, community-based organizations, and other maternal health stakeholders through the Maternal Health Task Force that will serve as the overarching body for developing and implementing DC's strategic plans to improve maternal health outcomes. The SMHI Maternal Health Task Force will work alongside the Title V team's MCH Advisory Council to streamline efforts and work in coordination with other groups that address the topics originally aligned with the Perinatal and Infant Health Advisory Council (PIHAC) and the Mayor's Lactation Commissions.

DC Health is also proposing to repeal to repeal D.C. Law 23-118. Better Access for Babies to Integrated Equitable Services Amendment Act of 2020 (DC BABIES Bill) that mandates the establishment of the Perinatal and Infant Health Advisory Committee (PIHAC), as well as the D.C. Act 20-340, the Breastmilk Bank and Lactation Support Act of 2014, to discontinue the mandate to establish the Lactation Commission. DC Health proposes dissolving the standalone commission and establishing a Lactation Committee under the already existing federally mandated DC MCH Advisory Council. Also, DC Health recommends establishing a sub-committee (DC BABIES BILL requirement), the DC Newborn Screening Advisory Sub-Committee, under the already existing DC American Academy of Pediatrics Fetus and Newborn Committee to address the specific needs of the newborn screening community as identified in the PIHAC. The committee will provide recommendations, guidance and support to the DC Health staff responsible for the planning, evaluation, modification, and management of the District-wide Newborn Screening Program.

The Title V MCH Advisory Council is best positioned to act as the governing body to ensure the requirements for the PIHAC and The Lactation Commission are met within the existing structures. Restructuring would eliminate administrative challenges with member recruitment and retention, and ensure continuity of information and strategic planning.

Q46: In recent communication with the Committee, DC Health reported that it was reprogramming the Mayor's $300,000 investment for the "Childcare for Pregnant and Birthing Parents Grants" BSA Subtitle in FY 2025. Was an RFP issued for this grant? What type of outreach did DC Health conduct to childcare providers regarding the grant?

Response:

DC Health published a NOFA on October 25, 2024, and released an RFA on November 1, 2024 for a Childcare for Pregnant and Birthing Parents Grant. In an effort to gauge interest, DC Health also required letters of Intent to be submitted by November 15, 2024 for which we did not get any responses. A pre-application meeting was also advertised and held on November 14, 2024 and had zero participants. Prior to the release of this RFA, DC Health collaborated with the OSSE to comprehend the requirements and specific licensing requirements that would need to be outlined in the request. This collaboration provided DC Health key information to include in the request as well as knowledge of a pending exemption for healthcare facilities providing childcare that would go into effect in 2025. DC Health also consulted with the District of Columbia Hospital Association (DCHA) on how this might be operationalized. In addition, DC Health shared the funding opportunity with community stakeholders including Unity Healthcare, Community of Hope, Medstar Washington Hospital, La Clinica Del Pueblo, and Howard University Hospital. DC Health solicited feedback on the need for emergency hospital/birthing center childcare services, current practices for handling such situations, and the ability to implement childcare at their facilities. DC Health also engaged the DC Perinatal Quality Collaborative. Members of the DC-PQC include all the birthing hospitals in the District. This opportunity was shared during the full meeting and also via email with its members. DC Health conducted market research and plans to meet with emergency childcare providers in the coming weeks to gauge their ability to support the intended outcomes of this grant program.

Q47: Please provide the following information for each of DC Health's place-based and clinical-based programs for FY 2024 and FY 2025, to date:

a. Description of each program, including target audience;
b. Current grantee organization(s);
c. Amount of grant awards and amount actually spent;
d. Number of residents served, by Ward;
e. Describe any excess demand for each program; and
f. Data provided by the grantee to show program outcomes.

Response:

a. **Description of each program, including target audience:**

DC Health's place-based and clinic-based programming includes Smart from the Start (place-based) and Healthy Steps (clinic-based).

Smart from the Start ensures that multi-generational children and families have access to a continuum of comprehensive, high-quality early childhood programs and services that promote child well-being, school readiness, and achievement and ensures that all children are healthy, ready to learn, and have a safe journey through their developmental years. Smart from the Start serves children aged 0-5 and their families in at-risk communities in Ward 8, specifically focusing on the Woodland/Fort Stanton, Garfield Heights, and Knox Hill neighborhoods.

Healthy Steps (Children's National and Unity) is an evidence-based, interdisciplinary pediatric primary care program that aims to provide infants and toddlers with social-emotional and developmental support by strengthening family engagement with the Medical Home. DC Health funds three grantees that implement the Healthy Steps Model to better address behavioral, developmental, and social concerns of children 0-3 year of age and their families, with an emphasis on low-income communities in Wards 5, 7 and 8.

Healthy Steps (HS) at MedStar Georgetown University Hospital (MGUH) KIDS Mobile Medical Clinic (KMMC) seeks to expand the capacity of existing HS services and implements performance enhancing information technology (IT) integrations to deliver the HS program to patient families residing in Wards 4, 7, and 8. KMMC has the unique capability of providing mobile health services on-site to families in these neighborhoods.

b. **Current grantee organizations**

The current and place-based program grantee for FY 2024 was Smart from the Start (SMART); and the current and FY 2024 grantees of clinic-based programming, Healthy Steps, include Unity Healthcare, Children's National, and Georgetown Medstar. Community of Hope Was added in FY 25.

c. Amount of grantee awards and amount actually spent;

The amount of grant awards and actual spending for FY 2023 and FY 2024 may be found in the table below.

Grantee	FY 2024		FY 2025	
Placed-Based	Award Total	Expenditures	Award Total	Expenditures (to date)
Smart from the Start (SMART)	$215,243.78	$215,243.78	$215,243.78	$0.00*
Clinic-Based	**FY 2024**		**FY 2025**	
Clinic-Based	Award Total	Expenditures	Award Total	Expenditures (to date)
Healthy Steps – Unity Healthcare	$879,479.92	$738,334.14	$640,000.00	$96,290.48
Healthy Steps – Children's National	$208,554.43	$206,656.12	$210,000.00	$33,718.40
Health Steps – Georgetown Med Star	$299,951.37	$279,876.00	$299,951.37	$0.00**
Healthy Steps- Community Of Hope			$200,000.00	$0.00***

*Resubmission of invoices required
**Invoices submitted quarterly (will be submitted on 1/15/2025.
***Community of Hope is a new grantee under the Clinic-based program with Healthy Steps. Expected invoices will begin in Q2 01/15/2025.

** Community of Hope is a new grantee under the Clinic-based program with HealthySteps. Expected invoices will begin in Q2 01/15/2025.*

d. **Number of residents served, by Ward**:

	HS Unity Healthcare		**HS Children's National**		**HS GU MedStar**	
Ward	# Served	% Medicaid Enrolled	#Served	% Medicaid Enrolled	#Served	% Medicaid Enrolled
1	11	82%	7	57%	11	100%
2	2	100%	3	67%	3	100%
3	6	100%	0	0%	7	43%
4	17	78%	9	89%	11	91%
5	58	90%	26	89%	14	64%
6	43	91%	29	72%	9	78%

7	410	91%	118	81%	21	90%
8	246	91%	227	83%	27	89%

**Note: The data provided were from the Ward/Medicaid reports patients seen for well-child visits, i.e., Tier 1 services. More children (n=74) were served in Tier 2 and 3 of Healthy Steps that I have no reported demographic data.*

e. **Describe any excess demand for each program**:

Healthy Steps grantees have communicated that there is an unmet need for an additional Healthy Steps Site in Ward 1, Upper Cardozo, as most of their pediatric population resides in that area.

f. **Data provided by the grantee to show program outcomes:**

A summary of metrics and outcomes provided by each grantee according to grant requirements are included below.

Place-based Programming

Smart from the Start

- Maintained 89 relationships and partnerships with various community organizations including Martha's Table, Community of Hope, WIC, Jumpstart, Children of Mine, Collaborative Solutions for Communities, Help Me Grow, House of Ruth, and Mary's Center. (Target: 17)
- Developed 7 new partnerships with organizations that serve the Woodland Terrace community. (Target is 12 partners (existing or new) and up to 5 additional partners annually)
- Screened 36 children under 5 for developmental delays (Target: 200)
- 32% of children whose families have be, for more than one year, were on track in physical health and development, cognitive and language development, and social-emotional development, as reported by their families. (Target: 75%)
- 1,286 adult participants attended at least two activities/workshops
- 807 participants were referred for other services (job training, GED, material assistance, substance, Domestic Violence, court advocacy, behavioral health, DCPS advocacy, etc.)

Clinic-based Programming

Unity Health Care, Inc.'s Healthy Steps Program

- Total number of new patients served: 793
- 80% of patients 0-3 years of age were screened for developmental concerns (Target: 75%)
- 80% of patients 0-3 years of age were screened for behavioral/social emotional concerns (Target: 75%)
- 68% of Healthy Steps children referred to early intervention were connected within 45 days
- 74% of adult patients were screened for post-partum depression
- 481 patients 0-3 years of age were newly enrolled in Tiers II or III

(Target: 438)

Children's National Medical Center's Healthy Steps Program

- Total number of new patients served: 335
- 38% of patients 0-3 years of age were screened for developmental concerns (Target: 50%)
- 17% of patients 0-3 years of age were screened for behavioral/social emotional concerns (Target: 50%)
- 28% of Healthy Steps children referred to early intervention were connected within 45 days
- 65% of adult patients were screened for post-partum depression (Target: 60%)
- 335 patients 0-3 years of age were newly enrolled in Tiers II or III

Georgetown MedStar Healthy Steps Program

- Total number of new patients served: 26 (Quarter 4 funded)
- 53% of patients 0-3 years of age were screened for developmental concerns (Target: 50%)
- 59% of patients 0-3 years of age were screened for behavioral/social emotional concerns (Target: 50%)
- 91% of Healthy Steps children referred to early intervention were connected within 45 days
- 92% of adult patients were screened for post-partum depression (Target: 50%)
- 26 patients 0-3 years of age were newly enrolled in Healthy Steps

**MedStar HealthySteps mobile van experienced maintenance concerns which resulted in the van being taken out of state (Ohio) for maintenance. Minimal TA support was needed during this time. Grantee was able to pivot and utilize MedStar Hospital location to administer services.*

Q48: For all public and public charter schools, please provide an update on current health suite staffing coverage, including:

a. A list of school health suite clusters, indicating the type of health professional assigned to each school in the cluster, and whether those positions are filled;
b. An updated list, by school and Ward, of hours/week of health suite coverage for each school, including the type of health professional assigned to each school; and
c. Number of days in the 2023-24 and 2024-2025, to date, school year each campus has not had in-person health suite staff coverage.

Response:

a.& b. SY23-24 Health Suite Staffing and Coverage Overview by School Cluster and Ward

School Name	Cluster	Ward	Actual RNs	Actual LPNs	Actual Health Techs	Total Health Suite Staff Assigned	Total In-Person Staffing Hours Assigned
Columbia Heights-Bell Multicultural High School	1	1	0	0	1	1	40
Columbia Heights-Lincoln Middle School	1	1	1	0	0	1	40
H.D. Cooke Elementary School	1	1	0	0	1	1	40
Marie Reed Elementary School	1	1	0	0	1	1	40
Bancroft Elementary School	2	1	1	0	0	1	40
Bruce-Monroe Elementary School @ Park View	2	1	0	0	1	1	40
E.L. Haynes PCS-Middle School	2	1	0	0	1	1	40
Meridian PCS Middle School	2	1	0	0	1	1	40
Cardozo Education Campus	3	1	0	0	1	1	40

Meridian PCS Elementary School	3	1	0	0	1	1	40
Oyster Adams Bilingual (Adams Campus)	3	1	0	0	1	1	40
Tubman Elementary School	3	1	0	1	0	1	40
Benjamin Banneker High School	4	2	0	0	1	1	40
Cleveland Elementary School	4	1	0	0	1	1	40
Garrison Elementary School	4	2	0	1	0	1	40
Seaton Elementary School	4	2	0	0	1	1	40
J.O. Wilson Elementary School	5	6	0	1	0	1	40
KIPP DC- (Will, Grow & Lead)	5	2	1	0	0	1	40
School-Within-School @ Goding	5	6	1	0	0	1	40
Walker-Jones Education Campus	5	6	1	0	0	1	40
KIPP DC - College Preparatory PCS	6	5	0	1	0	1	40
KIPP DC (Connect, Spring & Northeast)	6	5	1	0	0	1	40
Rocketship PCS -Infinity	6	5	0	0	1	1	40

Two Rivers PCS- 4th Street	6	6	0	0	1	1	40
DC Bilingual PCS	7	5	0	0	1	1	40
Elsie Whitlow Stokes Community Freedom PCS - Brookland	7	5	1	0	0	1	40
Friendship PCS - Woodridge International Elementary and Middle	7	5	0	0	1	1	40
The Children's Guild DC PCS	7	5	0	1	0	1	40
Dunbar High School	8	5	0	1	0	1	40
Friendship PCS - Armstrong Elementary and Middle	8	5	0	0	1	1	40
Noyes Elementary School	8	5	0	1	0	1	40
Wheatley Education Campus	8	5	0	0	1	1	40
Langley Elementary School	9	5	0	0	1	1	40
Mckinley Technology High School	9	5	0	0	1	1	40
McKinley Technology Middle School	9	5	0	0	1	1	40
School Without Wall @ FS	9	2	0	0	1	1	40
DC Scholars PCS	10	7	0	0	1	1	40
Elsie Whitlow Stokes	10	7	0	0	1	1	40

Community Freedom PCS - East End							
KIPP DC (Arts & Technology, Quest & Valor)	10	7	0	1	1	2	40
Maya Angelou PCS - High School	10	7	0	0	1	1	40
Burrville Elementary School	11	7	0	0	1	1	40
DC Prep PCS - Benning (Elementary, Middle)	11	7	0	0	1	1	40
Drew Elementary School	11	7	0	0	1	1	40
H. D. Woodson High School	11	7	0	0	1	1	40
Duke Ellington School of the Arts	12	2	1	0	0	1	40
Hardy Middle School	12	2	0	1	0	1	40
Hyde-Addison Elementary School	12	2	0	0	1	1	40
Ross Elementary School	12	2	0	0	1	1	40
Girls Global Academy PCS	13	2	0	0	1	1	40
School Without Walls High School	13	2	1	0	0	1	40
Thaddeus Stevens Early Learning Center	13	2	0	0	1	1	40

Thomson Elementary School	13	2	0	0	1	1	40
Eaton Elementary School	14	3	0	0	1	1	40
Jackson-Reed High School	14	3	0	0	1	1	40
Janney Elementary School	14	3	0	0	1	1	40
Murch Elementary School	14	3	0	1	0	1	40
Deal Middle School	15	3	0	0	1	1	40
Hearst Elementary School	15	3	0	0	1	1	40
Lafayette Elementary School	15	4	0	1	-	1	40
Oyster-Adams Bilingual EC	15	3	0	0	1	1	40
Key Elementary School	16	3	0	0	1	1	40
MacArthur High School	16	3	0	0	1	1	40
Mann Elementary School	16	3	0	0	1	1	40
Stoddert Elementary School	16	3	1	0	0	1	40
Amidon-Bowen Elementary School	17	6	0	0	1	1	40
Apple Tree-Southwest	17	6	0	0	0	0	40
Jefferson Middle School Academy	17	6	1	0	0	1	40

Washington Global PCS	17	6	0	0	1	1	40
Dorothy Height Elementary School	18	4	1	0	0	1	40
MacFarland Middle School	18	4	0	0	1	1	40
Powell Elementary School	18	4	0	0	1	1	40
Roosevelt High School	18	4	0	1	0	1	40
Barnard Elementary School	19	4	1	0	0	1	40
Center City PCS - Petworth	19	4	0	0	1	1	40
E.L. Haynes PCS - High School (Kansas Ave, also Elementary)	19	4	1	0	0	1	40
Raymond Elementary School	19	4	0	1	0	1	40
Brightwood Elementary School	20	4	0	1	0	1	40
District of Columbia International School	20	4	1	0	0	1	40
Military Road Early Learning Center	20	4	0	0	1	1	40
Paul PCS - Middle & High School	20	4	0	0	1	1	40
John Lewis Elementary School	21	4	0	0	1	1	40

Latin American Montessori Bilingual PCS	21	4	0	0	1	1	40
Truesdell Elementary School	21	4	0	0	1	1	40
Washington Latin PCS (Middle, Upper)	21	4	0	0	1	1	40
Coolidge High School with Ida B Wells Middle School	22	4	1	0	0	1	40
Shepherd Elementary School	22	4	0	0	1	1	40
Takoma Elementary School	22	4	0	0	1	1	40
Whittier Elementary School	22	4	0	0	1	1	40
Capital City PCS (Middle, Lower, High)	23	4	0	0	1	1	40
Friendship PCS - Ideal Elementary	23	4	0	0	1	1	40
Friendship PCS - Ideal Middle	23	4	0	0	1	1	40
Sela PCS	23	4	0	0		0	40
Brookland Middle School	24	5	1	0	0	1	40
Bunker Hill Elementary School	24	5	0	0	1	1	40
Burroughs Elementary School	24	5	0	0	1	1	40
Langdon Elementary School	24	5	0	1	0	1	40

Browne Education Campus ES and Middle School	25	5	0	1	0	1	40
Phelps Architecture, Construction and Engineering High School	25	5	0	0	1	1	40
Two Rivers PCS - Young (Elementary, Middle)	25	5	0	0	1	1	40
Capital Village	26	5	1	0	0	1	40
DC Prep PCS - Edgewood Elementary School	26	5	0	0	1	1	40
DC Prep PCS - Edgewood Middle School	26	5	0	0	1	1	40
Washington Latin Cooper Campus	26	5	0	0	0	0	40
Inspired Teaching Demonstration PCS	27	5	1	0	0	1	40
Lee Montessori PCS-Brookland and Washington Leadership Academy	27	5	0	0	0	1	40
Perry Street Preparatory PCS	27	5	0	1	0	1	40
The Sojourner Truth School PCS	27	5	0	0	1	1	40
Creative Minds International PCS	28	5	0	1	0	1	40

Mundo Verde Calle Ocho	28	5	0	0	1	1	40
Social Justice PCS	28	5	0	0		0	40
Washington Yu Ying PCS	28	5	0	0	1	1	40
Bridges PCS	29	5	1	0	0	1	40
LaSalle-Backus Elementary School	29	4	1	0	0	1	40
Luke C. Moore High School	29	5	0	0	1	1	40
Shining Stars PCS	29	5	0	0	0	0	40
Friendship PCS-Chamberlain Elementary	30	6	0	0	1	1	40
Payne Elementary School	30	6	0	0	1	1	40
Shirley Chisolm (Tyler) Elementary School	30	6	0	0	1	1	40
Watkins Elementary School (Capitol Hill Cluster)	30	6	0	0	1	1	40
Brent Elementary School	31	6	1	0	0	1	40
Eastern High School	31	7	0	0	1	1	40
Eliot-Hine Middle School	31	7	0	0	1	1	40
Maury Elementary School	31	6	0	0	1	1	40
Capitol Hill Montessori School @ Logan	32	6	0	0	1	1	40

Ludlow-Taylor Elementary School	32	6	1	0	0	1	40
Peabody Elementary School (Capitol Hill Cluster)	32	6	0	0	1	1	40
Stuart-Hobson Middle School (Capitol Hill Cluster)	32	6	0	1	0	1	40
Anacostia High School	33	8	0	0	1	1	40
Ketcham Elementary School	33	8	0	0	1	1	40
Kramer Middle School	33	8	0	0	1	1	40
Lawrence E. Boone Elementary School	33	8	1	0	0	1	40
Apple Tree Early Learning Center PCS-Oklahoma Ave.	34	7	0	0	1	1	40
Friendship PCS-Blow Pierce	34	6	1	0	0	1	40
Miner Elementary School	34	7	0	1	0	1	40
Van Ness Elementary School	34	8	0	0	1	1	40
Center City PCS - Capitol Hill	35	7	1	0	0	1	40
DC Prep Anacostia Elementary	35	8	0	1	0	1	40
Kingsman Academy PCS	35	6	0	0	1	1	40
Lee Montessori PCS-East End	35	8	0	0	1	1	40

Beers Elementary School	36	7	0	0	1	1	40
I Dream PCS	36	7	0	0	1	1	40
Kimball Elementary School	36	7	0	0	1	1	40
Randle Highlands Elementary School	36	7	1	0	0	1	40
C.W. Harris Elementary School	37	7	0	1	0	1	40
KIPP DC - Benning Campus (Key, Leap, Promise)	37	7	0	0	2	2	40
Malcolm X Elementary School	37	8	0	0	1	1	40
Sousa Middle School	37	7	0	1	0	1	40
Kelly Miller Middle School	38	7	0	0	1	1	40
Nalle Elementary School	38	7	0	1	0	1	40
Plummer Elementary School	38	7	0	0	1	1	40
Smothers Elementary School	38	7	0	1	0	1	40
Friendship PCS-Collegiate Academy	39	7	0	0	1	1	40
Lorraine H. Whitlock Elementary School	39	7	0	0	1	1	40
River Terrace Education	39	7	1	1	0	2	40

Center (80 hrs./2 nurses)							
Rocketship PCS-Legacy	39	7	0	0	1	1	40
Bard High School Early College DC (Bard DC)	40	8	0	0	1	1	40
Garfield Elementary School	40	8	0	0	1	1	40
Johnson Middle School	40	8	0	0	1	1	40
Turner Elementary School	40	8	1	0	0	1	40
Houston Elementary School	41	7	0	0	1	1	40
IDEA PCS	41	7	0	0	1	1	40
Ron Brown College Preparatory High School	41	7	0	0	1	1	40
Thomas Elementary School	41	7	0	0	1	1	40
KIPP DC - Douglass Campus (Aim, Discover, Heights)	42	8	0	0	2	2	40
Moten Elementary School	42	8	0	0	1	1	40
Rocketship PCS-Rise Academy/Apple Tree @Rocketship	42	8	0	0	1	1	40
Stanton Elementary	42	8	0	1	0	1	40

Hendley Elementary School	43	8	1	0	0	1	40
Ingenuity Prep PCS and Statesman College Preparatory Academy for Boys	43	8	1	0	1	2	40
Leckie Elementary School	43	8	0	0	1	1	40
Patterson Elementary School	43	8	0	1	0	1	40
Early Childhood Academy PCS	44	8	0	0	1	1	40
Excel Academy	44	8	1	0	0	1	40
Savoy Elementary School	44	8	0	0	1	1	40
Thurgood Marshall Academy PCS	44	8	0	0	1	1	40
DC Prep PCS-Anacostia Middle School	45	8	0	0	1	1	40
Friendship PCS - Southeast (Elementary, Middle)	45	8	0	1	0	1	40
Friendship PCS - Technology Preparatory High School	45	8	0	0	1	1	40
King Elementary School	45	8	0	0	1	1	40
Apple Tree Douglas Knoll	46	8	0	0	1	1	40
KIPP DC (Honor, Inspire	46	8	1	0	0	1	40

& Pride)-Wheeler Campus							
KIPP DC-Legacy	46	8	0	0	1	1	40
Ballou High School / Ballou STAY High School	47	8	0	0	1	1	40
Digital Pioneers	47	8	0	0	1	1	40
Hart Middle School	47	8	0	0	1	1	40
Simon Elementary School	47	8	1	0	0	1	40
		Totals:	34	29	123	186	

c. SY 23-24 Health Suite Staff Absences as of June 2024, by Ward

SY 23-24 Health Suite Staff Absences as of June 30, 2024, by Ward				
School Name	**Ward**	**Daily Count of Reported Schedule Changes**	**Replacement coverage via Phone**	**Daily Replacement coverage in person**
Anacostia MS	1	1	1	0
Bancroft ES	1	11	0	11
Bruce Monroe ES	1	28	21	7
Cardozo HS	1	25	18	7
Cleveland ES	1	17	15	2
Columbia Heights Bell	1	20	12	8
Columbia Heights Lincoln MS	1	4	2	2
EL Haynes PCS MS	1	18	14	4
H.D. Cooke ES	1	14	11	3
Houston ES	1	6	5	1
Lincoln MS	1	14	12	2
Marie Reed ES	1	27	21	6
Meridian MS	1	25	9	16
Meridian PCS ES	1	5	5	0

Oyster Adams Bilingual	1	3	0	3
Oyster Adams Bilingual EC	1	1	1	0
The Children's Guild	1	2	2	0
Tubman Elementary	1	1	0	1
Tubman ES	1	9	4	5
	Totals	**107**	**70**	**37**

School Name	**Ward**	**Count of Reported Schedule Change**	**Replacement Coverage Via Phone**	**Replacement coverage In person**
Benjamin Banneker HS	2	33	16	17
Duke Ellington School of the Arts	2	8	8	0
Garrison ES	2	13	5	8
Hardy MS	2	4	2	2
Hyde Addison ES	2	18	17	1
Ross ES	2	9	7	2
School without walls at Francis Stevens	2	9	3	6
School Without Walls HS	2	26	15	11
Seaton ES	2	1	1	0
Thaddeus Stevens ELC	2	21	5	16
Thomson ES	2	8	7	1
	Totals	**150**	**86**	**64**

School Name	**Ward**	**Count of Reported Schedule Change**	**Replacement coverage via Phone**	**Replacement coverage In person**
Deal MS	3	30	27	3
Eaton ES	3	12	12	0
Hearst ES	3	17	17	0
Jackson-Reed HS	3	17	16	1
Janney ES	3	26	15	11
Key ES	3	26	26	0

MacArthur HS	3	5	5	0
Mann ES	3	15	14	1
Murch ES	3	8	8	0
Oyster Adams Bilingual EC	3	33	21	12
Stoddert ES	3	17	12	5
	Totals:	**206**	**173**	**33**

School Name	**Ward**	**Count of Reported Schedule Change**	**Replacement Coverage via Phone**	**In person replacement coverage**
Barnard ES	4	3	1	2
Bridges PCS	4	11	5	6
Brightwood ES	4	10	1	9
Capital City PCS	4	3	1	2
Center City Petworth	4	11	10	1
Coolidge HS	4	1	0	1
DC International	4	6	0	6
District of Columbia International School	4	1	0	1
Dorothy Height ES	4	7	4	3
Friendship Ideal MS	4	7	6	1
Ida B. Wells	4	1	0	1
John Lewis ES	4	16	15	1
Lafayette ES	4	9	4	5
LaSalle Backus	4	10	8	2
Latin American Montessori Bilingual (LAMB)	4	6	3	3
MacFarland MS	4	7	6	1
Military Road Early Learning Center	4	5	4	1
Paul MS	4	1	1	0
Perry Street Preparatory PCS	4	16	16	0

Powell ES	4	6	6	0
Raymond ES	4	11	8	3
Roosevelt HS	4	8	3	5
Sela	4	1	0	1
Shepherd ES	4	6	6	0
Sojourner Truth	4	13	13	0
Takoma ES	4	13	10	3
Truesdell ES	4	8	8	0
Washington Latin	4	2	1	1
Whittier ES	4	8	6	2
	Totals	**183**	**139**	**44**

School Name	Ward	Count of Reported Schedule Change	Replacement coverage via Phone	In person replacement coverage
Elsie Whitlow Stokes Community Freedom PCS	5	1	0	1
Brent ES	5	1	1	0
Brookland and Washington Leadership	5	1	1	0
Brookland MS	5	8	5	3
Brown Middle School	5	1	0	1
Browne MS	5	14	2	12
Bunker Hill ES	5	21	17	4
Burroughs ES	5	13	11	2
Capital Village PCS	5	5	5	0
Children's Guild PCS	5	2	2	0
College Preparatory	5	5	5	0
Connect, Spring and Northeast Academy PCS	5	1	0	1
Creative Minds International PCS	5	12	8	4
DC Bilingual PCS	5	11	10	1
DC Prep Edgewood ES	5	29	16	13
DC Prep Edgewood MS	5	2	1	1
Dunbar HS	5	5	3	2

Edgewood ES	5	9	5	4
Elsie Whitlow Stokes Brookland	5	18	3	15
Friendship Armstrong ES and MS	5	7	6	1
Friendship Chamberlain	5	3	0	3
Friendship Woodridge International ES/MS	5	21	16	5
Inspired Teaching Demonstration	5	11	8	3
KIPP DC College Prep	5	1	0	1
Langdon ES	5	9	5	4
Langley ES	5	7	4	3
Lee Montessori/Washington Leadership	5	13	8	5
Luke C. Moore HS	5	23	5	18
McKinley Tech HS	5	16	16	0
McKinley Tech MS	5	6	5	1
Mundo Verde Bilingual Calle Ocho	5	9	9	0
Noyes ES	5	9	9	0
Phelps HS	5	31	5	26
Rocketship Infinity	5	10	9	1
The Children's Guild	5	9	8	1
Two Rivers Young ES/MS	5	8	5	3
Washington Yu Ying	5	10	8	2
Webb Campus	5	3	1	2
Wheatley EC	5	11	5	6
Young ES and MS	5	6	2	4
	Totals	**286**	**162**	**124**

School Name	**Ward**	**Count of Reported Schedule Change**	**Replacement Coverage via Phone**	**In person replacement coverage**
Amidon Bowen ES	6	22	19	3
Benning Elementary and Middle	6	5	3	2
Brent ES	6	34	27	7

Capitol Hill Montessori School	6	10	10	0
Center City Capitol Hill	6	18	7	11
Chamberlain ES	6	1	0	1
Eastern HS	6	20	16	4
Eliot Hines MS	6	17	9	8
Friendship Chamberlain	6	23	10	13
J. O. Wilson Elementary School	6	1	0	1
Jackson-Reed HS	6	1	1	0
Jefferson MS	6	11	9	2
KIPP DC Shaw Campus	6	19	7	12
Ludlow Taylor ES	6	16	16	0
Maury ES	6	28	25	3
Miner ES	6	6	0	6
Payne ES	6	15	15	0
Peabody ES	6	23	20	3
School Within School	6	11	0	11
Seaton ES	6	36	33	3
Stuart Hobson MS	6	14	8	6
Two Rivers PCS - 4th Street	6	12	7	5
Tyler ES	6	14	6	8
Van Ness ES	6	10	10	0
Walker Jones EC	6	15	2	13
Watkins ES	6	11	4	7
	Totals	**393**	**264**	**129**

School Name	**Ward**	**Count of Reported Schedule Change**	**Replacement coverage via Phone**	**In person replacement coverage**
Apple Tree Early Learning Center	7	1	1	0
Apple Tree Oklahoma	7	13	9	4

Arts and Tech, Quest and Valor PCS	7	1	0	1
Beers ES	7	13	9	4
Blow Pierce ES and MS	7	1	0	1
Burrville ES	7	10	9	1
CW Harris ES	7	9	2	7
DC Scholars PCS	7	19	14	5
Drew ES	7	20	17	3
Elsie Whitlow Stokes East End	7	5	5	0
Friendship Blow Pierce ES	7	14	8	6
Friendship Collegiate Academy	7	11	11	0
Garfield ES	7	6	6	0
H.D. Woodson HS	7	17	10	7
Houston ES	7	1	1	0
I Dream	7	7	7	0
IDEA PCS	7	5	3	2
Kelly Miller MS	7	6	5	1
Kimball ES	7	1	1	0
KIPP Benning	7	14	8	6
KIPP DC Smilow	7	13	7	6
Lorraine Whitlock ES	7	11	11	0
Maya Angelou HS	7	7	6	1
Nalle ES	7	5	0	5
Plummer ES	7	3	2	1
Randle Highlands ES	7	11	10	1

River Terrace EC	7	4	0	4
Rocketship Legacy	7	10	8	2
Ron Brown HS	7	6	4	2
Smothers ES	7	14	11	3
Sousa Middle School	7	1	1	0
Thomas ES	7	2	1	1
Woodson High School	7	2	1	1
	Totals	**263**	**188**	**75**

School Name	Ward	Count of Reported Schedule Change	Replacement Coverage via Phone	In person replacement coverage
Anacostia HS	8	18	18	0
Anacostia MS	8	3	1	2
Appletree @ Rocketship	8	1	1	0
Ballou High School	8	11	10	1
Ballou Stay High School	8	6	3	3
Bard High School	8	3	3	0
Boone ES	8	8	8	0
DC Prep Anacostia MS	8	10	5	5
Deal MS	8	3	3	0
Douglas Campus	8	2	1	1
Eagle Academy	8	1	1	0
Early Childhood PCS	8	7	6	1
Excel Academy	8	12	8	4
Friendship Southeast	8	5	2	3

Friendship Tech HS	8	11	9	2
Hart MS	8	7	5	2
Hendley ES	8	3	2	1
Ingenuity Prep PCS/Statesmen College Prep	8	16	9	7
Johnson MS	8	10	7	3
Ketcham ES	8	7	6	1
King ES	8	6	6	0
KIPP AIM - Douglas	8	1	0	1
KIPP College Prep	8	15	14	1
KIPP Webb Campus	8	3	3	0
KIPP Wheeler	8	6	5	1
Kramer MS	8	14	12	2
Lawrence E. Boone	8	5	5	0
Leckie EC	8	18	17	1
Malcolm X ES	8	7	4	3
Moten ES	8	5	5	0
Patterson ES	8	3	2	1
Rocketship Rise	8	7	2	5
Savoy ES	8	15	13	2
Simon ES	8	10	7	3
Southeast Elementary and Middle	8	2	2	0
Stanton ES	8	7	7	0
Statesman College Prep Academy for Boyes	8	1	0	1
Technology Preparatory HS	8	5	4	1
Thurgood Marshall Academy	8	13	6	7

Turner ES	8	19	15	4
Wheeler	8	2	1	1
	Totals	**308**	**238**	**70**

Total Number of Reported Schedule Changes	Total Number of Replacement Phone Coverage	Total Number of In Person Coverage Replacement
1896	1320	573

Q49: Please provide the current number of RN, LPN, and health technician positions included in the SHSP, including those employed by Children's School Services and DC Health, and indicate which positions are vacant.

a. Please include the contract staff funded by the Council in the FY 2025 budget, which DC Health reported would be filled by Q2 of FY 2025.

Response:

	FY25 SHSP Staffing- Children's School Services				
Position	**Total Planned**	**Total Hired**	**% Staffed**	**Total Vacant**	**% Vacant**
Total Nurses (RN + LPN)	**101**	**79**	**78%**	**22**	**21%**
RN	**47**	**44**	**93%**	**3**	**6%**
LPN	**54**	**35**	**64%**	**19**	**35%**
Health Techs	**143**	**132**	**92%**	**11**	**7%**
Total Staff	**244**	**211**	**86%**	**33**	**13%**

Children's School Services is currently 86% staffed. Given the current headcount, there are challenges with CSS's ability to assign role types to schools based on the plan and temporary solutions are implemented.

	FY25 SHSP Staffing- DC Health*				
Position	**Total Planned**	**Total Hired**	**% Staffed**	**Total Vacant**	**% Vacant**
Total Nurses (RN)	**9**	**0**	**0%**	**9**	**100%**

DC Health is currently conducting resume reviews and interviews for nursing candidates to support the school health services program. Q2 is still the target for filling the positions.

Q50: Please provide the updated percentages for FY 2024 and FY 2025, to date, on how many:

a. Students with asthma had an asthma action plan on file;
b. Students with diabetes had a diabetes management plan on file;
c. Students with diabetes had an anaphylaxis action plan on file; and
d. Students had a Universal Health Certificate on file.

Response:

Overall Students:

Question	Total Students with Condition FY24	Total Students with Action Plan FY24	Percent of Students with AAP FY24	Total Students with Condition FY25	Total Students with Action Plan FY25	Percent of Students with AAP FY25
Students with asthma that have an asthma action plan (AAP)	10,890	6,553	60%	11,117	6,879	62%
Students with diabetes that have a diabetes management Plan	228	181	79%	249	204	82%
Students with anaphylaxis that have an anaphylaxis action plan	5,940	458	8%	6,280	1,807	29%

Students with treatment scheduled in Health Suite:

Question	Total Students with Condition FY24	Total Students with Action Plan FY24	Percent of Students with AAP FY24	Total Students with Condition FY25	Total Students with Action Plan FY25	Percent of Students with AAP FY25

Students with asthma that have an asthma action plan (AAP)	**1,722**	**1,387**	**81%**	**1,577**	**1,316**	**83%**
Students with diabetes that have a diabetes management Plan	**99**	**83**	**84%**	**108**	**97**	**90%**
Students with anaphylaxis that have an anaphylaxis action plan	470	331	**70%**	496	371	**75%**

Students with Universal Health Certificate on file:

Question	**Total Program Reach FY24**	**Total Students with UHC on file FY24**	**Total Program Reach FY25**	**Total Students with new UHC Submitted for FY25**
Students that have an updated UHC on file	**79,272**	**39,361** (49.6%)	**84,487**	**3,830** (<1%)

Q51: At the close of FY 2024, how many unentered Universal Health Certificates were at health suites?

Response:
At the close of FY24, DC Health had record of 1,894 unentered Universal Health Certificates (UHCs) at the health suites. Since there is no formal submission deadline for UHCs, school administrators receive and deliver these documents to the health suite throughout the school year. Reviewing and entering UHCs is a core daily function of health suites. Health Suite Staff work diligently to process each document accurately and promptly, ensuring reliable student healthcare coordination. Notably, just two weeks before the end of FY24, the number of unentered UHCs was 3,881. The reduction of over 50% within a 10-day period highlights the collaborative process to manage periods significant volume of form submissions. The program actively monitors unentered document counts and collaborates with the program grantee, Children's School Services (CSS), to provide technical and entry assistance. Two forms of support are offered:

Standard Entry Assistance: Directed at health suites experiencing large volumes of unentered forms to ensure timely processing and accurate student health records.

Immunization Compliance Support: Focused on schools with high document counts in immunization enforcement grades, minimizing disruptions to students' education caused by record discrepancies.

These efforts are reinforced through regular data review meetings to address performance and tracking issues identified by DC Health or partnering agencies, including DCPS, PCSB, and OSSE. Additional measures include scheduled touchpoints with Health Suite Staff to review entry practices, office hours for requesting support, and coordination with Nurse Managers to ensure resources are effectively allocated and utilized. As of December 20, 2024, the number of unentered UHCs reported to DC Health stood at 1,295 due to prioritization of entering immunization records, medication administration and other forms for students with chronic conditions.

Q52: Please provide a detailed plan and timeline for DC Health to roll out an electronic submission portal for the medical forms listed above.

Response:

DC Health implemented the first phase of the electronic Universal Health Certificate (eUHC) in August 2023, allowing healthcare providers to submit eUHCs electronically through a secure provider portal. While the manual submission process is functioning, full integration between provider EHR vendors and the electronic school health record system (SHM) has not yet been completed. Full implementation of the original plan has been delayed due to pending requirements we need from health system/providers and their EHR vendors. In the meantime, we are working with DCPS on a solution to capture health forms from families through electronic upload to Aspen and granting nurse managers access to those forms. We anticipate that this would ease the burden on families and improve DC Health's ability to track health forms that are submitted to schools.

Current Status and Next Steps on eUHC:

1. **Continued Planning Meetings with EHR Vendors**
   a. Integration with EHR Systems (Oracle Cerner and eClinicalWorks): DC Health icontinues to meet with both Oracle Cerner and eClinicalWorks to finalize the integration of eUHC data directly from their electronic health record systems (EHR) into SHM. Discussions with these vendors are focused on confirming resource availability, technical requirements, and integration timelines. However, the timeline for moving forward with this integration has not yet been set, as it is dependent on leadership of the vendor organizations to realign priorities and confirm the resources needed for the project.
2. **Technical Development and System Integration**
   a. Data Mapping and Data Transformation: DC Health will complete the data mapping for all fields necessary for the eUHC submission, ensuring proper integration with SHM. This involves addressing any discrepancies between fields in the EHR systems and those required by SHM.
   b. Addressing Technical Challenges: Additional technical challenges, such as data transformations where fields in the EHR do not directly align with SHM, will be worked through once the vendors confirm resources needed for the project and anticipated timeline.
3. **Routing to Schools that do not use SHM:**
   a. Plans to ensure that eUHC submissions are routed to private, parochial, and non-participating charter schools will be developed. This will require DC Health to explore solutions for these schools to securely receive the data if they choose to not use SHM.
4. **Implementation of Additional Health Forms:**
   a. Expansion to Other Health Forms: DC Health is in the early stages of planning for the integration of asthma action plans, diabetes management plans, and anaphylaxis action plans into the system. Data mapping exercises with the School Health Services

Program (SHSP) grantee and the current electronic student health record system vendor are ongoing.

b. The timeline for the implementation of these additional health forms is contingent on the successful rollout of the eUHC and the resolution of integration issues.

5. **Continued Stakeholder Engagement:**
   a. DC Health will continue engaging healthcare providers, school health staff, and vendors to evaluate feasibility and timeline to ensure smooth integration and submission processes. Updates to the provider portal and user training would follow the finalization of the integration work.
6. **Monitoring and Quality Assurance:**
   a. System Testing: Comprehensive testing would be conducted once the integration is in place, and further steps would be planned for monitoring system functionality and compliance.

Q53: Please provide the number of students, broken down by school and Ward, that received services in FY 2024 and FY 2025, to date, from the School Based Oral Health Program.

a. Please detail any increase in services to high schools affected by the closure or downsizing of the School Based Health Centers in FY 2025.

Response:

In **FY24**, 2,518 students were served through the School Based Oral Health Program.
In **FY25**, to date, 312 students have been served through the School Based Oral Health Program.

Table 1: Students Served by School Based Oral Health Program in FY24 By Ward and School

FY 2024- October 1, 2023- September 30, 2024		
Facility Ward	Facility Name	Students Served
1	AppleTree Early Learning Center PCS - Columbia Heights	37
	Barbara Chambers Children's Center	31
	H.D. Cooke Elementary School	54
2	Edward C Mazique Parent And Child Center	49
	Milestones Enrichment Center, Inc.	25
4	Bridges PCS	69
	Hope Community PCS Lamond Campus	31
	Centronia @ Upshur Street	22
	Gap Community Cc Ctr, Inc	25
	Mary Mcleod Bethune Day Academy PCS (16th	42
	Loving Care Day Nursery -114 Kenn	25
	Powell Elementary School	110
	Spanish Education Dev. Ctr #1 & B&A	112
5	Browne Education Campus	14
	Noyes Elementary School	55
	Rocketship Infinity Community Prep	13
	Washington Yu Ying PCS	27
6	AppleTree Early Learning Center PCS - Southwest	24
	Eagle Academy PCS - Capitol Riverfront	28
	UPO @ Azeeze Bates	14
	UPO @ Edgewood Child Development Center	2
	Walker-Jones Education Campus	22
7	AppleTree Early Learning Center PCS - Oklahoma Avenue	41
	Beers Elementary School	72
	C.W. Harris Elementary School	41

	Drew Elementary School	49
	Kelly Miller Middle School	20
	Kimball Elementary School	99
	Plummer Elementary School	38
	Randle Highlands Elementary School	48
	Rocketship Legacy Prep	77
	Saint Phillip CDC & B&A	25
	Shining Star 2 Early Learning Ctr	24
8	Apple Tree Early Learning PCS - Douglas Knoll Campus	18
	Apple Tree Early PCS @ Parkland	28
	AppleTree Early Learning Center PCS - Parklands at THEARC	14
	Bethel Christian Fellowship CDC Infant Center	18
	Big Mama's Children's Center & B&A	20
	Bright Beginnings Mlk	80
	Community Edu Research Group Inc	21
	Eagle Academy PCS - Congress Heights	68
	Early Childhood Academy PCS	75
	Emergent Preparatory Academy	33
	Hart Middle School	39
	Hendley Elementary School	54
	Jewel's New Beginning Learning Center, LLC	30
	Ketcham Elementary School	42
	Kiddies Kollege & B&A	31
	Leckie Education Campus	30
	Malcolm X Elementary School @ Green	21
	Martin Luther King Elementary School	56
	Moten Elementary School	51
	National Children’s Center	36
	Patterson Elementary School	37
	Rocketship Rise Academy	26
	Savoy Elementary School	13
	Simon Elementary School	64
	Stanton Elementary School	78
	Sunshine Early Learning Center, Inc	44
	Thurgood Marshall Academy PCS	11
	UPO @ Atlantic Garden Early Childhood Center	4
	UPO @ Eagle Academy PCS	15
	UPO @ Frederick Douglass	23
	UPO @ Ketcham Elementary School	5

	UPO @ Martin Luther King ES	7

Table 2: Students Served by School Based Oral Health Program in FY25 (to date) By Ward and School

FY 2025- October 1, 2024 to date (October 31, 2024)		
Ward	Facility Name	Students Served
4	Ida B. Wells Middle School	13
	Mary Mcleod Bethune Day Academy PCS (16th	32
5	Israel Baptist Church CDC & B&A	14
	Mary Mcleod Bethune Day Academy PCS Slowe	10
	Wheatley Education Campus	25
6	UPO @ Azeeze Bates	14
8	Apple Tree Early Learning PCS - Douglas Knoll Campus	20
	Apple Tree Early PCS @ Parkland	34
	Bethel Christian Fellowship Early Childhood Development Center	26
	Jewel's New Beginning Learning Center II	22
	Martin Luther King Elementary School	26
	Stanton Elementary School	72
	UPO @ Ballou High School	4

Table 3: Total Students Served by School Based Oral Health Program FY24 and FY25 (to date), By Ward

Ward	**Students served in FY24**	**Students served in FY25 to date**
Ward 1	183	0
Ward 2	74	0
Ward 3	0	0
Ward 4	436	45
Ward 5	109	49
Ward 6	90	14
Ward 7	534	0
Ward 8	1092	204

a. Please detail any increase in services to high schools affected by the closure or downsizing of the School Based Health Centers in FY 2025.

DC Health is engaging a new vendor to serve all schools with a School Based Health Center through the School Based Oral Health Program. The Program provides no-cost dental exams, cleanings, fluoride, and referral to a dental home. Any schools affected by the closure or downsizing of a School Based Health Center would be eligible for services by the vendor.

Q54: Please provide the following utilization data for all school health suites, broken down by school and Ward:

a. Number of student encounters in FY 2024 and FY 2025, to date;
b. Number of services provided broken down by type; and
c. Occasions when EMT or 911 was called for a medical emergency.

Response:

FY24 District of Columbia Public and Chartered Schools Health Service Utilization, SY23- SY24 By Ward and School Level

Ward	School	Total Events	Acute Care Management	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Management	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
1	BANCROFT ELEMENTARY SCHOOL	3127	1913	0	0	0	885	19	266	0	37	1	0	3
1	BELL MULTICULTURAL HS	625	286	2	0	0	31	33	257	0	11	4	0	5
1	BENJAMIN BANNEKER HIGH SCHOOL	508	294	0	0	0	106	46	1	0	40	3	4	0
1	BRUCE-MONROE ELEMENTARY SCHOOL @ PARK VIEW	1784	649	0	0	0	783	7	299	0	32	4	0	2
1	CARDOZO EDUCATION CAMPUS	802	163	1	0	0	233	112	187	0	101	0	0	3

1	CLEVELAND ELEMENTARY SCHOOL	693	416	0	0	0	207	3	4	0	43	10	4	1
1	E.L. HAYNES PCS - MIDDLE SCHOOL	919	478	0	0	0	372	44	6	0	17	0	0	2
1	H.D. COOKE ELEMENTARY SCHOOL	705	363	0	0	0	309	2	0	0	28	1	0	1
1	LINCOLN MULTICULTURAL MS	570	442	1	0	0	54	27	0	0	40	2	0	5
1	MARIE REED ELEMENTARY SCHOOL	1021	650	0	0	0	240	9	88	0	29	1	0	2
1	MERIDIAN ES PCS	195	84	0	0	0	94	2	0	0	7	8	0	2
1	MERIDIAN MS PCS	466	423	1	0	0	28	8	0	0	6	0	0	2
1	OYSTER ADAMS BILINGUAL - ADAMS CAMPUS	138	103	0	0	0	0	31	0	0	0	1	0	0
1	TUBMAN ELEMENTARY SCHOOL	1385	594	0	0	0	396	3	341	0	31	19	0	1
1	OYSTER ADAMS BILINGUAL	758	309	0	0	0	261	120	0	0	68	0	0	0

Ward	**School**	**Total Events**	**Acute Care Management**	**Behavioral Health**	**Counseling Session**	**Covid Screening**	**Chronic Disease Management**	**Health Maintenance**	**Procedures**	**Reproductive Health**	**Preventative Care**	**Telehealth Services**	**Virtual Services**	**911/EMS**

2	DUKE ELLINGTON SCHOOL OF THE ARTS	1533	424	3	0	0	578	108	368	0	19	1	22	1
2	GARRISON ELEMENTARY SCHOOL	1733	559	0	0	0	650	8	502	0	6	1	0	2
2	GIRLS GLOBAL ACADEMY PCS	267	205	6	0	0	1	52	0	1	1	0	0	1
2	HARDY MIDDLE SCHOOL	1494	883	4	0	0	319	58	183	0	30	0	0	1
2	HYDE-ADDISON ELEMENTARY SCHOOL	1583	1243	2	0	0	256	32	0	0	50	0	0	2
2	ROSS ELEMENTARY SCHOOL	351	232	0	0	0	92	7	0	0	20	0	0	0
2	SCHOOL WITHOUT WALLS @ FRANCIS-STEVENS	1910	968	1	0	0	461	50	299	0	56	1	0	3
2	SCHOOL WITHOUT WALLS HIGH SCHOOL	495	361	4	0	0	2	36	0	0	40	0	0	1
2	THADDEUS STEVENS EARLY LEARNING CENTER	250	152	0	0	0	14	44	0	0	27	0	0	0

2	THOMSON ELEMENTARY SCHOOL	718	439	0	0	0	222	8	0	0	40	3	0	0

Ward	School	Total Events	Acute Care Management	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Management	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
3	DEAL MIDDLE SCHOOL	2104	959	7	0	1	987	86	4	0	21	0	0	2
3	EATON ELEMENTARY SCHOOL	1199	818	1	0	0	329	15	0	0	31	0	0	1
3	HEARST ELEMENTARY SCHOOL	238	59	0	0	0	178	1	0	0	0	0	0	1
3	JACKSON-REED HIGH SCHOOL	1341	450	5	0	15	637	35	130	0	58	0	0	4
3	JANNEY ELEMENTARY SCHOOL	405	192	0	0	0	167	3	20	0	21	0	0	2
3	KEY ELEMENTARY SCHOOL	852	587	0	0	0	210	8	0	0	46	1	0	0
3	MACARTHUR HIGH SCHOOL	185	139	0	0	0	2	12	0	0	24	0	0	2
3	MANN ELEMENTARY SCHOOL	1014	711	1	0	0	263	7	0	0	31	1	0	0

3	MURCH ELEMENTARY SCHOOL	3023	1450	1	0	0	1084	43	406	0	20	7	0	3
3	OYSTER ADAMS BILINGUAL - OYSTER CAMPUS	26	22	0	0	0	1	0	0	0	0	0	0	0
3	STODDERT ELEMENTARY SCHOOL	1289	769	0	0	0	122	43	283	0	31	0	0	1
3	OYSTER-ADAMS BILINGUAL EC	292	244	0	0	0	6	1	0	0	41	0	0	1

Ward	School	Total Events	Acute Care Management	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Management	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
4	BARNARD ELEMENTARY SCHOOL	3116	1797	0	0	0	699	14	503	0	88	4	0	3
4	BRIGHTWOOD ELEMENTARY SCHOOL	3453	1696	0	0	0	1120	39	476	0	115	0	0	0
4	CAPITAL CITY PCS - HIGH SCHOOL	129	18	1	0	0	50	2	0	1	56	0	0	2
4	CAPITAL CITY PCS - LOWER SCHOOL	284	99	0	0	0	78	2	39	0	66	0	0	0
4	CAPITAL CITY PCS - MIDDLE SCHOOL	156	131	0	0	0	3	4	0	0	15	0	0	0

4	CENTER CITY PCS - PETWORTH	310	228	0	0	0	69	4	0	0	7	2	0	0
4	COOLIDGE HIGH SCHOOL	1514	673	1	0	0	134	255	416	1	16	0	0	1
4	DISTRICT OF COLUMBIA INTERNATIONAL SCHOOL PCS	1898	1171	9	0	0	230	13	369	0	66	5	0	11
4	DOROTHY I. HEIGHT ELEMENTARY SCHOOL	1283	404	0	0	0	556	30	236	0	30	0	0	3
4	E.L. HAYNES PCS - ELEMENTARY SCHOOL	2307	1163	0	0	0	720	85	262	0	52	0	0	0
4	E.L. HAYNES PCS - HIGH SCHOOL	315	183	1	0	0	2	68	0	0	33	9	0	6
4	FRIENDSHIP PCS - IDEAL ELEMENTARY	418	397	0	0	0	0	3	0	0	17	1	0	0
4	FRIENDSHIP PCS - IDEAL MIDDLE	566	466	0	0	0	51	25	0	0	23	1	0	0
4	IDA B. WELLS MIDDLE SCHOOL	1462	1019	0	0	0	263	138	0	1	16	0	0	1
4	JOHN LEWIS ELEMENTARY SCHOOL	1292	646	0	0	0	494	7	86	0	40	0	0	2

4	LAFAYETTE ELEMENTARY SCHOOL	2193	337	0	0	0	1325	2	518	0	9	1	0	3
4	LASALLE-BACKUS ELEMENTARY SCHOOL	672	444	1	0	0	108	7	0	0	49	4	0	5
4	LATIN AMERICAN MONTESSORI BILINGUAL PCS	1881	1283	0	0	0	516	39	15	0	15	0	0	0
4	MACFARLAND MIDDLE SCHOOL	2057	1068	5	0	0	545	103	285	0	44	0	0	20
4	MILITARY ROAD EARLY LEARNING CENTER	259	240	0	0	0	9	0	0	0	10	0	0	0
4	PAUL PCS - INTERNATIONAL HIGH SCHOOL	1395	541	8	0	0	589	54	197	0	3	2	0	7
4	PAUL PCS - MIDDLE SCHOOL	1021	678	6	0	0	180	48	100	0	4	1	0	0
4	POWELL ELEMENTARY SCHOOL	1312	593	0	0	0	680	29	0	0	9	1	0	1
4	RAYMOND ELEMENTARY SCHOOL	1125	487	0	0	0	278	22	180	0	130	1	0	1
4	ROOSEVELT HIGH SCHOOL	2392	551	8	0	0	659	34	1089	0	42	0	0	12
4	SELA PCS	747	614	0	0	0	94	24	0	0	9	0	0	0

4	SHEPHERD ELEMENTARY SCHOOL	1713	923	0	0	0	721	18	0	0	44	0	1	1
4	TAKOMA ELEMENTARY SCHOOL	2183	1330	0	0	0	386	46	373	0	41	1	0	1
4	TRUESDELL ELEMENTARY SCHOOL	595	360	0	0	0	177	9	22	0	23	1	0	0
4	WASHINGTON LATIN PCS - MIDDLE SCHOOL	1255	434	1	0	0	650	23	100	0	29	0	0	1
4	WASHINGTON LATIN PCS - UPPER SCHOOL	214	106	3	0	0	71	13	0	0	17	0	0	1
4	WHITTIER ELEMENTARY SCHOOL	2119	1429	0	0	0	442	33	178	0	29	1	0	0
4	ROOSEVELT STAY HIGH SCHOOL	1	1	0	0	0	0	0	0	0	0	0	0	0

Ward	School	Total Events	Acute Care Management	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Management	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
5	BRIDGES PCS	2400	782	0	0	0	1221	7	269	0	108	13	0	1
5	BROOKLAND MIDDLE SCHOOL	1923	919	0	0	0	882	63	32	0	22	1	0	0

5	BROWNE EDUCATION CAMPUS ES	1541	784	0	0	0	504	10	228	0	11	1	0	0
5	BROWNE EDUCATION CAMPUS MS	863	278	4	0	0	362	9	204	0	4	0	0	1
5	BUNKER HILL ELEMENTARY SCHOOL	495	394	0	0	0	39	1	0	0	55	3	0	0
5	BURROUGHS ELEMENTARY SCHOOL	1052	278	0	0	0	488	14	253	0	8	0	0	1
5	CAPITAL VILLAGE PCS	487	381	0	1	0	41	55	0	0	5	0	0	1
5	CREATIVE MINDS INTERNATIONAL PCS	2217	706	4	0	0	720	15	690	0	3	69	0	2
5	DC BILINGUAL PCS	1130	460	0	0	0	630	2	0	0	27	8	0	2
5	DC PREP PCS - EDGEWOOD ELEMENTARY SCHOOL	1693	547	0	0	0	1088	22	3	0	20	1	0	2
5	DC PREP PCS - EDGEWOOD MIDDLE SCHOOL	1472	608	0	0	0	797	33	0	0	13	9	0	2
5	DUNBAR HIGH SCHOOL	1013	552	10	0	0	129	102	158	4	54	0	0	13

5	ELSIE WHITLOW STOKES COMMUNITY FREEDOM PCS - BROOKLAND	1182	827	0	0	0	58	3	278	0	8	5	0	0
5	FRIENDSHIP PCS - ARMSTRONG ELEMENTARY	392	248	0	0	0	135	4	0	0	0	0	0	1
5	FRIENDSHIP PCS - ARMSTRONG MIDDLE	455	288	0	0	0	163	0	0	0	3	0	0	2
5	FRIENDSHIP PCS - WOODRIDGE INTERNATIONAL ELEMENTARY	482	421	0	0	0	45	5	0	0	6	0	0	0
5	FRIENDSHIP PCS - WOODRIDGE INTERNATIONAL MIDDLE	246	222	0	0	0	1	7	0	0	9	4	0	1
5	INSPIRED TEACHING DEMONSTRATION PCS	1185	902	0	0	0	225	30	0	0	3	0	0	0
5	KIPP DC - COLLEGE PREPARATORY PCS	754	558	0	0	0	71	68	45	0	12	0	0	1

5	KIPP DC - CONNECT ACADEMY PCS	289	196	0	0	0	66	4	0	0	7	0	0	0
5	KIPP DC - NORTHEAST ACADEMY PCS	1637	937	0	0	0	374	83	235	0	5	0	0	2
5	KIPP DC - SPRING ACADEMY PCS	1039	590	0	0	0	444	3	0	0	0	1	0	0
5	LANGDON ELEMENTARY SCHOOL	2188	617	0	0	0	1067	56	384	0	33	0	0	2
5	LANGLEY ELEMENTARY SCHOOL	1804	1278	0	0	0	387	19	85	0	23	4	0	0
5	LEE MONTESSORI PCS - BROOKLAND	1291	878	0	0	0	383	3	0	0	11	9	0	1
5	LUKE C. MOORE HIGH SCHOOL	675	148	1	0	0	244	38	240	0	0	1	0	1
5	MCKINLEY MIDDLE SCHOOL	1130	869	1	0	0	140	47	46	0	25	1	0	11
5	MCKINLEY TECHNOLOGY HIGH SCHOOL	1006	380	1	0	0	357	95	132	0	28	1	0	4
5	MUNDO VERDE BILINGUAL PCS - CALLE OCHO	1156	956	0	0	0	185	7	0	0	0	1	0	0
5	NOYES ELEMENTARY SCHOOL	1624	970	2	0	0	569	23	2	0	52	2	0	1

5	PERRY STREET PREPARATORY PCS	617	275	3	0	0	199	10	123	0	1	2	0	2
5	PHELPS ARCHITECTURE, CONSTRUCTION AND ENGINEERING HIGH SCHOOL	656	531	1	0	0	0	88	0	0	23	0	0	1
5	ROCKETSHIP PCS - INFINITY COMMUNITY PREP	1619	481	0	0	0	1117	7	0	0	5	8	0	0
5	SOCIAL JUSTICE PCS	64	26	0	0	0	36	1	0	0	0	1	0	1
5	THE CHILDREN'S GUILD DC PCS	1983	751	12	0	0	578	97	507	0	9	2	0	3
5	THE SOJOURNER TRUTH SCHOOL PCS	21	18	0	0	0	0	3	0	0	0	0	0	0
5	TWO RIVERS PCS - YOUNG ELEMENTARY SCHOOL	1525	824	0	0	0	685	6	0	0	2	1	0	0
5	TWO RIVERS PCS - YOUNG MIDDLE SCHOOL	1019	127	0	0	0	715	5	167	0	2	1	0	0
5	WASHINGTON LEADERSHIP ACADEMY PCS	234	196	0	0	0	8	10	0	0	9	1	0	2

5	WASHINGTON YU YING PCS	2743	2079	0	0	0	457	14	178	0	0	1	0	3
5	WHEATLEY EDUCATION CAMPUS	229	183	0	0	0	38	1	0	0	7	0	0	0

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6	AMIDON-BOWEN ELEMENTARY SCHOOL	869	556	0	0	0	273	9	0	0	22	7	0	1
6	BRENT ELEMENTARY SCHOOL	1398	874	0	0	0	306	32	88	0	68	2	0	2
6	CAPITOL HILL MONTESSORI SCHOOL @ LOGAN	490	103	0	0	0	98	6	0	0	272	1	0	0
6	CENTER CITY PCS - CAPITOL HILL	702	289	0	0	0	205	19	172	0	9	1	0	0
6	DIGITAL PIONEERS ACADEMY PCS - JOHENNING	1414	625	9	0	0	473	32	259	0	3	0	0	2
6	EASTERN HIGH SCHOOL	1256	436	4	0	0	387	117	280	3	16	2	0	5
6	ELIOT-HINE MIDDLE SCHOOL	1043	558	2	0	0	295	75	84	0	22	0	0	0

6	FRIENDSHIP PCS - CHAMBERLAIN ELEMENTARY	1141	361	1	0	0	763	6	0	0	4	1	0	1
6	FRIENDSHIP PCS - CHAMBERLAIN MIDDLE	963	297	0	0	0	566	9	83	0	5	0	0	1
6	J. O. WILSON ELEMENTARY SCHOOL	1873	856	10	0	0	318	36	543	0	51	43	0	2
6	JEFFERSON MIDDLE SCHOOL ACADEMY	721	548	1	0	0	92	29	0	0	10	1	0	3
6	KIPP DC - GROW ACADEMY PCS	151	66	0	0	0	76	0	0	0	5	2	0	0
6	KIPP DC - LEAD ACADEMY PCS	1294	445	1	0	0	584	4	252	0	4	0	0	0
6	KIPP DC - WILL ACADEMY PCS	1002	221	0	0	0	446	5	318	0	9	0	0	0
6	LUDLOW-TAYLOR ELEMENTARY SCHOOL	1430	1035	0	0	0	242	44	0	0	68	6	0	3
6	MAURY ELEMENTARY SCHOOL	459	365	0	1	0	33	8	0	0	49	0	0	1
6	MINER ELEMENTARY SCHOOL	2076	843	0	0	0	1046	15	133	0	39	0	0	1

6	PAYNE ELEMENTARY SCHOOL	1061	700	2	0	0	196	39	0	0	78	7	0	0
6	PEABODY ELEMENTARY SCHOOL (CAPITOL HILL CLUSTER)	460	391	0	0	0	28	1	0	0	18	1	0	1
6	SCHOOL-WITHIN-SCHOOL @ GODING	1849	300	0	0	0	919	1	589	0	28	11	0	0
6	SEATON ELEMENTARY SCHOOL	1615	1344	1	0	0	193	10	0	0	10	26	4	2
6	SHIRLEY CHISOLM ELEMENTARY SCHOOL/TYLER ELEMENTARY SCHOOL	2347	1094	0	0	0	899	22	249	0	56	10	0	2
6	STUART-HOBSON MIDDLE SCHOOL (CAPITOL HILL CLUSTER)	1974	971	11	0	0	815	73	0	0	31	1	0	2
6	TWO RIVERS PCS - 4TH STREET	448	316	0	0	0	103	7	0	0	6	1	0	0
6	VAN NESS ELEMENTARY SCHOOL	1678	828	0	0	0	641	8	174	0	21	0	0	2

6	WALKER-JONES EDUCATION CAMPUS	1950	794	0	0	0	611	49	377	0	77	6	0	0
6	WASHINGTON GLOBAL PCS	685	325	3	0	0	247	8	77	0	19	2	0	0
6	WATKINS ELEMENTARY SCHOOL (CAPITOL HILL CLUSTER)	1566	684	0	0	0	815	35	0	0	25	0	0	0

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7	APPLETREE EARLY LEARNING CENTER PCS - OKLAHOMA AVENUE	48	43	0	0	0	0	0	0	0	1	4	0	0
7	BEERS ELEMENTARY SCHOOL	631	232	0	0	0	369	6	0	0	21	0	0	2

7	BURRVILLE ELEMENTARY SCHOOL	959	677	0	0	0	245	9	0	0	20	1	0	0
7	C. W. HARRIS ELEMENTARY SCHOOL	1953	1048	0	0	0	722	9	128	0	37	7	0	2
7	DC PREP PCS - BENNING ELEMENTARY SCHOOL	1905	723	0	0	0	747	0	428	0	3	1	0	0
7	DC PREP PCS - BENNING MIDDLE SCHOOL	1734	741	0	0	0	745	33	203	0	9	1	0	0
7	DC SCHOLARS PCS	1156	783	4	0	0	313	13	0	0	35	4	0	3
7	DREW ELEMENTARY SCHOOL	1196	599	1	0	0	411	10	144	0	27	2	0	0
7	ELSIE WHITLOW STOKES COMMUNITY FREEDOM	704	387	0	0	0	300	0	0	0	10	1	0	0

	PCS - EAST END													
7	FRIENDSHIP PCS - BLOW PIERCE ELEMENTARY	1403	540	2	0	0	541	12	289	0	15	2	0	0
7	FRIENDSHIP PCS - BLOW PIERCE MIDDLE	1260	360	1	0	0	570	19	284	0	18	1	0	2
7	FRIENDSHIP PCS - COLLEGIATE ACADEMY	1019	817	1	0	0	27	134	0	1	38	0	0	1
7	H. D. WOODSON HIGH SCHOOL	1798	540	1	0	0	616	180	409	1	49	0	0	3
7	HOUSTON ELEMENTARY SCHOOL	1227	683	0	0	0	494	9	0	0	36	1	0	0
7	I DREAM PCS	174	171	0	0	0	1	1	0	0	1	0	0	0

7	IDEA PCS	511	173	0	0	0	12	34	107	0	179	0	0	1
7	KELLY MILLER MIDDLE SCHOOL	508	281	0	0	0	200	19	0	0	7	0	0	0
7	KIMBALL ELEMENTARY SCHOOL	820	456	0	0	0	273	5	0	0	81	3	0	0
7	KIPP DC - ARTS AND TECHNOLOGY ACADEMY PCS	234	123	0	0	0	111	0	0	0	0	0	0	0
7	KIPP DC - KEY ACADEMY PCS	455	432	0	0	0	3	10	0	0	1	0	0	1
7	KIPP DC - LEAP ACADEMY PCS	137	62	0	0	0	68	0	0	0	0	0	0	1
7	KIPP DC - PROMISE ACADEMY PCS	1457	773	1	0	0	647	6	0	0	3	0	0	2

7	KIPP DC - QUEST ACADEMY PCS	984	690	0	0	0	268	0	0	0	24	0	0	0
7	KIPP DC - VALOR ACADEMY PCS	546	478	2	0	0	60	5	0	0	0	0	0	2
7	LORRAINE H. WHITLOCK ELEMENTARY SCHOOL	604	279	0	1	0	220	6	0	0	79	17	0	1
7	MAYA ANGELOU PCS - HIGH SCHOOL	1046	644	0	0	0	137	257	0	0	6	1	0	0
7	NALLE ELEMENTARY SCHOOL	1563	889	1	0	0	219	14	392	0	44	1	0	0
7	PLUMMER ELEMENTARY SCHOOL	1770	1216	1	0	0	268	8	264	0	2	6	0	3
7	RANDLE HIGHLANDS ELEMENT	1306	822	0	0	0	322	100	0	0	52	1	0	0

	ARY SCHOOL													
7	RIVER TERRACE EDUCATION CENTER	976	143	1	0	0	535	48	208	0	6	1	0	5
7	ROCKETSHIP PCS - LEGACY PREP	1021	815	0	0	0	147	9	0	0	22	0	0	1
7	RON BROWN COLLEGE PREPARATORY HIGH SCHOOL	263	144	0	0	0	99	4	0	0	11	4	0	3
7	SMOTHERS ELEMENTARY SCHOOL	1356	751	0	0	0	537	9	19	0	8	1	0	4
7	SOUSA MIDDLE SCHOOL	401	318	0	0	0	59	18	0	0	1	3	0	0
7	THOMAS ELEMENTARY SCHOOL	1026	705	0	0	0	114	21	138	0	44	0	0	2

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8	ANACOSTIA HIGH SCHOOL	362	175	3	0	0	90	11	20	0	47	1	0	6
8	APPLETREE EARLY LEARNING CENTER PCS - DOUGLAS KNOLL	240	228	0	0	0	0	6	0	0	1	0	0	0
8	BALLOU HIGH SCHOOL	448	150	1	0	0	121	10	148	1	15	0	0	10
8	BARD HIGH SCHOOL EARLY COLLEGE DC (BARD DC)	75	59	1	0	0	0	9	0	0	4	1	0	2
8	DC PREP PCS - ANACOSTIA ELEMENTARY SCHOOL	2194	1449	0	0	0	591	5	118	0	22	6	0	0
8	DC PREP PCS - ANACOSTIA MIDDLE SCHOOL	1120	283	0	0	0	236	12	578	0	10	1	0	1
8	EARLY CHILDHOOD ACADEMY PCS	1272	506	0	0	0	724	23	0	0	2	12	0	1

8	EXCEL ACADEMY	1297	947	0	0	0	270	26	0	0	23	5	0	1
8	FRIENDSHIP PCS - SOUTHEAST ELEMENTARY	1126	397	0	0	0	403	4	315	0	6	0	0	0
8	FRIENDSHIP PCS - SOUTHEAST MIDDLE	628	347	3	0	0	156	43	74	0	4	0	0	0
8	FRIENDSHIP PCS - TECHNOLOGY PREPARATORY HIGH SCHOOL	415	230	2	0	0	140	23	0	0	19	0	0	1
8	GARFIELD ELEMENTARY SCHOOL	473	263	0	0	0	45	13	0	0	12	0	0	1
8	HART MIDDLE SCHOOL	1644	862	4	0	0	669	41	0	0	45	0	0	2
8	HENDLEY ELEMENTARY SCHOOL	1668	1018	0	0	0	434	44	144	0	14	0	0	0
8	INGENUITY PREP PCS	1313	472	1	0	0	570	8	255	0	1	2	0	2
8	JOHNSON MIDDLE SCHOOL	655	501	0	0	0	6	8	114	0	16	0	0	4

8	KETCHAM ELEMENTARY SCHOOL	401	340	0	0	0	37	0	0	0	17	5	0	0
8	KING ELEMENTARY SCHOOL	706	97	0	0	0	601	1	0	0	7	0	0	1
8	KIPP DC - AIM ACADEMY PCS	2166	642	1	0	0	998	42	471	0	0	1	0	2
8	KIPP DC - DISCOVER ACADEMY PCS	272	161	0	0	0	109	0	0	0	0	1	0	1
8	KIPP DC - HEIGHTS ACADEMY PCS	1759	995	0	0	0	481	6	262	0	5	2	0	1
8	KIPP DC - HONOR ACADEMY PCS	1572	892	1	0	0	413	20	243	0	1	0	0	0
8	KIPP DC - INSPIRE ACADEMY PCS	800	281	0	0	0	384	5	124	0	0	0	0	0
8	KIPP DC - PRIDE ACADEMY PCS	390	96	0	0	0	286	1	0	0	3	0	0	0
8	KIPP DC PCS - LEGACY COLLEGE PREPATORY PCS	187	134	3	0	0	26	2	1	0	12	8	0	7

8	KRAMER MIDDLE SCHOOL	186	141	0	0	0	0	10	0	1	3	1	0	1
8	LAWRENCE E. BOONE ELEMENTARY SCHOOL	2261	1791	0	0	0	367	39	0	0	38	14	0	4
8	LECKIE ELEMENTARY SCHOOL	330	86	0	0	0	187	3	43	0	3	0	0	0
8	LEE MONTESSORI PCS - EAST END	401	283	0	0	0	6	3	0	0	33	0	0	1
8	MALCOLM X ELEMENTARY SCHOOL @ GREEN	1621	332	0	0	0	1238	22	0	0	11	8	0	2
8	MOTEN ELEMENTARY SCHOOL	31	20	0	0	0	0	0	0	0	10	0	0	0
8	PATTERSON ELEMENTARY SCHOOL	3117	877	0	0	0	1412	20	729	0	48	5	0	0
8	ROCKETSHIP RISE PCS	1809	741	1	0	0	546	41	399	0	15	24	0	5
8	SAVOY ELEMENTARY SCHOOL	1139	546	0	0	0	465	3	0	0	119	0	0	1

8	SIMON ELEMENTARY SCHOOL	1468	893	0	0	0	362	12	185	0	8	0	0	1
8	STANTON ELEMENTARY SCHOOL	790	567	0	0	0	165	6	0	0	46	4	0	2
8	STATESMEN COLLEGE PREPARATORY ACADEMY FOR BOYS PCS	952	310	0	0	0	502	2	93	0	25	1	0	3
8	THURGOOD MARSHALL ACADEMY PCS	374	317	0	0	0	3	35	0	0	16	0	0	4
8	TURNER ELEMENTARY SCHOOL	2500	1708	2	0	0	535	14	220	0	14	3	0	2
8	BALLOU STAY HIGH SCHOOL	24	7	0	0	0	2	0	0	0	15	0	0	2
8	EAGLE ACADEMY PCS - CONGRESS HEIGHTS	1922	906	0	0	0	964	20	0	0	31	1	0	0

FY25 District of Columbia Public and Chartered Schools Health Service Utilization, SY24-25 To Date By Ward and School Level														
Ward	**School**	**Total Events**	**Acute Care Management**	**Behavioral Health**	**Counseling Session**	**Covid Screening**	**Chronic Disease Management**	**Health Maintenance**	**Procedures**	**Reproductive Health**	**Preventative Care**	**Telehealth Services**	**Virtual Services**	**911/EMS**

1	BANCROFT ELEMENTARY SCHOOL	340	329	1	0	0	0	6	0	0	0	0	0	0
1	BELL MULTICULTURAL HS	92	76	2	0	0	6	7	0	0	0	0	0	0
1	BRUCE-MONROE ELEMENTARY SCHOOL @ PARK VIEW	43	40	0	0	0	0	1	0	0	0	0	0	0
1	CARDOZO EDUCATION CAMPUS	8	8	0	0	0	0	0	0	0	0	0	0	0
1	CLEVELAND ELEMENTARY SCHOOL	53	39	0	0	0	0	9	0	0	0	0	0	0
1	E.L. HAYNES PCS - MIDDLE SCHOOL	2	2	0	0	0	0	0	0	0	0	0	0	0
1	H.D. COOKE ELEMENTARY SCHOOL	89	73	0	0	0	16	0	0	0	0	0	0	0
1	LINCOLN MULTICULTURAL MS	196	181	0	0	0	2	10	0	0	0	0	0	0
1	MARIE REED ELEMENTARY SCHOOL	142	139	0	0	0	0	3	0	0	0	0	0	0
1	MERIDIAN ES PCS	12	12	0	0	0	0	0	0	0	0	0	0	0
1	MERIDIAN MS PCS	128	128	0	0	0	0	0	0	0	0	0	0	0
1	OYSTER ADAMS BILINGUAL -	181	79	0	0	0	0	101	0	0	0	0	0	0

	ADAMS CAMPUS													
1	TUBMAN ELEMENTARY SCHOOL	183	167	2	0	0	1	3	0	0	0	1	0	1

Ward	School	Total Events	Acute Care Management	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Management	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/ EMS
2	BENJAMIN BANNEKER HIGH SCHOOL	83	77	0	0	0	1	3	0	0	0	0	0	0
2	DUKE ELLINGTON SCHOOL OF THE ARTS	138	92	1	0	0	3	40	0	0	0	0	0	2
2	GARRISON ELEMENTARY SCHOOL	137	128	0	0	0	4	3	0	0	0	0	0	0
2	GIRLS GLOBAL ACADEMY PCS	44	30	0	0	0	1	10	0	0	0	0	0	1
2	HARDY MIDDLE SCHOOL	179	169	3	0	0	0	0	0	0	0	0	0	0
2	HYDE-ADDISON ELEMENTARY SCHOOL	109	106	0	0	0	0	2	0	0	0	0	0	0
2	KIPP DC - GROW ACADEMY PCS	27	21	0	0	0	0	1	0	0	0	0	0	0
2	KIPP DC - LEAD ACADEMY PCS	142	139	0	0	0	0	2	0	0	0	0	0	0
2	KIPP DC - WILL ACADEMY PCS	68	56	0	0	0	3	2	0	0	0	0	0	0

2	ROSS ELEMENTARY SCHOOL	76	74	0	0	0	0	2	0	0	0	0	0	0
2	SCHOOL WITHOUT WALLS @ FRANCIS-STEVENS	397	334	0	0	0	47	3	0	0	0	1	0	0
2	SCHOOL WITHOUT WALLS HIGH SCHOOL	100	92	0	0	0	2	2	0	0	0	0	0	0
2	SEATON ELEMENTARY SCHOOL	180	177	0	0	0	0	0	0	0	0	1	0	1
2	THADDEUS STEVENS EARLY LEARNING CENTER	26	26	0	0	0	0	0	0	0	0	0	0	1
2	THOMSON ELEMENTARY SCHOOL	54	50	0	0	0	0	0	0	0	0	1	0	0

Ward	School	Total Events	Acute Care Management	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Management	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
3	DEAL MIDDLE SCHOOL	338	295	4	0	0	2	15	0	0	0	0	0	2
3	EATON ELEMENTARY SCHOOL	227	209	0	0	0	1	4	0	0	0	0	0	0
3	HEARST ELEMENTARY SCHOOL	12	12	0	0	0	0	0	0	0	0	0	0	0

3	JACKSON-REED HIGH SCHOOL	131	106	0	0	0	6	17	0	1	0	0	0	4
3	JANNEY ELEMENTARY SCHOOL	103	101	0	0	0	1	0	0	0	0	0	0	0
3	KEY ELEMENTARY SCHOOL	99	99	0	0	0	0	0	0	0	0	0	0	1
3	MACARTHUR HIGH SCHOOL	55	51	0	0	0	0	3	0	0	0	0	0	0
3	MANN ELEMENTARY SCHOOL	133	128	0	0	0	1	4	0	0	0	0	0	0
3	MURCH ELEMENTARY SCHOOL	213	182	0	0	0	0	4	0	0	0	5	0	0
3	OYSTER ADAMS BILINGUAL - OYSTER CAMPUS	30	30	0	0	0	0	0	0	0	0	0	0	0
3	STODDERT ELEMENTARY SCHOOL	6	6	0	0	0	0	0	0	0	0	0	0	0

Ward	School Name	Total Events	Acute Care Mgmt	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Mgmt	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
4	BARNARD ELEMENTARY SCHOOL	142	123	0	0	0	0	14	0	0	0	0	0	0
4	BRIGHTWOOD ELEMENTARY SCHOOL	359	319	0	0	0	0	19	0	0	0	0	0	0

4	CAPITAL CITY PCS - HIGH SCHOOL	0	0	0	0	0	0	0	0	0	0	0	0	0
4	CAPITAL CITY PCS - LOWER SCHOOL	7	6	0	0	0	0	0	0	0	0	0	0	0
4	CAPITAL CITY PCS - MIDDLE SCHOOL	2	2	0	0	0	0	0	0	0	0	0	0	0
4	CENTER CITY PCS - PETWORTH	32	32	0	0	0	0	0	0	0	0	0	0	0
4	COOLIDGE HIGH SCHOOL	289	240	0	0	0	4	41	0	0	0	0	0	3
4	DISTRICT OF COLUMBIA INTERNATIONAL SCHOOL PCS	340	282	1	0	0	0	18	0	0	0	0	0	1
4	DOROTHY I. HEIGHT ELEMENTARY SCHOOL	88	63	0	0	0	0	11	0	0	0	0	0	0
4	E.L. HAYNES PCS - ELEMENTARY SCHOOL	175	158	0	0	0	5	8	0	0	0	0	0	0
4	E.L. HAYNES PCS - HIGH SCHOOL	33	26	0	0	0	0	1	0	0	0	0	0	1
4	FRIENDSHIP PCS - IDEAL ELEMENTARY	86	75	0	0	0	0	11	0	0	0	0	0	0
4	FRIENDSHIP PCS - IDEAL MIDDLE	49	41	0	0	0	0	7	0	0	0	0	0	0

4	IDA B. WELLS MIDDLE SCHOOL	377	325	3	0	0	1	39	0	0	0	0	0	0
4	JOHN LEWIS ELEMENTARY SCHOOL	150	137	0	0	0	2	6	0	0	0	1	0	0
4	LAFAYETTE ELEMENTARY SCHOOL	185	181	0	0	0	0	1	0	0	0	1	0	0
4	LASALLE-BACKUS ELEMENTARY SCHOOL	126	121	0	0	0	2	0	0	0	0	2	0	0
4	LATIN AMERICAN MONTESSORI BILINGUAL PCS	208	206	0	0	0	0	2	0	0	0	0	0	0
4	MACFARLAND MIDDLE SCHOOL	333	248	2	0	0	10	38	0	0	0	0	0	0
4	MILITARY ROAD EARLY LEARNING CENTER	37	36	0	0	0	0	0	0	0	0	1	0	0
4	PAUL PCS - INTERNATIONAL HIGH SCHOOL	47	46	0	0	0	0	1	0	0	0	0	0	0
4	PAUL PCS - MIDDLE SCHOOL	77	72	0	0	0	1	4	0	0	0	0	0	1
4	POWELL ELEMENTARY SCHOOL	139	135	0	0	0	0	4	0	0	0	0	0	0

4	RAYMOND ELEMENTARY SCHOOL	104	102	0	0	0	0	1	0	0	0	0	0	0
4	ROOSEVELT HIGH SCHOOL	135	124	1	0	0	1	5	0	0	0	0	0	2
4	SELA PCS	0	0	0	0	0	0	0	0	0	0	0	0	0
4	SHEPHERD ELEMENTARY SCHOOL	364	364	0	0	0	0	0	0	0	0	0	0	0
4	TAKOMA ELEMENTARY SCHOOL	74	74	0	0	0	0	0	0	0	0	0	0	0
4	TRUESDELL ELEMENTARY SCHOOL	77	73	0	0	0	0	1	0	0	0	0	0	0
4	WASHINGTON LATIN PCS - MIDDLE SCHOOL	63	58	0	0	0	0	5	0	0	0	0	0	0
4	WASHINGTON LATIN PCS - UPPER SCHOOL	24	22	0	0	0	0	2	0	0	0	0	0	1
4	WHITTIER ELEMENTARY SCHOOL	134	110	0	0	0	0	2	0	0	0	0	0	0

Ward	School	Total Events	Acute Care Mgmt	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Mgmt	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
5	BRIDGES PCS	118	116	0	0	0	0	1	0	0	0	0	0	1
5	BROOKLAND MIDDLE SCHOOL	187	180	0	0	0	0	6	0	0	0	0	0	0

5	BROWNE EDUCATION CAMPUS ES	122	114	0	0	0	0	0	0	0	0	3	0	0
5	BROWNE EDUCATION CAMPUS MS	69	66	0	0	0	0	2	0	0	0	0	0	0
5	BUNKER HILL ELEMENTARY SCHOOL	64	62	0	0	0	0	1	0	0	0	1	0	0
5	BURROUGHS ELEMENTARY SCHOOL	187	144	0	0	0	11	13	0	0	0	0	0	0
5	CAPITAL VILLAGE PCS	39	24	0	0	0	0	4	0	0	0	0	0	0
5	CREATIVE MINDS INTERNATIONAL PCS	242	208	0	0	0	0	13	0	0	0	6	0	0
5	DC BILINGUAL PCS	67	61	0	0	0	0	0	0	0	0	0	0	0
5	DC PREP PCS - EDGEWOOD ELEMENTARY SCHOOL	72	61	0	0	0	0	9	0	0	0	0	0	0
5	DC PREP PCS - EDGEWOOD MIDDLE SCHOOL	143	138	0	0	0	0	4	0	0	0	0	0	0
5	DUNBAR HIGH SCHOOL	163	120	0	0	0	3	28	0	1	0	0	0	1
5	ELSIE WHITLOW STOKES COMMUNITY FREEDOM PCS - BROOKLAND	117	115	0	0	0	0	1	0	0	0	0	0	0

5	FRIENDSHIP PCS - ARMSTRONG ELEMENTARY	63	57	1	0	0	0	1	0	0	0	0	0	0
5	FRIENDSHIP PCS - ARMSTRONG MIDDLE	68	65	0	0	0	0	0	0	0	0	0	0	1
5	FRIENDSHIP PCS - WOODRIDGE INTERNATIONAL ELEMENTARY	148	133	0	0	0	0	6	0	0	0	0	0	0
5	FRIENDSHIP PCS - WOODRIDGE INTERNATIONAL MIDDLE	72	67	0	0	0	0	3	0	0	0	1	0	0
5	INSPIRED TEACHING DEMONSTRATION PCS	199	178	0	0	0	0	6	0	0	0	0	0	0
5	KIPP DC - COLLEGE PREPARATORY PCS	247	227	1	0	0	1	16	0	0	0	0	0	0
5	KIPP DC - CONNECT ACADEMY PCS	48	36	0	0	0	0	0	0	0	0	0	0	0
5	KIPP DC - NORTHEAST ACADEMY PCS	216	166	1	0	0	0	27	0	0	0	0	0	0
5	KIPP DC - SPRING	148	133	1	0	0	0	2	0	0	0	0	0	0

	ACADEMY PCS													
5	LANGDON ELEMENTARY SCHOOL	164	107	0	0	0	1	54	0	0	0	0	0	0
5	LANGLEY ELEMENTARY SCHOOL	220	214	0	0	0	0	6	0	0	0	0	0	0
5	LEE MONTESSORI PCS - BROOKLAND	254	248	0	0	0	0	2	0	0	0	0	0	0
5	LUKE C. MOORE HIGH SCHOOL	87	33	0	0	0	0	15	0	0	0	0	0	1
5	MCKINLEY MIDDLE SCHOOL	215	182	2	0	0	14	15	0	0	0	1	0	0
5	MCKINLEY TECHNOLOGY HIGH SCHOOL	123	87	0	0	0	0	30	0	0	0	0	0	0
5	MUNDO VERDE BILINGUAL PCS - CALLE OCHO	446	435	0	0	0	0	10	0	0	0	1	0	0
5	NOYES ELEMENTARY SCHOOL	229	217	0	0	0	0	12	0	0	0	0	0	0
5	PERRY STREET PREPARATORY PCS	59	56	0	0	0	0	2	0	0	0	1	0	0
5	PHELPS ARCHITECTURE, CONSTRUCTIO	244	185	0	0	0	0	26	0	0	0	0	0	0

	N AND ENGINEERING HIGH SCHOOL													
5	ROCKETSHIP PCS - INFINITY COMMUNITY PREP	20	20	0	0	0	0	0	0	0	0	0	0	0
5	SOCIAL JUSTICE PCS	0	0	0	0	0	0	0	0	0	0	0	0	0
5	THE CHILDREN'S GUILD DC PCS	305	222	1	0	0	0	33	0	0	0	0	0	0
5	THE SOJOURNER TRUTH SCHOOL PCS	2	0	0	0	0	0	0	0	0	0	0	0	0
5	TWO RIVERS PCS - YOUNG ELEMENTARY SCHOOL	308	301	0	0	0	0	3	0	0	0	0	0	0
5	TWO RIVERS PCS - YOUNG MIDDLE SCHOOL	48	40	1	0	0	0	4	0	0	0	0	0	0
5	WASHINGTON LEADERSHIP ACADEMY PCS	101	94	0	0	0	1	2	0	0	0	0	0	0
5	WASHINGTON YU YING PCS	253	249	0	0	0	0	0	0	0	0	0	0	0
5	WHEATLEY EDUCATION CAMPUS	6	6	0	0	0	0	0	0	0	0	0	0	0

Ward	School	Total Events	Acute Care Mgmt	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Mgmt	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
6	AMIDON-BOWEN ELEMENTARY SCHOOL	171	166	0	0	0	0	3	0	0	0	2	0	0
6	BRENT ELEMENTARY SCHOOL	361	239	0	0	0	1	88	0	0	0	0	0	0
6	CAPITOL HILL MONTESSORI SCHOOL @ LOGAN	41	38	0	0	0	0	2	0	0	0	0	0	0
6	FRIENDSHIP PCS - BLOW PIERCE ELEMENTARY	158	153	0	0	0	5	0	0	0	0	0	0	0
6	FRIENDSHIP PCS - CHAMBERLAIN ELEMENTARY	13	13	0	0	0	0	0	0	0	0	0	0	0
6	FRIENDSHIP PCS - CHAMBERLAIN MIDDLE	13	12	0	0	0	0	0	0	0	0	0	0	0
6	J. O. WILSON ELEMENTARY SCHOOL	226	203	1	0	0	2	3	0	0	0	6	0	0
6	JEFFERSON MIDDLE SCHOOL ACADEMY	77	73	0	0	0	0	0	0	0	0	0	0	1
6	LUDLOW-TAYLOR	224	163	0	0	0	0	14	0	0	0	0	0	0

	ELEMENTARY SCHOOL													
6	MAURY ELEMENTARY SCHOOL	18	18	0	0	0	0	0	0	0	0	0	0	0
6	PAYNE ELEMENTARY SCHOOL	205	186	0	0	0	0	16	0	0	0	1	0	0
6	PEABODY ELEMENTARY SCHOOL (CAPITOL HILL CLUSTER)	51	51	0	0	0	0	0	0	0	0	0	0	0
6	SCHOOL-WITHIN-SCHOOL @ GODING	68	56	0	0	0	4	2	0	0	0	1	0	0
6	SHIRLEY CHISOLM ELEMENTARY SCHOOL	78	71	0	0	0	1	0	0	0	0	0	0	0
6	STUART-HOBSON MIDDLE SCHOOL (CAPITOL HILL CLUSTER)	269	219	0	0	0	0	27	0	0	0	0	0	0
6	TWO RIVERS PCS - 4TH STREET	83	64	0	0	0	0	0	0	0	0	0	0	0
6	WALKER-JONES EDUCATION CAMPUS	377	296	2	0	0	0	8	0	0	0	0	0	3

6	WASHINGTON GLOBAL PCS	28	26	0	0	0	0	1	0	0	0	1	0	0
6	WATKINS ELEMENTARY SCHOOL (CAPITOL HILL CLUSTER)	76	69	0	0	0	0	7	0	0	0	0	0	0

Ward	School	Total Events	Acute Care Mgmt	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Mgmt	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
7	APPLETREE EARLY LEARNING CENTER PCS - OKLAHOMA AVENUE	19	19	0	0	0	0	0	0	0	0	0	0	0
7	BEERS ELEMENTARY SCHOOL	58	52	0	0	0	1	3	0	0	0	1	0	0
7	BURRVILLE ELEMENTARY SCHOOL	114	77	2	0	0	0	1	0	0	0	3	0	0
7	C. W. HARRIS ELEMENTARY SCHOOL	136	128	0	0	0	2	2	0	0	0	0	0	0
7	DC PREP PCS - BENNING ELEMENTARY SCHOOL	179	178	0	0	0	0	0	0	0	0	1	0	0
7	DC PREP PCS - BENNING MIDDLE SCHOOL	211	204	0	0	0	0	2	0	0	0	4	0	0
7	DC SCHOLARS PCS	144	140	0	0	0	0	3	0	0	0	1	0	0

7	DREW ELEMENTARY SCHOOL	187	168	0	0	0	7	3	0	0	0	0	0	3
7	EASTERN HIGH SCHOOL	102	66	3	0	0	7	20	0	0	0	1	0	0
7	ELIOT-HINE MIDDLE SCHOOL	155	131	0	0	0	9	13	0	0	0	1	0	0
7	ELSIE WHITLOW STOKES COMMUNITY FREEDOM PCS - EAST END	113	112	0	0	0	0	1	0	0	0	0	0	0
7	FRIENDSHIP PCS - BLOW PIERCE MIDDLE	89	81	0	0	0	1	6	0	0	0	0	0	0
7	FRIENDSHIP PCS - COLLEGIATE ACADEMY	104	82	0	0	0	1	18	0	0	0	0	0	0
7	H. D. WOODSON HIGH SCHOOL	105	60	0	0	0	0	44	0	0	0	0	0	1
7	HOUSTON ELEMENTARY SCHOOL	232	227	0	0	0	0	3	0	0	0	1	0	0
7	I DREAM PCS	71	69	0	0	0	0	0	0	0	0	0	0	0
7	IDEA PCS	31	23	0	0	0	0	0	0	0	0	0	0	1
7	KELLY MILLER MIDDLE SCHOOL	159	132	0	0	0	0	22	0	0	0	0	0	1

7	KIMBALL ELEMENTARY SCHOOL	6	6	0	0	0	0	0	0	0	0	0	0	0
7	KIPP DC - ARTS AND TECHNOLOGY ACADEMY PCS	35	35	0	0	0	0	0	0	0	0	0	0	0
7	KIPP DC - KEY ACADEMY PCS	63	53	0	0	0	7	2	0	0	0	0	0	0
7	KIPP DC - LEAP ACADEMY PCS	13	12	0	0	0	0	1	0	0	0	0	0	1
7	KIPP DC - PROMISE ACADEMY PCS	83	82	0	0	0	0	1	0	0	0	0	0	0
7	KIPP DC - QUEST ACADEMY PCS	202	201	0	0	0	1	0	0	0	0	0	0	0
7	KIPP DC - VALOR ACADEMY PCS	116	114	0	0	0	0	2	0	0	0	0	0	0
7	LORRAINE H. WHITLOCK ELEMENTARY SCHOOL	33	33	0	0	0	0	0	0	0	0	0	0	0
7	MAYA ANGELOU PCS - HIGH SCHOOL	226	142	0	0	0	33	50	0	0	0	0	0	0

7	MINER ELEMENTARY SCHOOL	121	116	1	0	0	0	0	0	0	0	0	0	0
7	NALLE ELEMENTARY SCHOOL	93	93	0	0	0	0	0	0	0	0	0	0	0
7	PLUMMER ELEMENTARY SCHOOL	143	130	2	0	0	0	2	0	0	0	2	0	0
7	RANDLE HIGHLANDS ELEMENTARY SCHOOL	285	230	0	0	0	0	36	0	0	0	0	0	0
7	RIVER TERRACE EDUCATION CENTER	81	50	0	0	0	4	4	0	0	0	0	0	1
7	ROCKETSHIP PCS - LEGACY PREP	221	200	0	0	0	0	2	0	0	0	0	0	0
7	RON BROWN COLLEGE PREPARATORY HIGH SCHOOL	30	30	0	0	0	0	0	0	0	0	0	0	0
7	SMOTHERS ELEMENTARY SCHOOL	153	145	0	0	0	0	1	0	0	0	0	0	0
7	SOUSA MIDDLE SCHOOL	196	186	1	0	0	2	1	0	0	0	2	0	1
7	THOMAS ELEMENTARY SCHOOL	115	106	0	0	0	0	7	0	0	0	0	0	0

Ward	School	Total Events	Acute Care Mgmt	Behavioral Health	Counseling Session	Covid Screening	Chronic Disease Mgmt	Health Maintenance	Procedures	Reproductive Health	Preventative Care	Telehealth Services	Virtual Services	911/EMS
8	ANACOSTIA HIGH SCHOOL	2	1	0	0	0	0	0	0	0	0	0	0	0
8	APPLETREE EARLY LEARNING CENTER PCS - DOUGLAS KNOLL	73	58	1	0	0	0	9	0	0	0	0	0	0
8	BALLOU HIGH SCHOOL	28	27	0	0	0	0	1	0	0	0	0	0	2
8	BALLOU STAY HIGH SCHOOL	0	0	0	0	0	0	0	0	0	0	0	0	0
8	BARD HIGH SCHOOL EARLY COLLEGE DC (BARD DC)	16	12	0	0	0	0	3	0	0	0	0	0	0
8	CENTER CITY PCS - CAPITOL HILL	170	162	0	0	0	3	4	0	0	0	0	0	0
8	DC PREP PCS - ANACOSTIA ELEMENTARY SCHOOL	234	233	0	0	0	0	0	0	0	0	1	0	0
8	DC PREP PCS - ANACOSTIA MIDDLE SCHOOL	69	65	0	0	0	0	4	0	0	0	0	0	0
8	DIGITAL PIONEERS ACADEMY PCS - JOHENNING	61	61	0	0	0	0	0	0	0	0	0	0	0

8	EARLY CHILDHOOD ACADEMY PCS	131	105	0	0	0	0	21	0	0	0	3	0	1
8	EXCEL ACADEMY	256	223	0	0	0	1	11	0	0	0	0	0	0
8	FRIENDSHIP PCS - SOUTHEAST ELEMENTARY	111	80	0	0	0	31	0	0	0	0	0	0	0
8	FRIENDSHIP PCS - SOUTHEAST MIDDLE	65	35	0	0	0	27	2	0	0	0	0	0	0
8	FRIENDSHIP PCS - TECHNOLOGY PREPARATORY HIGH SCHOOL	26	25	0	0	0	0	1	0	0	0	0	0	0
8	GARFIELD ELEMENTARY SCHOOL	99	64	0	0	0	0	2	0	0	0	0	0	0
8	HART MIDDLE SCHOOL	150	75	0	0	0	63	9	0	0	0	0	0	0
8	HENDLEY ELEMENTARY SCHOOL	125	79	0	0	0	0	29	0	0	0	0	0	0
8	INGENUITY PREP PCS	96	66	1	0	0	0	3	0	0	0	0	0	0
8	JOHNSON MIDDLE SCHOOL	65	62	0	0	0	2	0	0	0	0	0	0	0
8	KETCHAM ELEMENTARY SCHOOL	12	12	0	0	0	0	0	0	0	0	0	0	0
8	KING ELEMENTARY SCHOOL	6	5	0	0	0	0	0	0	0	0	0	0	0

8	KIPP DC - AIM ACADEMY PCS	91	79	0	0	0	0	5	0	0	0	0	0	1
8	KIPP DC - DISCOVER ACADEMY PCS	20	16	0	0	0	0	2	0	0	0	0	0	0
8	KIPP DC - HEIGHTS ACADEMY PCS	93	82	0	0	0	0	9	0	0	0	0	0	0
8	KIPP DC - HONOR ACADEMY PCS	162	159	0	0	0	0	3	0	0	0	0	0	0
8	KIPP DC - INSPIRE ACADEMY PCS	65	64	0	0	0	0	0	0	0	0	0	0	0
8	KIPP DC - PRIDE ACADEMY PCS	15	14	0	0	0	0	0	0	0	0	0	0	0
8	KIPP DC PCS - LEGACY COLLEGE PREPATORY PCS	18	17	0	0	0	0	1	0	0	0	0	0	1
8	KRAMER MIDDLE SCHOOL	43	36	1	0	0	0	4	0	0	0	0	0	0
8	LAWRENCE E. BOONE ELEMENTARY SCHOOL	306	287	0	0	0	0	9	0	0	0	0	0	0
8	LECKIE ELEMENTARY SCHOOL	7	6	0	0	0	0	0	0	0	0	0	0	0
8	LEE MONTESSORI PCS - EAST END	92	66	0	0	0	0	0	0	0	0	0	0	0

8	MALCOLM X ELEMENTARY SCHOOL @ GREEN	117	114	0	0	0	0	2	0	0	0	1	0	0
8	MOTEN ELEMENTARY SCHOOL	8	8	0	0	0	0	0	0	0	0	0	0	0
8	PATTERSON ELEMENTARY SCHOOL	145	121	0	0	0	0	12	0	0	0	2	0	0
8	ROCKETSHIP RISE PCS	188	142	0	0	0	4	19	0	0	0	3	0	0
8	SAVOY ELEMENTARY SCHOOL	10	9	0	0	0	0	1	0	0	0	0	0	0
8	SIMON ELEMENTARY SCHOOL	53	52	0	0	0	0	1	0	0	0	0	0	0
8	STANTON ELEMENTARY SCHOOL	69	67	0	0	0	1	1	0	0	0	0	0	1
8	STATESMEN COLLEGE PREPARATORY ACADEMY FOR BOYS PCS	94	51	0	0	0	2	7	0	0	0	0	0	0
8	THURGOOD MARSHALL ACADEMY PCS	42	37	0	0	0	0	5	0	0	0	0	0	1
8	TURNER ELEMENTARY SCHOOL	279	268	0	0	0	0	4	0	0	0	2	0	0
8	VAN NESS ELEMENTARY SCHOOL	70	70	0	0	0	0	0	0	0	0	0	0	0

Q55: Please provide the following information on school-based health centers (SBHCs) in FY 2024:

a. The number of students who utilized each center;
b. The number of students who sought care for each offered service, disaggregated by health center;
c. The number of health care staff at each school, including their professions; and
d. The amount of funding allocated to each health center.

Response:

a. The number of students who utilized each health center

Number of Unduplicated Student Visits by School	
School	**FY 24 (SY 2023 – 2024)**
Anacostia	554
Ballou	285
Cardozo	1261
Coolidge	1082
Dunbar	212
Roosevelt	436
Woodson	844
Total	4674

b. The number of students who sought care for each offered service, disaggregated by health center

FY 24 School-Based Health Centers Utilization by Service and School (SY 2023 – 2024)							
	Anacostia	Ballou	Cardozo	Coolidge	Dunbar	Roosevelt	Woodson
Total Visits	663	345	1790	1434	491	564	1346
Total number of students who visited SBHC (unduplicated count number as seen above)	554	285	1261	1082	212	436	844
Well Child Visits	185	0	308	169	0	165	263
Mental/ Behavioral Health Visits	106	64	1732	593	11	184	39

Sexual Health Visits	416	73	326	423	65	345	211
Oral Health Visits	87	55	244	524	43	64	94
Asthma Care Visits	36	0	41	35	0	35	86

c. The number of health care staff at each school, including their professions

FY 24 School-Based Health Center Staff at Anacostia	
Position	Number of Staff
Medical Director/Pediatrician	1
Program Administrator	1
Nurse Practitioner	1
Nurse Midwife	1
License Practical Nurse	1
Patient Services Supervisor	1
Licensed Clinical Social Worker	1
Psychiatrist	1
Total:	8

FY 24 School-Based Health Center Staff at Ballou	
Profession	Number
Medical Director/Pediatrician	1
Principal Investigator	1
Program Manager	1
Reproductive Health Provider	1
Nurse Practitioner	1
Reproductive Health Coordinator	1
Clinical Operations Representative	1
Vaccine Coordinator	1
Operations Director	1
Mental Health Provider	1
Total	10

FY 24 School-Based Health Center Staff at Cardozo	
Profession	Number
Medical Director /Pediatrician	1
Health Center Director	1
Nurse Practitioner	1
Medical Assistant	1
Care Coordinator	1
Dental Provider	1
Dental Assistant	1
Case Manager	1
Program Manager	1
Total	9

FY 24 School-Based Health Center Staff at Coolidge	
Profession	Number
Medical Director/Nurse Practitioner	1
School Based Health Navigator	1
Medical Assistant	1
Dentist	2
Dental Hygienist	2
Dental Assistant	2
Mental Health Provider	1
Total	10

FY 24 School-Based Health Center Staff at Dunbar	
Profession	Number
Medical Director/Pediatrician	1
Principal Investigator	1
Program Manager	1
Reproductive Health Provider	1
Nurse Practitioner	1
Reproductive Health Coordinator	1
Clinical Operations Representative	1
Vaccine Coordinator	1
Operations Director	1
Mental Health Provider	1

Total	10

FY 24 School Based Health Center Staff at Roosevelt	
Profession	Number
Medical Director /Pediatrician	1
Pediatrician	1
Program Administrator	1
Patient Services Coordinator	1
Medical Assistant	1
Social Worker	1
Psychiatrist	1
Certified Nurse Midwife	1
Total	8

FY 24 School-Based Health Center Staff at Woodson	
Profession	Number
Health Center Director	1
Medical Director	1
Nurse Practitioner	1
Medical Assistant	1
Care Coordinator	1
Case Manager	1
Mental Health Clinician	1
Dentist	1
Dental Assistant	1
Total	9

d. The amount of funding allocated to each health care center

School-Based Health Center	FY 24 Funding Allocation
Anacostia High School	$300,000
Ballou High School	$300,000
Cardozo Education Campus	$300,000
Coolidge High School	$300,000
Dunbar High School	$300,000

Roosevelt High School	$300,000
Woodson High School	$300,000
Total	**$2,100,000.00**

Q56: Please provide the following information for the SBHCs still in operation in FY 2025, to date, given the budget reduction to this program:

a. The number of health care staff at each school, including their professions;
b. The amount of funding allocated to each health center;
c. Hours of operation; and
d. Description of changes to available health services, compared to FY 2024.

Response:

a. The number of health care staff at each school, including their profession

FY 24 School-Based Health Center Staff at Anacostia			
Profession	Number of Staff	FTE	In-Kind
Medical Director/Pediatrician	1	10%	N
Program Administrator	1	10%	Y
Nurse Practitioner	1	80%	N
Nurse Midwife	1	10%	Y
License Practical Nurse	1	100%	N
Patient Services Supervisor	1	100%	N
Licensed Clinical Social Worker	1	10%	Y
Psychiatrist	1	10%	Y
Total:	8		

FY 24 School-Based Health Center Staff at Ballou			
Profession	Number of Staff	FTE	In-Kind
Medical Director/Pediatrician	1	20%	Y
Principal Investigator	1	1%	Y
Program Manager	1	30%	N
Adolescent Health Provider	1	2.5%	N
Nurse Practitioner	1	40%	N
Clinical Operations Representative	1	50%	N
Vaccine Coordinator	1	0.5%	N
Operations Director	1	0.5%	N
Mental Health Provider	1	37.5%	N

Total	9

FY 24 School-Based Health Center Staff at Cardozo			
Profession	Number of Staff	FTE	In-Kind
Medical Director /Pediatrician	1	20%	Y
Health Center Director	1	50%	Y
Nurse Practitioner	1	70%	Y
Nurse Practitioner (alt)	1	10%	Y
Medical Assistant	1	100%	N
Care Coordinator	1	100%	N
Dental Provider	1	10%	N
Dental Assistant	1	10%	N
Case Manager	1	40%	Y
Program (Data)Manager	1	3%	N
Total	9		

FY 24 School-Based Health Center Staff at Coolidge HS			
Profession	Number of Staff	FTE	In-Kind
Medical Director /Nurse Practitioner	1	20%	N
School-Based Health Navigator	1	80%	N
Nurse Practitioner	1	25%	N
Medical Assistant	1	80%	N
Dentist	2	16 hrs/month	N
Dental Hygienist	2	16 hrs/month	N
Dental Assistant	2	16 hrs/month	N
Mental Health Provider	1	50%	Y
Data Analyst	1	10%	Y
Total	10		

FY 24 School-Based Health Center Staff at Dunbar			
Profession	Number of Staff	FTE	In-Kind
Medical Director/Pediatrician	1	20%	Y
Principal Investigator	1	1%	Y

Program Manager	1	30%	N
Adolescent Health Provider	1	2.5%	N
Nurse Practitioner	1	40%	N
Clinical Operations Representative	1	50%	N
Vaccine Coordinator	1	0.5%	N
Operations Director	1	0.5%	N
Mental Health Provider	1	37.5%	N
Total	9		

FY 24 School-Based Health Center Staff at Roosevelt			
Profession	Number of Staff	FTE	In-Kind
Medical Director/Pediatrician	1	10%	N
Program Administrator	1	10%	Y
Nurse Practitioner	1	80%	N
Nurse Midwife	1	10%	Y
License Practical Nurse	1	100%	N
Patient Services Supervisor	1	100%	N
Licensed Clinical Social Worker	1	10%	Y
Psychiatrist	1	10%	Y
Total:	8		

FY 24 School-Based Health Center Staff at Woodson			
Profession	Number of Staff	FTE	In-Kind
Medical Director /Pediatrician	1	20%	Y
Health Center Director	1	50%	Y
Nurse Practitioner	1	70%	Y
Nurse Practitioner (alt)	1	10%	Y
Medical Assistant	1	100%	N
Care Coordinator	1	100%	N
Dental Provider	1	10%	N

Dental Assistant	1	10%	N
Case Manager	1	40%	Y
Program (Data)Manager	1	3%	N
Total	9		

b. The amount of funding allocated to each health center

FY25 Funding Allocation for School-Based Health Centers	
School	**FY25 Budget**
Anacostia High School	$207,069.24
Ballou High School	$93,909.00
Cardozo Education Campus	$284,688.08
Coolidge High School	$191,257 .00
Dunbar High School	$93,909.00
Roosevelt High School	$207,069.23
Woodson High School	$284,688.10
Total	**$1,362,589.65**

FY 25 Funding Allocation for School-Based Health Centers		
Operator	**Schools Covered**	**FY25 Budget**
Medstar	Anacostia High School Roosevelt High School	$414,138.47
Children's National	Ballou High School Coolidge High School Dunbar High School	$379,075.00
Unity	Cardozo Education Campus Woodson High School	$569,376.18
Total		$1, 362,589.65

c. Hours of Operation

School	**Days of Operation**	**Hours of Operation**
Anacostia High School	Monday, Wednesday, and Alternate Wednesdays	8:00 am–4:30 pm
Ballou High School	Monday and Tuesday	8:00 am–4:30 pm
Cardozo Education Campus	Monday, Tuesday, and Wednesday	8:00 am–4:30 pm

Coolidge High School*	**Temporarily Closed- Reopening Quarter 2 of 2025**	
Dunbar High School	Wednesday and Friday	8:00 am–4:30 pm
Roosevelt High School	Tuesday and Friday, alternate Wednesday	8:00 am–4:30 pm
Woodson High School	Monday, Tuesday, and Wednesday	8:00 am–4:30 pm

d. Description of changes to available health services, compared to FY2024

In FY2025, several changes were made to the available health services compared to FY2024. One significant change was in the hours of operation of the seven School-Based Health Centers (SBHCs). These centers reduced their operations from five days a week to two or three days a week due to funding constraints and based on utilization trends. Another notable change was the temporary closure of the Coolidge School-Based Health Center, as the operator decided to leave the program. A new operator will launch services at Coolidge SBHC by Quarter 2 of 2025.

Q57: Please provide an update on the Health Professional Loan Repayment Program, including:
a. The total number of current participants, including profession;
b. Service location and terms of current participants; and
c. FY 2024 and FY 2025 funding and expenditures, broken down by source.

Response:

a. Total number of current participants, including profession:

Discipline	Count
Primary Care	20
Dental Health	8
Mental Health	19
Total	**47**

b. FY 2024 Service Location and Term of Current Participants

Term	Site	Ward
3 Years	Children's Health Center - Anacostia	Ward 8
2 Years	Children's Health Project of DC (The ARC)	Ward 8
2 Years	Children's Health Project of DC (The ARC)	Ward 8
2 Years	Children's Health Project of DC (The ARC)	Ward 8
3 Years	Community of Hope - Conway Health and Resource Center	Ward 8
3 Years	Community of Hope - Conway Health and Resource Center	Ward 8
2 Years	Community of Hope - Health and Birth Center	Ward 5
2 Years	Community of Hope - Health and Birth Center	Ward 5
2 Years	Confidential Care Medical, LLC	Ward 7
4 Years	DBH - Malcolm X School Health Center	Ward 8
3 Years	Family and Medical Counseling Services, Inc	Ward 8
2 Years	Howard University Hospital - Women's Wellness Center	Ward 1
2 Years	Life Enhancement Services, LLC	Ward 7
3 Years	Mary's Center - Gallatin Street	Ward 5
2 Years	Mary's Center - Gallatin Street	Ward 5
4 Years	Mary's Center - Ontario Rd	Ward 1
3 Years	Max Robinson Medical Center	Ward 8
4 Years	Max Robinson Medical Center	Ward 8
2 Years	Prestige Healthcare Resources, Inc	Ward 8
2 Years	Prestige Healthcare Resources, Inc	Ward 8

2 Years	PSI Services III, Inc.	Ward 8
Term	**Site**	**Ward**
2 Years	SOME, Inc.	Ward 5
2 Years	St. Elizabeth's Hospital	Ward 8
3 Years	St. Elizabeth's Hospital	Ward 8
2 Years	St. Elizabeth's Hospital	Ward 8
3 Years	St. Elizabeth's Hospital	Ward 8
4 Years	St. Elizabeth's Hospital	Ward 8
4 Years	St. Elizabeth's Hospital	Ward 8
4 Years	St. Elizabeth's Hospital	Ward 8
4 Years	St. Elizabeth's Hospital	Ward 8
4 Years	St. Elizabeth's Hospital	Ward 8
2 Years	Unity Health Care - Anacostia Health Center	Ward 8
3 Years	Unity Health Care - Anacostia Health Center	Ward 8
3 Years	Unity Health Care - Anacostia Health Center	Ward 8
2 Years	Unity Health Care - Brentwood Health Center	Ward 5
2 Years	Unity Health Care - Brentwood Health Center	Ward 5
3 Years	Unity Health Care - Brentwood Health Center	Ward 5
2 Years	Unity Health Care - Central Detention Facility	Ward 7
2 Years	Unity Health Care - Central Detention Facility	Ward 7
3 Years	Unity Health Care - Central Detention Facility	Ward 7
3 Years	Unity Health Care - Correctional Treatment Facility	Ward 7
2 Years	Unity Health Care - Parkside	Ward 7
4 Years	Unity Health Care - Parkside	Ward 7
3 Years	Unity Health Care - Upper Cardozo Health Center	Ward 1
4 Years	Unity Health Care - Upper Cardozo Health Center	Ward 1
2 Years	Whitman Walker - 1525	Ward 2
3 Years	Whitman Walker - 1525	Ward 2

c. FY 2024 and FY 2025 funding and expenditures, broken down by source.

	FY24	FY25
Federal	$820,147.00	$814,342
Local	$159,786.10	$159,786
Expenditure	$979,933.10	$814,342

Q58: Please provide the most recent data regarding compliance with the school immunization mandate for students in pre-school through 12th grade, grouped by school type (DCPS, charter, parochial, and private). Please include disaggregated data by race, age, and Ward.

a. Please summarize DC Health's efforts to promote child immunizations for SY 2024-25. Please include any metrics used to determine success of initiatives.

Response:

Vaccine Compliance by School Type

DCPS					
Grade	**Non-Compliant**	**% Non-Compliant**	**Compliant**	**% Compliant**	**Total Enrolled**
Pre-S	255	10.3%	2,220	89.7%	2,475
Pre-K	1,198	34.7%	2,251	65.3%	3,449
KG	464	11.1%	3,717	88.9%	4,181
01	539	13.0%	3,596	87.0%	4,135
02	727	17.2%	3,496	82.8%	4,223
03	608	14.6%	3,547	85.4%	4,155
04	537	13.5%	3,439	86.5%	3,976
05	1,069	29.8%	2,522	70.2%	3,591
06	360	12.4%	2,533	87.6%	2,893
07	252	8.8%	2,622	91.2%	2,874
08	528	18.9%	2,273	81.1%	2,801
09	1,198	28.5%	3,006	71.5%	4,204
10	895	24.7%	2,734	75.3%	3,629
11	405	13.3%	2,647	86.7%	3,052
12	511	18.8%	2,202	81.2%	2,713
Total	**9,546**	**18.2%**	**42,805**	**81.8%**	**52,351**

Vaccine Compliance by School Type – Cont'd

District of Columbia Public Charter Schools					
GRADE	**Non-Compliant**	**% Non-Compliant**	**Compliant**	**% Compliant**	**Total Enrolled**
Pre-S	185	6.3%	2,763	93.7%	2,948
Pre-K	1,098	33.2%	2,205	66.8%	3,303
KG	211	6.6%	2,971	93.4%	3,182
01	261	8.8%	2,711	91.2%	2,972

02	326	11.1%	2,613	88.9%	2,939
03	280	9.9%	2,559	90.1%	2,839
04	212	7.9%	2,487	92.1%	2,699
05	732	26.3%	2,053	73.7%	2,785
06	220	6.9%	2,987	93.1%	3,207
07	141	4.5%	3,008	95.5%	3,149
08	390	13.1%	2,596	86.9%	2,986
09	658	24.5%	2,026	75.5%	2,684
10	327	15.2%	1,831	84.8%	2,158
11	157	8.4%	1,720	91.6%	1,877
12	240	14.3%	1,434	85.7%	1,674
Total	**5,438**	**13.1%**	**35,964**	**86.9%**	**41,402**

Vaccine Compliance by School Type – Cont'd

Private School					
GRADE	**Non-Compliant**	**% Non-Compliant**	**Compliant**	**% Compliant**	**Total Enrolled**
Pre-S	44	34.6%	83	65.4%	127
Pre-K	159	49.1%	165	50.9%	324
KG	144	32.4%	301	67.6%	445
01	80	16.9%	393	83.1%	473
02	57	12.2%	409	87.8%	466
03	54	11.6%	411	88.4%	465
04	86	16.0%	451	84.0%	537
05	186	33.5%	369	66.5%	555
06	103	16.4%	526	83.6%	629
07	121	20.0%	484	80.0%	605
08	185	30.5%	421	69.5%	606
09	150	27.4%	397	72.6%	547
10	146	26.4%	406	73.6%	552
11	148	26.5%	410	73.5%	558

12	233	40.1%	348	59.9%	581
Total	**1,896**	**25.4%**	**5,574**	**74.6%**	**7,470**

Vaccine Compliance by School Type – Cont'd

Parochial Schools					
GRADE	**Non-Compliant**	**% Non-Compliant**	**Compliant**	**% Compliant**	**Total Enrolled**
Pre-S	9	40.9%	13	59.1%	22
Pre-K	24	35.3%	44	64.7%	68
K	60	39.7%	91	60.3%	151
01	52	33.3%	104	66.7%	156
02	25	17.5%	118	82.5%	143
03	31	17.1%	150	82.9%	181
04	39	20.7%	149	79.3%	188
05	62	29.7%	147	70.3%	209
06	33	16.0%	173	84.0%	206
07	33	16.4%	168	83.6%	201
08	60	29.9%	141	70.1%	201
09	146	39.7%	222	60.3%	368
10	92	24.9%	278	75.1%	370
11	122	34.5%	232	65.5%	354
12	139	38.0%	227	62.0%	366
Total	**927**	**29.1%**	**2,257**	**70.9%**	**3,184**

Vaccine Coverage by Race, Ethnicity, and Ward – Age 5 years

Population Count by Race: Age 5					
Asian	**Black or African American**	**Other/multi-race**	**Unknown**	**White**	**Total**
128	4270	496	735	2108	7737

Vaccine Coverage by Race: Age 5						
	Asian	**Black or African American**	**Other/multi-race**	**Unknown**	**White**	**Total**
5+ DTaP	95%	79%	88%	44%	91%	80%

2+ MMR	95%	90%	95%	49%	96%	88%
4+ Polio	96%	87%	94%	51%	94%	86%
2+ Varicella	95%	89%	94%	48%	96%	87%
2+ HepA	96%	93%	96%	55%	97%	91%
3+ HepB	98%	95%	98%	56%	97%	92%
2+ COVID-19	52%	10%	49%	31%	58%	28%

Population Count by Ethnicity: Age 5			
Hispanic / Latino	**Not Hispanic / Latino**	**Unknown**	**Total**
1267	5953	517	7737

Vaccine Coverage by Ethnicity: Age 5				
	Hispanic / Latino	**Not Hispanic / Latino**	**Unknown**	**Total**
5+ DTaP	81%	81%	64%	80%
2+ MMR	90%	89%	71%	88%
4+ Polio	86%	87%	73%	86%
2+ Varicella	89%	88%	70%	87%
2+ HepA	91%	92%	79%	91%
3+ HepB	91%	93%	81%	92%
2+ COVID-19	28%	27%	44%	28%

Population Count by Ward: Age 5								
Ward 1	**Ward 2**	**Ward 3**	**Ward 4**	**Ward 5**	**Ward 6**	**Ward 7**	**Ward 8**	**Total**
613	266	637	1235	1168	635	1353	1526	7432

Vaccine Coverage by Ward: Age 5									
	Ward 1	**Ward 2**	**Ward 3**	**Ward 4**	**Ward 5**	**Ward 6**	**Ward 7**	**Ward 8**	**Total**
5+ DTaP	81%	79%	85%	86%	79%	88%	77%	76%	81%
2+ MMR	93%	85%	90%	92%	89%	93%	86%	87%	89%
4+ Polio	87%	83%	90%	90%	86%	92%	86%	82%	87%
2+ Varicella	92%	83%	88%	91%	88%	92%	86%	86%	88%

2+ HepA	94%	89%	91%	93%	91%	94%	90%	90%	92%
3+ HepB	94%	91%	93%	94%	92%	95%	92%	91%	93%
2+ COVID-19	39%	35%	57%	41%	28%	45%	12%	8%	28%

Vaccine Coverage by Race, Ethnicity, and Ward – Age 12 years

Population Count by Race: Age 12					
Asian	**Black or African American**	**Other/multi-race**	**Unknown**	**White**	**Total**
101	3970	401	903	1439	6814

Vaccine Coverage by Race: Age 12						
	Asian	**Black or African American**	**Other/multi-race**	**Unknown**	**White**	**Total**
1+ Tdap	90%	77%	85%	63%	89%	79%
1+ HPV	80%	73%	84%	54%	88%	74%
2+ HPV	49%	36%	53%	34%	57%	41%
1+ Mening ACWY	90%	76%	86%	64%	89%	78%
2+ COVID-19	77%	31%	73%	61%	76%	48%

Population Count by Ethnicity: Age 12			
Hispanic / Latino	**Not Hispanic / Latino**	**Unknown**	**Total**
1139	4873	802	6814

Vaccine Coverage by Ethnicity: Age 12				
	Hispanic / Latino	**Not Hispanic / Latino**	**Unknown**	**Total**
1+ Tdap	85%	78%	71%	79%
1+ HPV	85%	74%	61%	74%
2+ HPV	54%	39%	38%	41%
1+ Mening ACWY	84%	77%	72%	78%
2+ COVID-19	60%	41%	69%	48%

Population Count by Ward: Age 12								
Ward 1	**Ward 2**	**Ward 3**	**Ward 4**	**Ward 5**	**Ward 6**	**Ward 7**	**Ward 8**	**Total**
496	222	661	1133	969	519	1156	1318	6474

Vaccine Coverage by Ward: Age 12									
	Ward 1	**Ward 2**	**Ward 3**	**Ward 4**	**Ward 5**	**Ward 6**	**Ward 7**	**Ward 8**	**Total**
1+ Tdap	84%	82%	82%	84%	79%	82%	76%	76%	80%
1+ HPV	82%	73%	75%	81%	75%	81%	72%	71%	76%
2+ HPV	48%	44%	49%	50%	43%	49%	34%	34%	42%
1+ Mening ACWY	83%	82%	82%	84%	78%	82%	75%	73%	79%
2+ COVID-19	54%	65%	78%	60%	49%	56%	32%	27%	48%

a. Please summarize DC Health's efforts to promote child immunizations for SY 2024-25. Please include any metrics used to determine success of initiatives.

DC Health's Immunization Division aims to increase and sustain immunization coverage to prevent vaccine preventable diseases across the lifespan and engages in several key strategies to achieve this:

- Maintaining and strengthening a DC Immunization Information Registry (DOCIIS) so that health care providers are aware of all vaccinations administered to residents and can administer additional vaccinations based on this information.
- Engaging vaccine providers to inform them about immunization practices and assist them in maintaining a high level of vaccination coverage of their patients.
- Enhancing access to vaccination for populations that are especially vulnerable or have low vaccination coverage.
- Community listening and engagement.
- Analyzing immunization data to evaluate ongoing vaccination efforts, assess the impact of initiatives, and identify populations in need of special attention; and
- Supporting school leaders' efforts to improve and sustain high vaccination coverage of students.

Key FY 2024 Milestones and Initiatives:

- **Continuous Improvement of the Immunization Registry.** The Immunization Division maintains the DC Immunization Information Registry (DOCIIS 2.0), which supports vaccine supply management, data quality, and data completeness, and allows greater population-level immunization efforts. As additional interfaces are built

between DOCIIS 2.0 and the electronic health records of health care providers, the data in this registry and in the hands of users will be increasingly complete.

- **Digital Connections to Other Immunization Registries.** The District maintains bidirectional digital connections with the immunization registries of Maryland and the Veteran's Health Administration. A similar connection with Virginia is expected in FY 2025, however routine data exchanges have occurred in FY24.
- **Enhanced Immunization Compliance Portal.** This user-friendly web-based tool was developed with the input of the education sector and school nurses, facilitates reporting of compliance with and enforcement of the school immunization mandate. In FY 2024, it was enhanced to include additional compliance reports and user support documentation.
- **School Immunization Compliance Support.** In the fall of 2024, DC schools continued to enforce the school immunization mandate, including temporary exclusion of students in the key grades of PreK 3, kindergarten, 7th grade, and 11th grade. In FY23, these grades were selected since most students in these grades will not age into non-compliance during the school year and each of these grades occurs soon after ages in which various vaccines are first recommend. DC Health provided extensive support for this enforcement, including training school staff and immunization points of contact, data support for schools, and enhanced vaccination clinic access. While immunization compliance and enforcement are an ongoing activity, significant progress has been made with student immunization compliance in School Year 24-25 to date.
    - Among DCPS and Public Charter school key grades between October 2024 and January 2025, immunization compliance climbed from 78% (5,000 noncompliant students) to 93% (1,500 noncompliant students).

Q59: Please provide the most updated data on the number and percentage of DC residents who have received the flu vaccine, RSV vaccine (among eligible population), and COVID booster in the summer/fall of 2024. Please include disaggregated data by race, age, and Ward.:

a. Please summarize DC Health's efforts to promote vaccines for winter respiratory diseases in FY 2024 and FY 2025, to date. Please include any metrics used to determine success of initiatives.

Response:

Figure 1
*Updated 2024-2025 COVID-19 Vaccine Coverage (%) by Age Group/Race/Sex/Ethnicity – DC Residents**

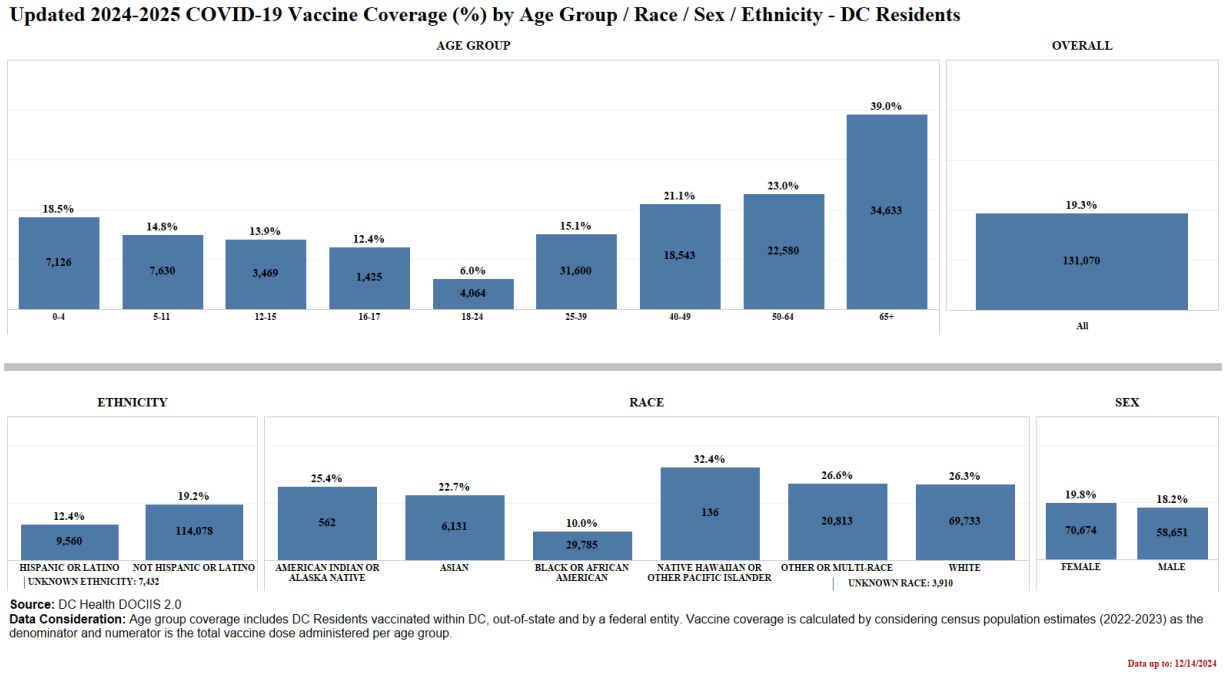


Figure 2
Updated 2024-2025 COVID-19 Vaccine Coverage (%) by Ward (DC Residents)

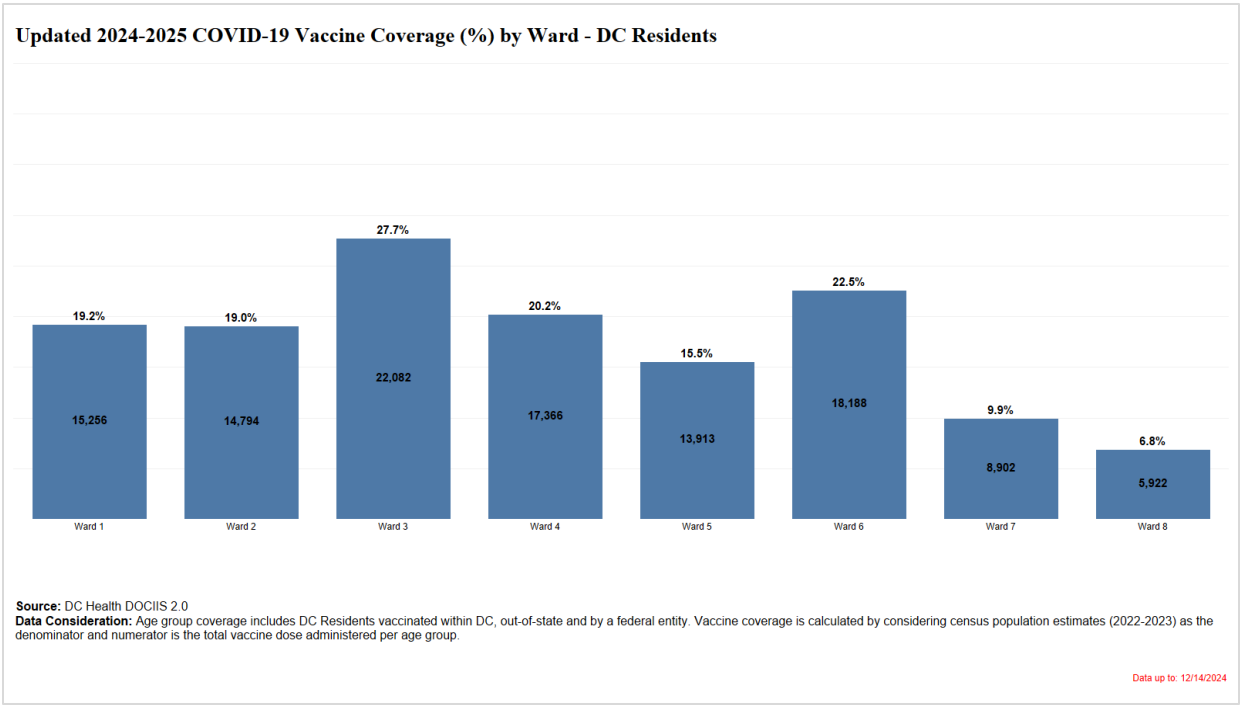


Figure 3

Summary Report – Influenza Vaccine Administrations for DC Residents in 2024-2025

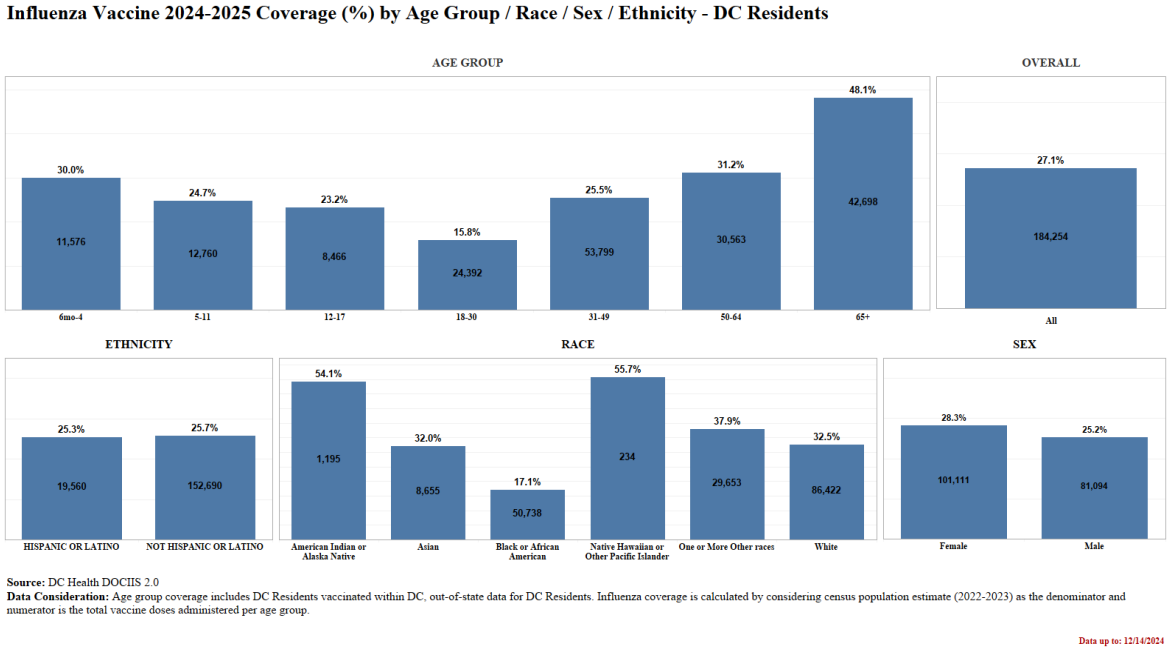


Figure 4

Influenza Vaccine Coverage (%) by Ward (DC Residents)

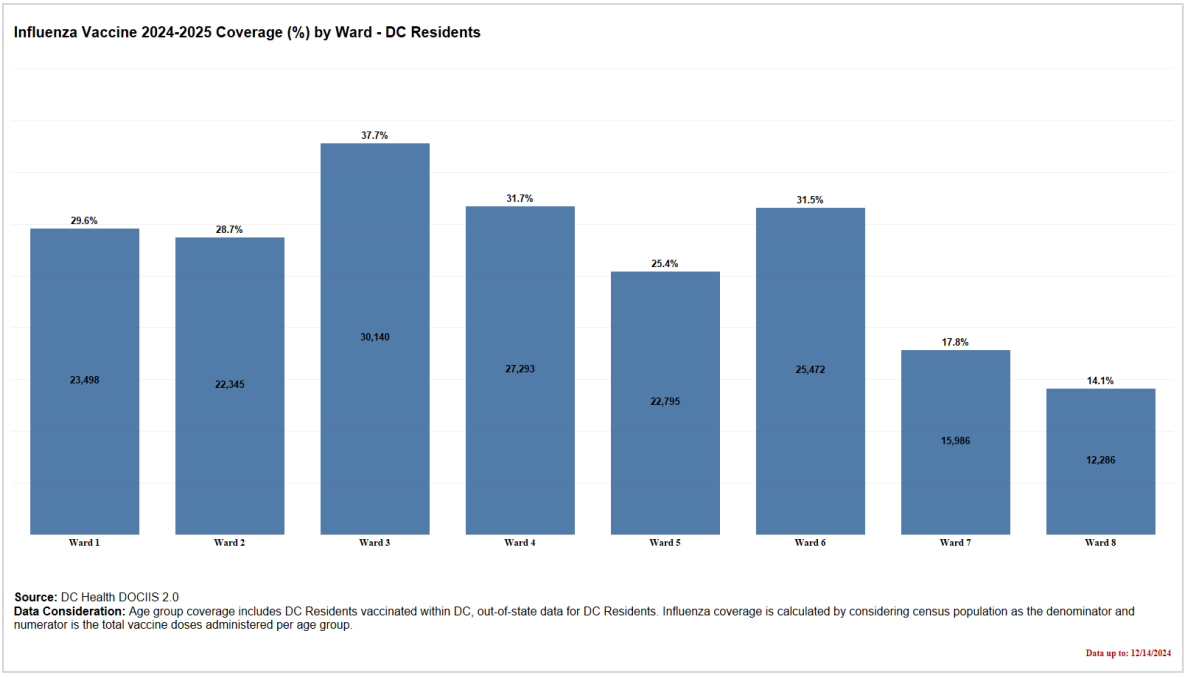


Figure 5

RSV Vaccinations by Age Group / Race / Sex / Ethnicity (DC Residents) – Age 60+ Years

Figure 6

RSV Vaccinations by Ward (DC Residents) – Age 60+ Years

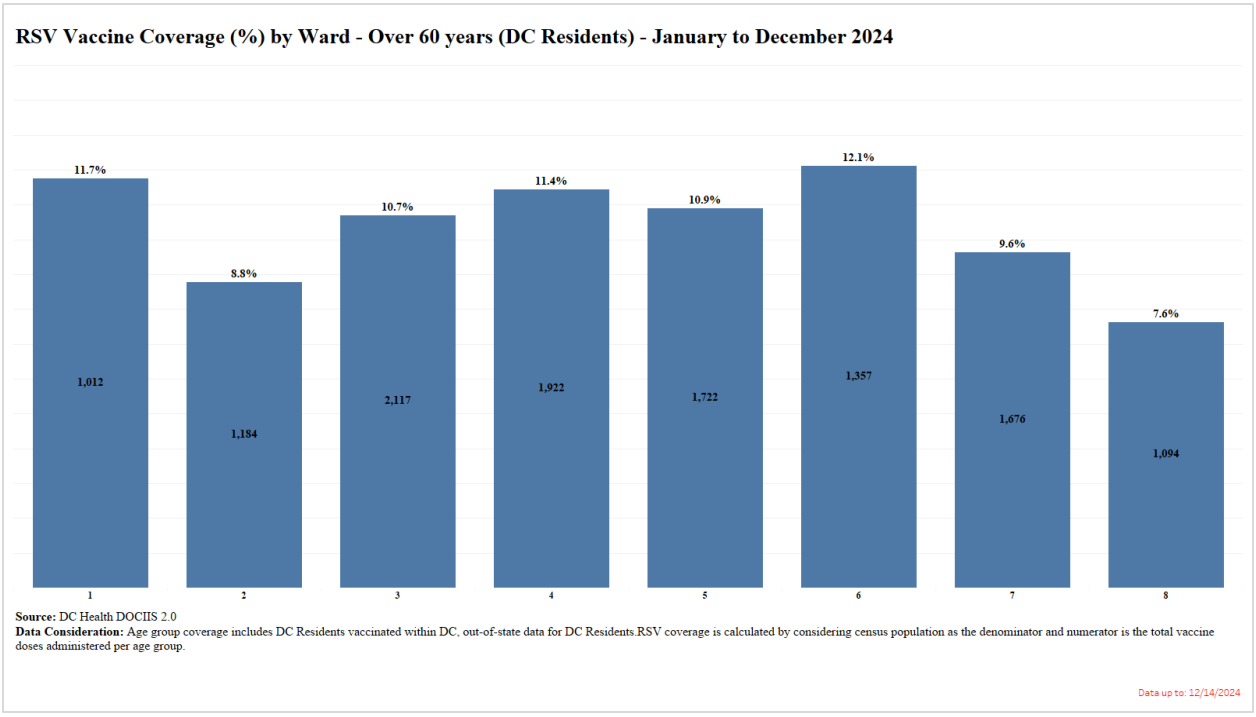


Figure 7

RSV Vaccinations by Age Group, Race, Ethnicity (DC Residents) – Females Aged 18-45 Based on Population Pregnancy Estimates

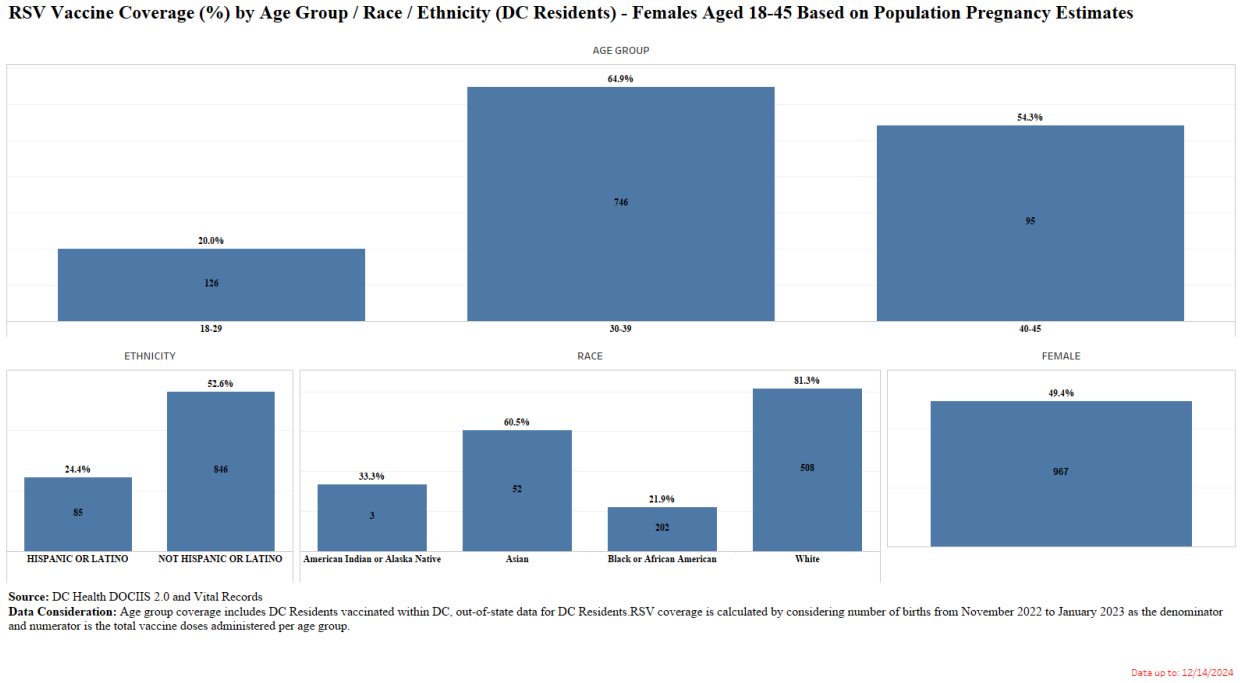


Figure 8

RSV Vaccinations by Ward (DC Residents) – Females Aged 18-45 Based on Population Pregnancy Estimates

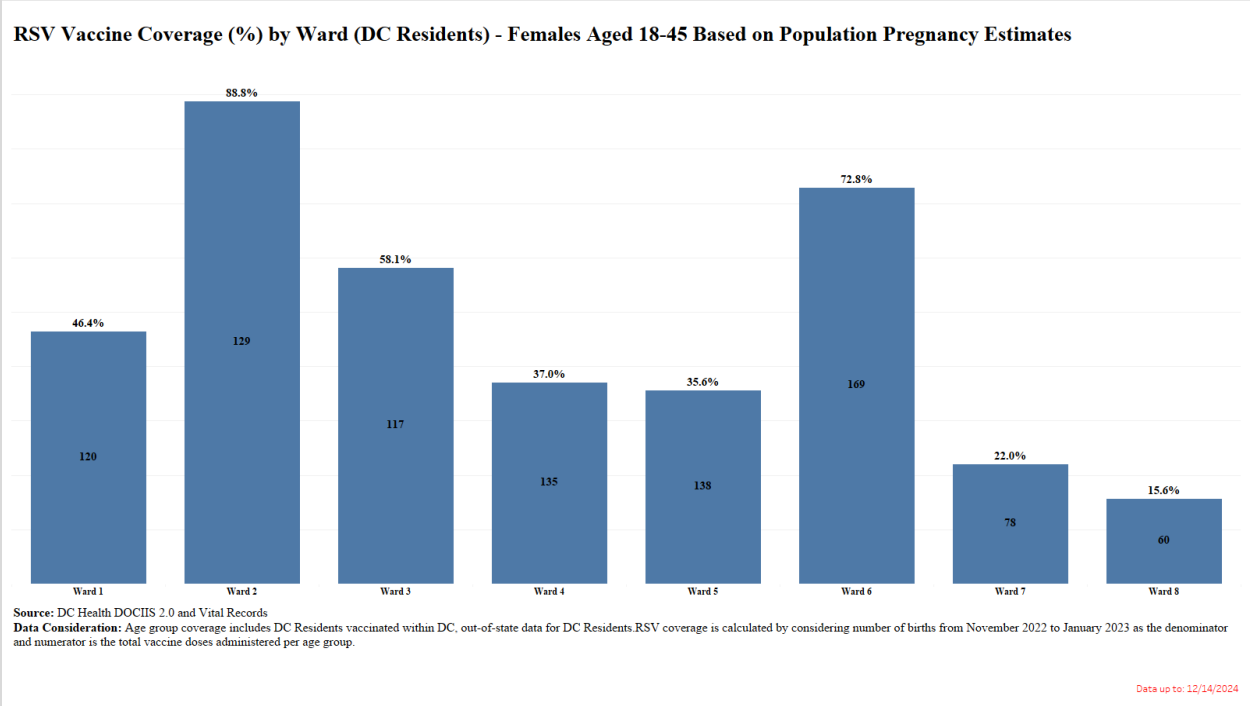


Figure 9

RSV Vaccinations by Race / Ethnicity / Sex (DC Residents) – Age 8 Months or Less

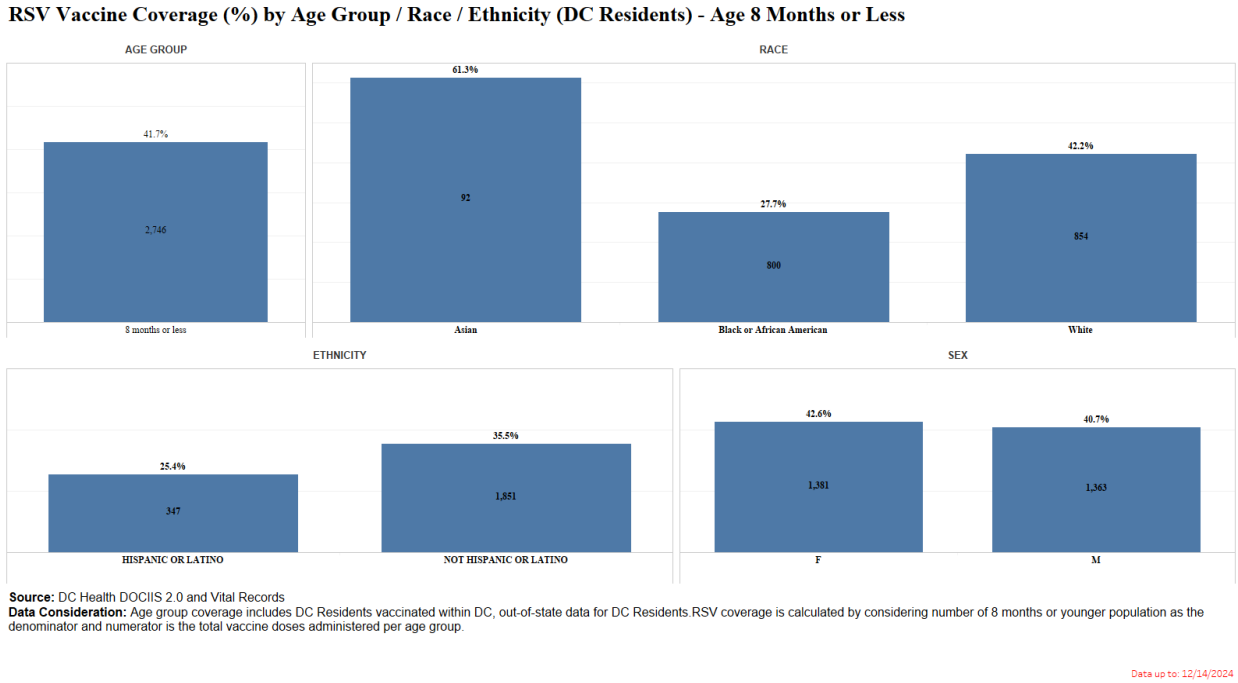
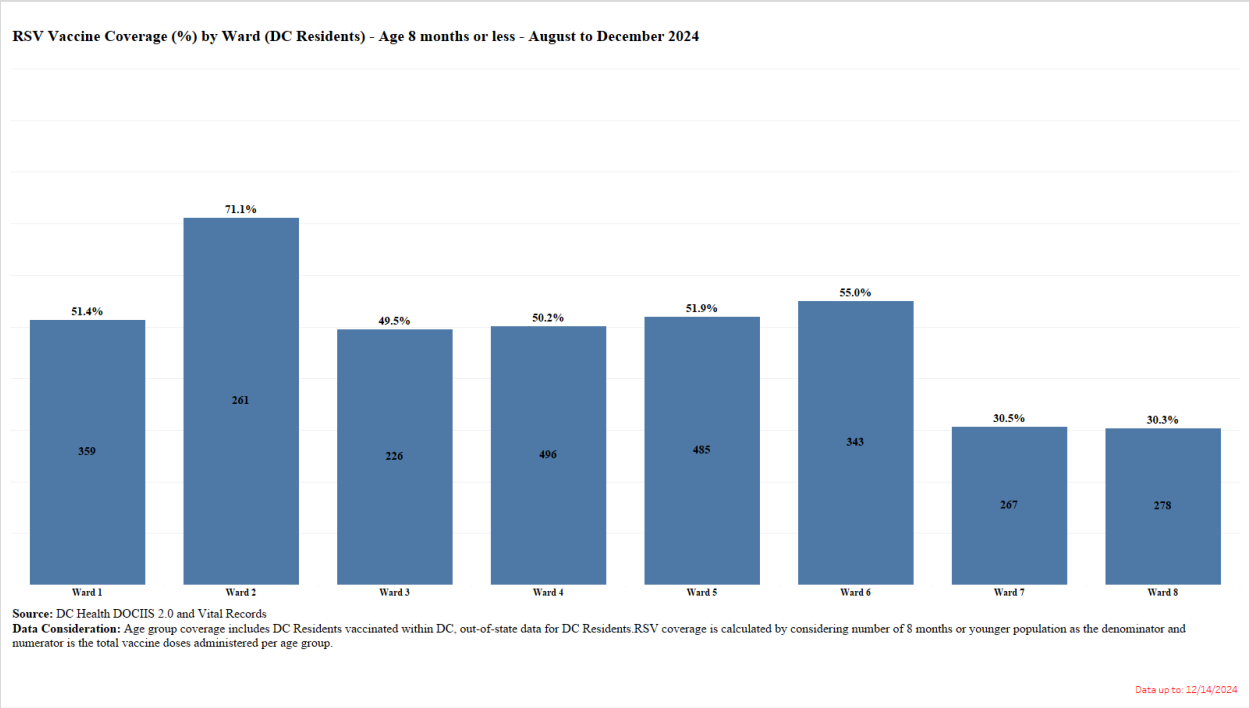


Figure 10

RSV Vaccinations by Ward (DC Residents) – Age 8 Months or Less



Please summarize DC Health's efforts to promote vaccines for winter respiratory diseases in FY 2024 and FY 2025, to date. Please include any metrics used to determine success of initiatives.

DC Health took an enterprise-wide approach to the prevention of respiratory viruses in winter FY24 and fall FY25. The Fall/Winter Respiratory Plan included enhanced strategies for surveillance of respiratory illness, mitigation of illness (including vaccination), communications, community engagement and outreach, as well as policy to prevent and mitigate respiratory disease this Fall and Winter.

The strategies to promote the flu vaccine, RSV vaccine, COVID booster in included:

- Information-sharing, technical assistance, and coordination with District healthcare providers,
- Communications with the largest health systems, FQHCs, and pharmacies in the District to monitor vaccine supply in the District,
- Traditional and social media marketing,
- Grantee technical assistance with health communications, health education and health behavior change strategies, such as methods for countering vaccine misinformation, and,
- Regular outreach to and engagement with community partners.

DC Health incorporated the reach of our community partners to address the 2024 respiratory virus season. During winter 2023/2024, DC Health held a bimonthly Community Immunization Connection (CIC) virtual meeting to share current information and resources and feature guest speaker from local medical associations. In addition to routine virtual meetings DC Health

supported direct, in person community engagement activities such as educational and promotional tabling by staff and administrative support during city-wide immunization clinics. Through in-person or virtual presentations, the Immunization Division offered 49 community engagement events sharing information on the fall virus season and COVID-19, influenza, and RSV immunizations.

DC Health partnered with one grantee to increase COVID-19 vaccine uptake and improve vaccine confidence among under and unvaccinated priority populations (i.e. residents who are home-bound or have limited mobility; newly arrived immigrants, undocumented residents, and asylees; racial/ethnic groups who are consistently under-vaccinated; individuals experiencing homelessness; residents in neighborhoods with particularly low COVID vaccination rates; and residents who are over age 65). Due to the early suspension of the CDC COVID-19 Bridge Access Program for uninsured and underinsured adults, a revised outreach approach to provide vaccine education, referrals and appointment follow-up. Since July 2024, the grantee has successfully vaccinated over 500 persons through referral, and recorded vaccine confidence engagements with over 1100 District residents.

In Fall 2024, we piloted a new program called the Vaccination Community Navigators (VCN). This program provided training and resources to a small cadre of District residents to educate and encourage persons in their circle of influence to get vaccinated with the updated 2024-2025 vaccines, specifically COVID and flu. The pilot cohort included 11 District residents primarily from Wards 4, 5, 7 and 8. This activity remains ongoing through winter FY25, but it already showing the value of person-to-person community engagement and its impact on vaccine confidence.

We also refreshed materials that educated residents on why the COVID-19, influenza, and RSV vaccines were important and where they could go to get vaccinated in the District. OCCR continues to utilize a multichannel approach combining organic social media presence with targeted paid advertising across digital, traditional print media, and public transit systems. This strategy leveraged each platform's unique strengths to maximize reach across diverse demographic groups and proved particularly effective during peak vaccination periods in September and November, when heightened engagement across all channels paralleled increased vaccination rates in target communities. The success of social media marketing is measured by several distinct metrics, most importantly, the number of impressions, engagements, and the engagement rate (per impression). Data metrics reveal strong engagement in September and November with messaging around COVID, Flu, and RSV. By these metrics, DC Health's communications strategy was successful in promotion of winter respiratory diseases.

Q60: Regarding sickle cell disease (SCD) among District residents:

a. Please provide the District's current estimate for the prevalence of SCD;

b. Please provide an update on DC Health's efforts to improve surveillance and treatment of SCD in FY 2024 and FY 2025, to date.

Response:

a. Please provide the District's current estimate for the prevalence of SCD:

According to the Centers for Disease Control and Prevention, sickle cell disease (SCD) affects about 100,000 people in the United States. More than 90% are non-Hispanic Black or African American, and an estimated 3%–9% are Hispanic or Latino. Using national prevalence estimates and the 2023 American Community Survey Population Estimates, *752 District residents* have sickle cell disease. As the current measure of new sickle cell cases, DC Health's Newborn Metabolic Screening (NMS) Program collects presumptive positive, not confirmed, SCD cases annually from our designated newborn screening laboratory, Revvity Omics, based on newborn metabolic (dried blood spot) screenings performed on infants at birth. In FY 2023, there were 15 presumptive positive SCD results among babies who were born to mothers living in the District out of a total of 11,284 births in the District (6,998 babies were born to mothers living in the District and 4,286 were born to mothers living outside of the District)

b. Please provide an update on DC Health's efforts to improve surveillance and treatment of SCD in FY 2024 and FY 2025, to date:

- **Provider Follow-Up**: The DC Newborn Metabolic Screening (NMS) Program facilitates efficient communication of presumptive positive and other abnormal screening results to an infant's provider(s) to recommend further actions and ensure timely management of the case. The DC NMS Program's follow-up team coordinates with each infant's primary care provider (PCP) to follow-up and refer all infants with abnormal (presumptive positive) SCD results to specialty care (i.e. Children's National Hospital (CNH)) for further testing and care as needed. Specialists (most commonly at CNH) will coordinate with the infant's PCP for follow-up, intervention and long-term management. DC NMS records and tracks all abnormal results and follow-up activities in an internal database management system. In addition to CNH, Howard University Hospital and Washington Hospital Center provide specialty SCD services.
- **Tracking and Surveillance**: The DC NMS Program has continued to collaborate with the national newborn screening resource center, Association of Public Health Laboratories' Newborn Screening Technical Assistance and Evaluation Program (NewSTEPs) Program. NewSTEPs is a nationally recognized resource center equipped with technology tools to assist with creating a data repository to manage and store health care information technology. DC Health and NewSTEPs have a Memorandum of Understanding in place to build a framework for the DC NMS Program to share data with the data repository for tracking and surveillance of de-identified case data for all newborn disorders DC screens for, including SCD, as well as various quality indicator data. The DC NMS Program is

building a process with providers providing District infants with specialized care and treatment to collect data on individual confirmed (diagnosed) cases. The DC NMS Program aims to submit 2023 data for upload in the DC NewSTEPs data repository by the end of FY25. These efforts will provide a streamlined approach and allow comparisons of the prevalence of screening disorders to enhance surveillance and follow-up efforts (including SCD data).

- **Regional Genetics Network**: DC Health and other District organizations, agencies and health systems are part of the New York-Mid-Atlantic-Caribbean (NYMAC) Regional Genetics Network, one of seven Regional Genetics Networks in the country funded by the Health Resources and Services Administration. NYMAC includes DC, DE, MD, NJ, NY, PA, PR, USVI, VA, and WV, and is led by genetics providers. They partner with key stakeholders including families, healthcare providers, and public health organizations (i.e. State Health Departments) to support access to quality care and appropriate genetic expertise, regional infrastructure for genetic services and provide education and resources to families and providers. See more about NYMAC DC's resources for children and families with genetic conditions: nymacgenetics.org/dc/
- **Howard University's Sickle Cell Disease Center of Excellence**: To address the burden of sickle cell disease and barriers to care within the District, DC Health provided technical support to Howard University's Sickle Cell Disease (SCD) Center of Excellence from FY20 thru FY24. The SCD COE aimed to increase utilization of HUH's comprehensive sickle cell disease program as well as open a SCD Day Hospital with dedicated space and updated equipment.
    - **HU SCD Program**: In FY24, Howard University reported 1,094 patients seen in the sickle cell clinic (target-934) and 262 patients received disease modifying therapy (target-74). Howard also strengthened partnerships with Medicaid MCO's AmeriGroup and Medstar Family Choice to increase referrals for SCD treatment.
    - **HU COE Day Hospital**: Using Howard COE funding, a new SCD clinic and acute treatment day hospital was built at Howard University Hospital in 2024. The SCD Day Hospital will provide disease modifying therapy to SCD patients living in the District to improve access and quality of SCD care. The SCD Day Hospital will offer acute treatment for pain and provide patients an opportunity to use one of eight treatment options to make acute care visits less frequent and improve overall quality of life. The SCD Day Hospital is expected to open in March 2025. In FY25, DC Health will partner with Howard University Hospital on a communications and community engagement campaign to promote awareness and utilization of the day hospital. This fiscal year, the SCD Day Hospital lease has been executed, and construction is underway to complete renovations of the space.

Q61: How many seniors received dental services through the DC Health grant to Community of Hope in FY 2024, before the funding expired for FY 2025?

Response:

In FY24, 130 seniors were served through the Senior Dental Services Program.
In FY25, the Senior Dental Services Program was not funded.

Q62: Earlier this year, DC Health released the DC Plan on Alzheimer's & Related Dementia 2024-2028. What steps has DC Health taken in FY 2024 and FY 2025, to date, to implement the elements of the plan? What steps does DC Health anticipate taking in the balance of FY 2025?

a. What is the status of implementation of the Dementia Training for Direct Care Workers Act of 2019?
b. Please describe all public campaigns to increase awareness about brain health in FY 2024 and FY 2025, to date. Please provide the results of metrics used to gauge the efficacy of these campaigns, and any plans to continue these campaigns in the future.
c. What data does DC Health currently collect concerning dementia in DC, and have any assessments of such data been conducted?
d. Please provide an update on how DC Health has spent federal funds to support activities relating to Alzheimer's & Related Dementia.

Response:

a. What steps has DC Health taken in FY 2024 and FY 2025, to date, to implement the elements of the plan? What steps does DC Health anticipate taking in the balance of FY 2025?

The District of Columbia Plan on Alzheimer's Disease and Related Dementias 2024-2028 (Brain Health State Plan) was finalized and disseminated in April 2024. The Plan outlines goals, objectives, and strategies to 1) increase the proportion of older adults with subjective cognitive decline who have talked about their symptoms with a provider and 2) increase the proportion of residents diagnosed with Alzheimer's Disease and Related Dementias (ADRD) receiving social and other support services. The Plan was developed from feedback received during the 2020 Brain Health Needs Assessment and from Brain Health Advisory Coalition partners and community members. Strategies focus on 1) improving organizational and individual dementia literacy, 2) building multisectoral partnerships, 3) strengthening the workforce to treat persons with ADRD, 4) enhancing data collection and surveillance, and 5) creating community-clinical linkages.

FY24 and FY25 progress highlights are shared below:

Educate and Empower

- DC Health re-launched the mass media campaign, additional details provided below.
- The Brain Health and Dementia Resource Guide was updated and shared with LinkU for integration into the online referral platform. LinkU is a closed-loop social needs screening and referral platform with a database of community resources to support residents in health seeking behaviors. Through LinkU, residents and partners will be able to access brain health and ADRD resources and make direct referrals, improving access and coordination of care for persons with ADRD and their caregivers.

- The Brain Health Initiative cobranded seven (7) brain health education materials (rack cards) the National Association of Chronic Disease Directors to promote brain health, healthy lifestyles and chronic disease self-management. Topics include *Healthy Blood Pressure*, *Healthy Blood Sugar*, *Hearing, Diet, Physical Activity, Sleep, and Brain Injury*. All rack cards are available in English and Spanish. In FY25, the Brain Health Initiative will print and disseminate these materials during education and community events and share them with community partners.
- DC Health provided education and information on the Brain Health Initiative to partners and community members including DC Villages, senior centers, and faith-based organizations, reaching more than 30 partners and 100 community members. Outreach included recurring meetings with Age-Friendly DC, Commission on Aging, and the Ward 2 & 3 Senior Wellness Center Taskforce. One-time events included the Mayor's Senior Symposium, DC Public Library, and the Bernice Fonteneau Senior Center. Education was delivered through in-person presentations and discussions, focusing on topics such as senior well-being, brain health, and dementia. Chronic disease prevention resources including tobacco Quitline services, food access programs, breast, cervical, and colorectal cancer screening programs were also shared.
- In FY25, DC Health's Brain Health Initiative will lead several activities focused on educating and empowering healthcare professionals and the public. We will promote the Direct Care Worker Training through webinars and speaking at association meetings and other venues, aiming for 300 direct care workers to complete the training. We will integrate an educational component into the monthly Brain Health Newsletter to share best practices on ADRD and caregiving. Additionally, we will continue to support the Brain Health Advisory Coalition in community-focused engagements, including George Washington University Brain Health Institute's Brain Health Month in June 2025.

Mobilize Partnerships

- DC Health led quarterly Brain Health Coalition meetings, including a request for nominations for a coalition chair and co-chair. In FY24, Brain Health Advisory Coalition membership increased by 19% from 39 to 47 members including caregivers, academic and healthcare professionals, DC Public Library, Department of Health Care Finance, and the Association of State and Territorial Health Officials (ASTHO).
- In FY24, the Brain Health Initiative focused on connecting community partners with available partners/resources, for example BHI connected DC Public Library (DCPL) to all three CDC Building Our Largest Dementia Infrastructure Public Health Program (BOLD) Centers of Excellence to access best practices and materials focused on ADRD. Additionally, BHI staff facilitated meetings with DCPL and the Alzheimer's Association to provide brain health education workshops at DCPL.
- In FY24, the Brain Health Initiative developed a digital Brain Health Initiative newsletter to share brain health, Alzheimer's Disease, and dementia education,

resources and partner highlights. The newsletter will be distributed quarterly in FY25.

- In FY25, DC Health's Brain Health Initiative will expand the Brain Health Advisory Coalition by addressing membership gaps and recruiting representatives from unrepresented organizations and communities, particularly those serving seniors. We will continue to strengthen alignment with Age-Friendly DC, Department of Aging and Community Living, and Alzheimer's Association initiatives to achieve impactful outcomes.

Monitor and Evaluate

- DC Health's Brain Health Initiative developed and disseminated a survey to 47 Advisory Coalition members to identify current activities related to the Brain Health State Plan being implemented in the District and request volunteers for workgroups.
- DC Health's Brain Health Initiative developed a Brain Health provider survey to assess clinical practices related to screening and referring patients to brain health resources and to identify Brain Health resource gaps within the community. The survey will be distributed in winter FY25 to health care and service providers in the District. Results will be used to inform future program strategies and strengthen the health care workforce caring for individuals with Alzheimer's Disease and dementia and their caregivers.
- In FY25, DC Health's Brain Health Initiative is working to implement and track collective implementation of the Brain Health State Plan across Brain Health Advisory Coalition members. Also, DC Health will develop a data surveillance system to support monitoring Alzheimer's disease and related dementias trends in the District over time.

b. What is the status of implementation of the Dementia Training for Direct Care Workers Act of 2019?

In FY24, the DC Health's Brain Health Initiative within the Community Health Administration and the Health Systems and Preparedness Administration (HSPA) released a request for proposals and finalized a contract to develop and implement a Dementia Care Training for Direct Care Workers. The training, aligns the Dementia Training for Direct Care Workers Act of 2019 (D.C. Law 23-201) and is designed for direct care staff, including healthcare providers, nurses, covered administrative staff, and other personnel who interact with or support individuals with Alzheimer's and dementia-related diseases. To support this initiative, additional federal funds were allocated to develop a comprehensive training that was easily integrated into DC Government learning management system and DC Brain Health website. The curriculum reflects up-to-date, evidence-based practices and courses were developed by local subject matter experts in the field.

DC Health worked closely with the contracted vendor to complete development and production of the trainings that launched on ***December 16, 2024***. The curriculum is comprised of the following six courses and can be accessed at learning.brainhealth.dc.gov:

- **Understanding Dementia -** Provides an overview of the types and stages of dementia, risk factors, prevention strategies and how to provide culturally respectful care (1 Hour CE).
- **Collaborative Dementia Care -** Provides an overview of the various roles of healthcare professionals in dementia care and how collaboration among healthcare workers, including nurses, therapists, and physicians, can improve patient outcomes and how to create effective care plans (2 Hour CE).
- **Compassionate Dementia Care -** Provides an overview of person-centered care principles, effective communication skills, managing challenging behaviors, and providing support to caregivers (1 Hour CE).
- **Protecting Rights in Dementia Care –** Provides an overview of legal and ethical responsibilities involved in dementia care, advance care planning, guardianship, and recognizing signs of abuse or neglect to protect patients' rights and well-being (1 Hour CE).
- **Empowering Caregivers -** Provides an overview how caregivers can access resources and skills to assist caregivers emotionally and address the challenges they face while caring for loved ones with dementia (1 Hour CE).
- **Building a Dementia Care Team –** Provides an overview on improving care quality based on best practices for staffing, creating emergency plans, and fostering a positive team culture. Also includes strategies to ensure team members are engaged, supported, and committed to providing high-quality dementia care (2 Hour CE).

c. Please describe all public campaigns to increase awareness about brain health in FY 2024 and FY 2025, to date. Please provide the results of metrics used to gauge the efficacy of these campaigns, and any plans to continue these campaigns in the future.

- **FY2024**:
  - Launch: DC Health re-launched the FY23 Brain Health Initiative media campaign from June to September 2024.
  - Messaging: Campaign messaging aimed to continue momentum to increase utilization of the BHI website and increase awareness and education on brain health, cognitive aging, evidence-informed interventions and District resources.
  - Assets: Campaign assets included TV, streaming/digital, radio and print media (Metro stations, buses, bus shelters), focusing on priority Wards (Wards 5, 7, and 8), which experience elevated burdens of subjective cognitive decline and mortality rates.
  - Community input: Print and streaming media was revised based on community feedback and input from Brain Health Advisory Coalition members.
  - Evaluation: FY24 campaign data is currently being evaluated and finalized, evaluation metrics include reach, number of impressions (digital, print, tv and radio), number of bus lines in Wards 5, 7 and 8, and Brain Health Initiative website traffic.
- **FY2025**:
  - Launch: DC Health will re-launch a Brain Health Initiative media campaign June – September 2025.

- Messaging: DC Health is planning a continued mass media campaign to reach additional priority populations with support from the CDC's BOLD Public Health Programs to Address Alzheimer's Disease and Related Dementias funding. The media campaign focuses on promoting the Brain Health Initiative website, raising awareness about brain health, and normalizing discussions about cognitive health.
- Assets: The FY25 campaign will include multilingual 60 and 30-second radio ads, bus ads targeting Wards 5,6, 7 and 8, and promotion of existing video messages on various social media platforms to increase awareness.
- Community input: DC Health will collect community input on messaging and assets prior to dissemination, working closely with the Brain Health Initiative Advisory Coalition.
- Evaluation: Evaluation will include analyzing data from digital tracking tools of TV, radio, social media ads, metrics include reach, effectiveness of campaign in reaching targeted audience and the number of visits to brainhealth.dc.gov website.

d. What data does DC Health currently collect concerning dementia in DC, and have any assessments of such data been conducted?

- **Surveillance**:
  To assess the prevalence of dementia in the District, DC Health conducts the Behavioral Risk Factor Surveillance System (BRFFS) survey. Through local and federal funding, the Brain Health Initiative has added the Subjective Cognitive Decline (SCD) and Caregiver modules to the District's annual BRFSS survey. All responses are self-reported. Questions on SCD focus on perceived decline in cognitive function (such as memory, attention, or problem-solving abilities).

  In February 2024, DC Health's data team, analyzed the latest available BRFSS data (2019 – 2022). Which yielded the following:
  - 11% of District residents aged 45 and above reported experiencing SCD.
  - Only 42% of those affected with SCD discussed their symptoms with a healthcare provider.
  - When categorized by race and ethnicity, non-Hispanic Black residents were almost two times more likely to experience subjective cognitive decline (13%) compared to 8% for non-Hispanic White individuals.
  - Wards 7 and 8 had the highest prevalence rates of SCD at 16.4% and 13.3%, respectively, while Ward 3 had the lowest prevalence at 5.7%.
  - The caregiver module showed that an estimated one in five District residents are caregivers (22.3%) and an estimated 80.8% expect to provide care or assistance for someone with ADRD.
  - DC Health will build out a data dashboard in FY25 to support monitoring Alzheimer's disease and related dementias trends in the District over time, setting District goals and objectives regarding ADRD, understanding which populations are most at risk, and accurately reflect the ADRD burden in the District.
- **Vital Records:**

DC Health utilizes Vital Records data to identify mortality rates due to ADRD in the District. Mortality rates for ADRD show an age-adjusted standardized rate of 42 per 100,000 individuals in 2022, one of the top 20 causes of death in DC (13th leading cause of death).

- **Future Data Indicators**: The following outcomes will be tracked to identify success in completion of planned Brain Health activities for FY25:
  - Increased proportion of adults with subjective cognitive decline who have talked with their provider about their symptoms.
  - Increased proportion of adults living with dementia who are receiving social and other support services.
  - Increased use of LinkU by health care providers, community organizations, and residents with ADRD and their caregivers for referral making that leads to increased utilization of ADRD community services and resources.
  - Increased awareness and understanding of ADRD topics among the general public, providers, and other professionals through the mass media campaign and the Dementia Care Training for Direct Workers.

e. Please provide an update on how DC Health has spent federal funds to support activities relating to Alzheimer's & Related Dementia.

FY2024 Federal Funding Overview		
Category	**Activities**	**Percent of Federal Funding**
Personnel	Funding supported two staff to lead program development, implementation, and evaluation; partnership building; and community engagement.	29%
Grants and Contracts	Funding supported adding population-level survey questions to enhance DC Health's data and surveillance, enhancing the scope of the direct care worker training, and implementing the mass media campaign.	55%
Travel	Funding supported travel for one staff to a training conference on Brain Health and ADRD.	0.4%
Indirect Cost	Applied to salary and fringe for staffing costs.	14.6%