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Introduction

Good morning, Chairperson Henderson, and members of the Committee. My name is Leah Castelaz. I am a Senior Policy Attorney at Children's Law Center and a resident of the District. Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify today regarding the Department of Health's (DC Health) performance over the last year. Children's Law Center has worked with thousands of children and families through individual advocacy in our guardian-ad litem program, our Medical-Legal Partnership, Healthy Together, and our prevention program, Families Together. Many of the children we work with – children in the foster care system or receiving special education services – have faced multiple adverse childhood experiences resulting in complex trauma and the need for access to high-quality health services to achieve stability. Additionally, we see firsthand – through our work with families seeking remediation of poor rental housing conditions – how

conditions in a child's physical environment, especially their home, can deeply impact their health and well-being. For example, exposure to lead through lead-based paint or lead-contaminated drinking water can inhibit a child's mental and physical development.¹

Our clients rely on DC Health to provide critical services that improve navigation and access, strengthen a child's youngest years and support their caregivers, increase workforce capacity, and remedy poor, unhealthy housing conditions. Ensuring high-functioning, accountable, accessible government programming, processes, and procedures at DC Health is vital to our clients' health and well-being. DC Health works to strike a balance between addressing immediate needs while making investments in critical prevention services in the District.

For families to succeed, the District must invest in both meeting immediate needs and providing services that prevent negative outcomes or experiences from arising in the future. To this end, my testimony will discuss the following aspects of DC Health's work to support District children and their families:

- New investments in DC Health's LinkU to improve how residents navigate and access services, resources, and information;
- Opportunities to strengthen HealthySteps by addressing financial stability and reducing administrative burden;

- The need for improved coordination across home visiting to support improved implementation, streamline funding, and reduce administrative burden;
- Concerns regarding the performance of DC Mental Health Access as well as the circumstances and communication regarding the transfer of this program from Department of Behavioral Health to DC Health;
- Opportunities for DC Health to do more to develop a robust behavioral health workforce;
- The impact of delayed legislation from DC Health on community health worker certification, stalling much needed workforce expansion; and
- The transition of the Healthy Homes Program from DOEE to DC Health.

Additional Funding to LinkU for FY2026 Plays a Critical Role to Expand System Navigation Work in the District

While DC has a variety of navigation tools across agencies in health and human services, none of them are unified. Providers, residents, the government, and community-based organizations are not aligned on a single system. This causes an immense amount of confusion. A simple question like – “who is available now to provide this service?” – becomes a labor-intensive task that often leads to frustration for those seeking assistance. This is something LinkU is working to address.

LinkU is a free online resource directory and e-referral platform for District residents, clients, and community providers.² LinkU is powered by Findhelp³ and

administered by DC Health.⁴ The platform works to connect users with social care resources across the DC, Maryland, and Virginia region, while also tracking search trends and client outcome.⁵

DC Health first rolled out LinkU to address gaps in navigation for residents living with HIV/AIDS.⁶ DC Health's Health, HIV/AIDS, Hepatitis, STD, & TB Administration (HASTA) initially designed LinkU to support the case managers helping residents navigate HIV/AIDS prevention and care services and ensure close looped referrals.⁷ DC Health, seeing the utility of having a centralized navigation platform with closed loop referrals, has, in recent years, worked to expand LinkU to more District agencies to utilize in their own case management and referral efforts.⁸

Over the last year, we have heard LinkU referenced in many of the spaces Children's Law Center participates in. For example, the Department of Health Care Finance (DHCF) DC Medicaid Care Advisory Committee (MCAC) included LinkU in its 1115 Waiver work as an example of existing technology infrastructure that can be leveraged for health-related social needs (HRSN) screening, closed-loop referrals, and data sharing.⁹

We are pleased to see LinkU continue to be integrated across the District and appreciate the work DC Health is doing with other government agencies to create a more unified navigation and referral system in the District. Creating a more unified navigation system is a critical need in the District.

We are grateful for Councilmember Parker and this Committee's additional investment in LinkU for Fiscal Year 2026. By funding the Child Behavioral Health Services Dashboard Act of 2024 (Dashboard Act), the DC Council ensured further investment in LinkU specifically by funding an additional FTE to work on the platform. DC Health, in our last conversation, was in the process of hiring the additional FTE that was funded for LinkU through the Dashboard Act. Before the hiring of this additional FTE, DC Health only had one part-time DC Health team member working on LinkU.

In the coming year, 2026, the new FTE will not only work on continuing to integrate LinkU across the District but also will work on implementing the Dashboard Act requirements. This work includes ensuring a directory for DBH's school-based behavioral health programs – something that is desperately needed so that parents, students, and the community have an understanding of the behavioral health resources available in the District's public and public charter schools.¹⁰ Additionally, the updates to LinkU must also include access to information like (1) the number of psychiatric service beds available at hospitals for children up to age 17; (2) the treatment modalities at each hospital; and (3) whether the hospital accepts children and youth who are justice involved. The ultimate goal of the Dashboard Act and the expansion of a DC Health FTE working on LinkU is to create an online, user-friendly, publicly available dashboard of behavioral health services in the District to help address the District's current piecemeal

approach to behavioral health services navigation to create a more cohesive approach to navigation.¹¹

DC Health has been an excellent partner in this work – including making numerous presentations on LinkU and partnering across the District to spread awareness of LinkU. Last year, at the request of community partners, DC Health developed a YouTube informational and training video.¹² We applaud DC Health for their efforts.

Going forward, we would like to see DC Health continue to work with partners across the District. In particular, this next year, we believe that DC Health, DBH, and DMHHS should work together to implement the Dashboard Act and improve LinkU by addressing usability and relevancy as well as conducting outreach to other government agencies, DC residents, and DC service providers to ensure they participate in the platform. We ask this Committee to work closely with DC Health and its sister agencies on this effort and hold the relevant agencies accountable for the effective implementation of the Dashboard Act.

HealthySteps Greatly Improves Access to Behavioral Health Supports, but Administrative Burdens and Financial Sustainability Must Be Discussed

HealthySteps is an evidence-based national program model that provides infants and toddlers with social-emotional and development support by integrating child behavioral health professionals into primary care.¹³ District families rely on HealthySteps to address issues within the pediatrician’s office, improve the mental health of caregivers,

and connect them with resources and referrals to ensure that District children and family's needs are met. Embedding behavioral health professionals in the primary care setting allows for increased integration of care, earlier identification of behavioral health issues for both child and caregiver, and greater connection to community support and resources.¹⁴

The Birth-to-Three for All DC Amendment Act of 2018 (Birth-to-Three) required the expansion and evaluation of HealthySteps in Wards 5, 7, and 8.¹⁵ Five years after this legislation was signed into law, there are six HealthySteps sites in DC that utilize local DC funds to support their work while there are several others that utilize private, philanthropic funds to operate.¹⁶

However, there is more work to be done. First, Birth-to-Three envisioned expansion to Ward 5, 7, and 8 – there are still no HealthySteps sites in Ward 5. Secondly, DC Health has identified the need for HealthySteps to exist in the Upper Cardozo area of Ward 1. DC Health has not made any additional financial investments into HealthySteps to expand into either of these Wards. Moreover, DC Health has not made any additional financial investments to increase the grant amounts for HealthySteps grants. There is a need for further investment in HealthySteps. Therefore, the next section will discuss financial stability for HealthySteps that would support expansion as well as existing sites. Specifically, we encourage DC Health in partnership with DHCF to look into Medicaid reimbursement for HealthySteps services as a way to leverage federal dollars.

Recognizing the financial constraints on the District at this time, we also recommend that DC Health address administrative burdens. While the District may not be ready at this time to expand funding – which should only be determined after a thorough investigation of funding avenues – addressing administrative burden can make a substantial improvement by reducing costs for those working on HealthySteps even without additional funds. Reducing administrative burden also alleviates stress on the workforce and allows more time with children and families.

At the time of the passage of Birth-to-Three there was a lot of attention on the programs included in the legislation. We need a renewed sense of attention on HealthySteps, as well as the other Birth-to-Three health programs, to continue to strengthen the District’s investment in its youngest and most vulnerable population. While we are excited by the progress over the last six years, we know there is more work to be done. Therefore, we ask this Committee to keep HealthySteps front of mind when thinking about opportunities for early intervention investments and when discussing key supports for District families.

DC Health Must Explore Additional Ways to Address Financing for HealthySteps to Create More Sustainable Path and Potential Increased Funding

DC Health has not raised the HealthySteps grant amount since 2019. As a result, as expenses go up grantees must find that cost from internal budgets – for example sites have not been able to increase the salary of the clinician or the family service coordinator

through the grant. Aside from raising existing grant amounts to address the costs of HealthySteps, such as retaining care coordination services and the realities of hiring in behavioral health, which this Committee is very familiar with, increased grant amounts may support recruitment to additional sites who are not confident that they can absorb additional costs if the grant amount remains static. This is something DC Health must explore and address with sites and future potential sites particularly in Wards 1 and 5.

To address these financial constraints, we believe that DC Health should explore opportunities to partner with DHCF to leverage Medicaid funding for HealthySteps. As we have testified before, HealthySteps is eligible for enhanced payments, similar to Maryland, or through reimbursement, similar to California.¹⁷ However, to the best of our knowledge, neither DHCF nor DC Health have worked to take up these opportunities to create a more sustainable path forward for HealthySteps funding. Not leveraging Medicaid reimbursement for HealthySteps leaves money on the table that could be used to better support the needs of the program, including increasing salaries to recruit and retain clinicians.¹⁸

DC Health Can Reduce Administrative Burden for HealthySteps By Streamlining Reporting, and Ultimately, Allowing More Resources to Go to Providers to Spend More Time with Patients

Through our leadership of DC HealthySteps Learning Collaborative,¹⁹ we have identified several areas where HealthySteps is unnecessarily administratively burdened. First, most of the data DC Health currently collects from HealthySteps sites²⁰ are

irrelevant or only tangentially related to HealthySteps programming (e.g., percent of infants and toddlers up to date on lead screening) or not available to pediatric primary care staff (e.g., number of children not placed in home visiting due to lack of availability), and more importantly do not measure the intended impact of the program on the families served.²¹

Currently, DC Health requires the monthly reports to be due at the same time as a mid-year site visit and then later as the comprehensive site reports. A lot of information is being repeated in these reports, but it is administratively burdensome to have to sort through and pull out the duplicated data pieces. Moreover, DC Health requires some reports that are duplicative of one another (e.g., monthly and quarterly data; site visit slide decks and annual report). Additionally, there are some reports that may be better done across all HealthySteps sites. While we recognize each organization may utilize their grants differently, having singular site sustainability reports is not helpful to improve the program in the District.

Finally, it remains unclear how DC Health utilizes the data that is collected. DC Health, per Birth-to-Three, is required to have an “external evaluation contractor to conduct a community-based evaluation of the effectiveness of the Program.” Such an outcome evaluation has not been conducted, nor has an evaluation contractor been secured by DC Health. We know anecdotally from our work with the sites that the

program is having a tremendous impact but cannot point to an evaluation from DC Health that speaks to the impact of HealthySteps in the District on children and families.

We further ask this Committee to review the Birth-to-Three legislation to ensure alignment with the national model of HealthySteps, its fidelity metrics, and grant agreements with DC Health. We also recommend that DC Health assess their role in HealthySteps, especially with the perspective of the various and numerous reporting requirements for HealthySteps. We encourage the agency to take a broader approach to assessing the sustainability of HealthySteps across the board (e.g., reimbursement policy, mental health workforce pipelines) with input from all the sites. The DC HealthySteps Learning Collaborative, composed of program leadership from all 4 institutions with DC Health funding, would be happy to engage in this thought process with the agency.

Finally, DC Health should assess when reports are due and work to streamline reporting timelines. One suggestion would be for DC Health to simply add questions to the monthly reports at the relevant time points (mid-year and end-of-year) instead of creating entirely separate reports. Overall, streamlining data collection, increasing transparency for data use, and overall reducing administrative burden is a low lift that can have a huge impact on program implementation. We encourage the agency to work closely with HealthySteps sites on how to move these and other recommendations forward to ensure an effective program that serves DC's youngest children and families with critical behavioral health supports and services.

Home Visiting is a Critical Program for the District's Perinatal to Five Population, But Needs Continued Support to Improve Implementation

Similarly, home visiting programs could use a renewed sense of energy and investment to support their implementation and growth. Home visiting programs are voluntary programs that pair families with in-home support workers during children's earliest years.²² Home visiting supports the development of meaningful and sustained relationships with families to improve outcomes for children and families including in areas of "maternal and child health; prevention of child injuries, child abuse or maltreatment; improvement in school readiness and achievement; reduction in crime or domestic violence; and improvements in family economic self-sufficiency."²³

This year, home visiting through DC Health underwent a significant shift in its landscape. Last year, FY2025, DC Health used local funds for two programs at Community of Hope and Georgetown University and administers federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding for two additional programs through Mary's Center.²⁴ DC Health also funds the evaluation of Mamatoto Village's home visiting program. This year, DC Health released a new request for application (RFA) for their MIECHV funding and awarded MIECHV funding to 3 new organizations to expand their services to MIECHV – United Planning Organization, Lutheran Social Services, and Georgetown. The other resulting change in FY2026 was that

Mary's Center had to close down both its Parents as Teachers and Healthy Families America programs due to being cut from MIECHV and local funds.²⁵

This changing landscape is on top of an already confusing landscape of home visiting in the District. In particular, the funding has remained confusing and opaque. Changing budget lines for programs is destabilizing and causes programs to pause hiring, increase caseloads for current home visitors, and, ultimately, lower the number of families they are able to serve.²⁶ Programs head into each year feeling uncertain about what they will be able to accomplish given the way the budgets fluctuate throughout the year. Last year, when some grantees received cuts they were told by DC Health that the cuts to their programs were due to there being vacant positions.²⁷ Vacant positions continue to persist because of low wages and lack of investment in the home visiting workforce.²⁸ Creating a better understanding of the funding available to home visiting programs in the District (even those outside DC Health) would be tremendously helpful in creating transparency on home visiting programs.

The uncertain budget is not the only burden programs face, they also experience high administrative burden. A report released by DC Action found that "home visitors ... spend nearly 75% of the work week reporting data from home visits and collecting family information for internal reporting and funding source."²⁹ Home visitors reported that the administrative burden negatively affected family visits. The time spent on documentation took away from home visitors being out in the field and conducting home

visits. The report goes on to make recommendations to reduce administrative burden on home visitors. These recommendations and the recommendations from an earlier report, *Voices from the Field: The Experiences of the District's Home Visitors*, offer concrete solutions to improve home visiting in the District.³⁰

Given this confusion and frustration, Children's Law Center reached out to DC Health during the summer of 2025. We have since had more regular meetings with DC Health to try to improve home visiting in the District. We proposed to DC Health a workshop that would convene DC Health, CFSA, DHCF, and Office of State Superintendent on Education (OSEE) with home-visiting Community Based Organizations (CBOs) to create a shared vision for home visiting in the District. The progress to convene this workshop has been slow but steady, and we appreciate DC Health's continued partnership and willingness to engage. DC Health is still working to convene government partners before convening the broader community. We are hopeful that by the summer of 2026 we will be able to host a home visiting workshop to make progress on the numerous barriers of successful home visiting implementation.

DC Health has tangible, concrete options to improve home visiting in the District and the support of community partners. We ask DC Health to continue to work with us and others to make the workshops a reality to comprehensively improve home visiting implementation in the District. We ask this Committee to engage in this work with DC Health to better assess how the District can implement home visiting programs in the

District – to reduce administrative burden, improve access to residents, and ensure sufficient funding.

Years of Mismanagement by the District Have Eroded the Functionality of DC MAP, a Previously Successful Program

DC Mental Health Access in Pediatrics (DC MAP) is a long-standing DC program that provides pediatricians who have mental health-related inquiries about specific children real-time phone access to psychiatrists, psychologists, social workers, and care coordinators.³¹ Research shows that integrating mental health care within pediatric primary care settings has repeatedly improved service delivery and patient health outcomes as well as reduced costs.³²

Critical components of DC MAP include providing education and technical assistance to pediatricians regarding how to identify and address mental health issues in the primary care setting – improving pediatricians' abilities to assess patients and treat patients with anxiety and mood disorders. The program also facilitates referrals and coordination for patients who need community-based specialty services. DC MAP can even be used to identify services for parents who need post-partum depression support services. We have previously testified to the cost-effectiveness and innovation of the DC MAP's population-based, prevention framework and the ways it helps to address the mental health needs of the District's children by reaching them where they already are.

The Council recognized the need for this critical program by including it in DC Act 20-539 Fiscal Year 2014 Budget Support Act of 2013 (DC Act 20-539). DC Act 20-539

requires the District to establish a Behavioral Health Access Project in order to improve the mental health of youth in the District by promoting the integration of mental health and primary care through increasing pediatric primary care providers' understanding and ability to treat children and adolescents with mental health issues that can be appropriately managed in primary care.³³

DC MAP is an already established program accomplishing these requirements. Originally, DC MAP was funded by DBH and administered by Children's National Hospital and MedStar Georgetown University Hospital from 2015 to 2021.³⁴ Beginning November 19, 2021, the program transitioned to a new provider, Paving the Way. We previously testified about this rocky transition in 2021 – including delays in communication from Paving the Way and confusion regarding proper processes for making a referral to a community provider.³⁵ Additionally, the DC Collaborative for Integration of Mental Health in Pediatric Primary Care, the oversight and convening entity for DC MAP, dissolved after the transition. The transition caused significant disruption that the program has not recovered from – including both a significant drop in the number of patient referrals for behavioral health consultants as well as the number of enrolled providers with DC MAP utilizing the program.³⁶

We do not mean this as critique of Paving the Way but as a critique of the decisions of DBH to poorly identify, equip, and support community providers to run programs. It has been felt that Paving the Way was not ready for this task from the get-go of the

contract and more oversight should have been allocated to ensure a smooth transition. This is a failure of DC government, not of a community-based organization.

Adding further to the instability of DC MAP is the end of the DC Collaborative for Integration of Mental Health in Pediatric Primary Care – which provide critical coordination and oversight to the implementation of DC MAP. Although DBH reports that Paving the Way was required to collaborate with the Collaborative, it is our understanding as a member of the Collaborative that it has not met in several years. This transition has slowly chipped away at a once successful program – which included sufficient infrastructure and support from providers, the community, and DC government.

Finally, the transition from DBH to DC Health has added to the further diminishment of DC MAP. As an initial matter, this transition was never announced – in fact we did not learn of the transition until February 2026. We believe the transition from DBH to DC Health occurred due to DC Health receiving a Health Resources and Service Administration grant to support DC MAP.³⁷ Transferring the grant from DC Health to DBH was onerous and would have delayed funds. While the grant is exciting including supporting the establishment of a regional consortium of telehealth practices with Virginia and Maryland – both of whom have expanded mental health access lines compared to DC – we are concerned about this transition from one agency to another. Particularly, we are unsure of DC Health’s understanding of the program or their

commitment to continue it after the expiration of the grant. Alarminglly it appears funding was decreased after receiving the grant.³⁸

We, therefore, are left with significant questions about the future of this program including:

- What the infrastructure at DC Health is to support DC MAP and does the DC Health staff have expertise in pediatric behavioral health;
- The details on the HRSA grant for DC Health – specifically, when did the funds begin and when will they expire? Are there still local dollars available for DC MAP;
- What is the plan for DC MAP after the expiration of the HRSA grant – will there be local funds to continue to support DC MAP;
- It was our understanding the contract for Paving the Way would expire November 2026 – what are the plans for the continuation of DC MAP – will there be a contract extension or a new request for proposal;
- How has DBH continued to help DC Health with DC MAP;
- Is there a plan for implementation oversight as required by the contract? Should the DC Collaborative for Mental Health in Pediatric Primary Care be reconvened for this function; and
- How is DC Health evaluating the performance of Paving the Way as the provider for DC MAP.

To ensure compliance with DC Act 20-539, and improved implementation so that physicians feel confident enough to continue using the service, we ask the Committee to focus oversight on the program's implementation. Specifically, we ask this Committee to ask DC Health these questions and others that they may identify to understand how to ensure the District continues to have DC MAP as an available resource.

Moreover, we ask this Committee to scrutinize the performance of DC MAP since 2021 and assess in partnership with DC Health and DBH how to sustain and support the program to ensure future success. We hope to see DC MAP continue to serve as a valuable resource to pediatricians and meet the behavioral health needs of District children and families. Renewed oversight during the transitional period from DBH to DC Health and into the coming years would greatly support this goal.

DC Health Can Do More to Develop a Robust Behavioral Health Workforce

The most recent data provided by DC Health show that there are 11,878 behavioral health professionals licensed in the District.³⁹ The data do not allow for enumerating the full behavioral health workforce, including psychiatrists⁴⁰ and psychiatric nurses⁴¹ or non-clinical staff who may provide certain types of behavioral health support, like community support workers and peer specialists, but gives a rough idea of how many people can potentially provide direct clinical services. In order to know to what extent these 11,878 professionals are meeting the behavioral health needs of DC residents utilizing the public system, we would have to know where they work

and what they do. Not all licensed professionals provide direct clinical services, some are professors or consultants, and others may provide therapy in a private practice that doesn't accept Medicaid.

We testified last year about the utility of adding questions to DC Health's workforce survey that licensed health professionals complete when renewing their licenses.⁴² Questions around work setting,⁴³ years in that setting, and populations served⁴⁴ could help the District better understand the distribution of behavioral health professionals in the workforce which can inform workforce development strategies. The job market for behavioral health professionals is diverse, and if the District wants to improve staffing in the public system, it has to make those jobs attractive and worth staying in. Children's Law Center clients receiving behavioral health services continue to experience significant provider turnover, resulting in disruptions of care.⁴⁵ One of our clients had three therapists this past year due to the widespread issue of staffing instability within the District's behavioral health provider network.⁴⁶ Much of the benefit of behavioral health care relies on the therapeutic relationship developed between the therapist and client, so frequent turnover destabilizes the client's ability to build that relationship.

There have been promising developments over the past year that support the growth of the workforce. In June 2025, the Certificate of Need Improvement Amendment Act of 2025 became law, in part establishing a pathway for those with a

Master of Social Work (MSW) to obtain licensure as a Licensed Graduate Social Worker (LGSW) without taking the national exam.⁴⁷ This non-exam pathway to LGSW licensure lowers a barrier for many, removing the requirement to pass what has been demonstrated to be a biased exam.⁴⁸ DC Health reports that since launching the educational pathway in September 2025, 285 licenses have been issued through it,⁴⁹ and 87% of those licensees are Black.⁵⁰ These encouraging numbers demonstrate that lowering licensure barriers contributes to workforce growth and diversity. We encourage DC Health to leverage this opportunity and ensure that information about the non-exam pathway is widely shared.

Still, the non-exam pathway for LGSWs only accomplishes part of what was intended with the Social Work License Modernization Amendment Act of 2023⁵¹ which would have also exempted associate social workers from examination and established a task force to identify an assessment method for independent clinical social work licensure. In order for LGSWs to become Licensed Independent Clinical Social Workers (LICSW), there remains a similarly biased exam to pass. In light of the seeming effectiveness of the non-exam LGSW pathway, the Committee should revisit the utility of a task force to look at non-exam pathways to LICSW licensure.

In October 2025, the Interstate Social Work Licensure Compact Act of 2025 was introduced, which would authorize DC to join the National Social Work Compact, an interstate agreement that allows licensed social workers in participating states and

territories to practice across state lines, either in person or via telehealth, without obtaining multiple state licenses.⁵² DC has been a member of the psychologist compact, known as PSYPACT, since 2020⁵³ and joined the Counseling Compact in 2024,⁵⁴ so should follow suit in joining the social work compact. While compacts are beneficial to each of these professions, they do not directly address the many pressing workforce issues in DC's public behavioral health system. Compacts help therapists maintain care continuity with clients who move out of state and assist with licensure portability as therapists themselves move from state to state. Compacts also benefit private telehealth providers⁵⁵ that prefer to employ therapists licensed in multiple states, thus able to reach a broader client base. For DC's public behavioral health system, a compact is only beneficial as far as the jobs within the system can attract clinicians licensed in other states, most of whom would likely be those who live in Maryland and Virginia and could commute to work in DC. So, salary, working conditions, protection against burnout, and upward mobility remain among the things DC must focus on to ensure that jobs in the public system are worthwhile. We urge the Committee to look beyond licensure flexibility to further workforce development.

Delayed Legislation on CHW Certification Has Stalled Workforce Expansion

Community health workers (CHWs) are a workforce investment in community-based care. Their contributions to health care systems are being leveraged well in states across the country, but the District must make changes to sufficiently utilize CHWs.⁵⁶

CHWs are trained lay people working in non-clinical roles who serve as a bridge between health care systems and their communities through trusted connections. For instance, they can assist with encouraging patients to keep up with recurring appointments through conversations in community settings where a patient may feel more comfortable disclosing barriers to maintaining their health. They are a key part of the health care workforce, exemplifying how health systems can function better by not only relying on licensed professionals. There is strong evidence that the integration of CHWs into health care teams to provide services such as care coordination and system navigation leads to improved health care outcomes and cost reductions.⁵⁷

A critical barrier to integrating CHWs is the lack of a certification for CHWs.⁵⁸ Without certification, the regulatory infrastructure for CHWs remains weak, and the ability to get reimbursed through commercial insurance is left on the table. In our testimony last year, we were expecting DC Health to introduce legislation for CHW certification by summer 2025, but this has yet to happen.⁵⁹ CHWs play an important role in helping residents access services and receive needed health information. We urge this Committee to push DC Health to introduce the CHW legislation.

The Division of Indoor Environment Needs Continued Support to Meet Its Mission to Protect Children From Lead Exposure.

DC Health's Division of Indoor Environment⁶⁰ (DC Health's component of the "Healthy Homes Program") plays a critical role in protecting children from lead exposure and other environmental health hazards in their homes by participating in the broader

DC government Healthy Homes Program, and preparing technical reports examining lead conditions within the housing of families referred to the Division.⁶¹ The program shows meaningful strengths, but also structural weaknesses that limit its effectiveness and undermine lead enforcement across the District. This section identifies the lead dashboard as a success for the Healthy Homes team and suggests potential action for improvements.

The Healthy Homes Program's Lead Dashboard Is a Model for the District.

One of the program's most significant strengths is its commitment to public transparency through the Healthy Homes Lead Dashboard, which stands out as a model of how District agencies can present complex regulatory and public health information in a clear and accessible way.⁶² The dashboard is intuitive, thoughtfully designed, and allows advocates, policymakers, researchers, and the general public to understand trends in lead testing, case volume, inspections, and follow up- activity.

Importantly, this tool was not created in a vacuum, it was developed in response to requests from community stakeholders who needed clearer visibility into lead exposure risks and government response.⁶³ DC Health should be commended for not only listening to those requests, but producing a tool that genuinely adds value to public understanding.

The Council should encourage DC Health to maintain and expand this dashboard over time. As the program strengthens its coordination with enforcement partners, the

dashboard could eventually incorporate enforcement-related metrics, such as the number of violations referred, actions taken by enforcement agencies, or recurrence rates for properties with past hazards. The dashboard and collaborative development process should be treated as a model for other agencies that manage complex regulatory or public health data.

Staffing Capacity Within the Program Was Likely Weakened in the Transfer from DOEE and Must be Addressed.

While the dashboard is a major strength, the Division of Indoor Environment faces internal challenges that directly limit its effectiveness. One of the most consequential is the potential reduced staffing following the program's transfer from the Department of Energy and Environment (DOEE) to DC Health. It is our understanding that when the transfer occurred the program did not move with its full staffing levels or equivalent staffing support.⁶⁴ If true, the result is a program operating with fewer inspectors, fewer staff who perform follow-up with families, and diminished administrative and coordination capacity.

Any constraints on employees have direct consequences. Limited capacity can lead to delays in identifying hazards or ensuring timely mitigation. Each delay increases the amount of time children remain at risk, potentially compounding the harm of exposure.

To be effective, the program must be staffed at least at the level it operated under DOEE. Adequate staffing is a foundational issue, as without enough trained personnel, the District cannot meaningfully prevent or reduce childhood lead exposure. We ask the

Committee to clarify the staffing and the transition from DOEE to DC Health. Moreover, we ask the Council to ensure DC Health is provided with adequate resources to achieve necessary staffing.

The Division of Indoor Environment Needs Enforcement Authority or a Strategic Partner

Another structural challenge is the enforcement gap embedded in the current lead regulatory system. Healthy Homes identifies lead hazards during inspections, but the program does not directly enforce lead regulatory violations.⁶⁵ Instead, enforcement responsibility rests with external agencies.⁶⁶ This separation between hazard identification and enforcement can lead to inconsistent follow-through, weak deterrence, and, in some cases, the persistence of known hazards at properties where children continue to live.⁶⁷

Whether by granting DC Health enforcement authority for lead regulatory violations or by coordination with an enforcement agency lead violations must be met with enforcement action to protect DC residents. Additionally, we encourage the Committee to task DC Health with designing performance metrics that track lead enforcement activity resulting from the Division of Indoor Environment referrals and tracking interagency collaboration (e.g., timeliness, outcomes, repeat violations). Without these systems, the District cannot evaluate whether its lead prevention system is succeeding. With sufficient staffing, meaningful enforcement coordination, and an

updated legal framework, the Division of Indoor Environment can more fully realize its potential to protect District children from exposure to hazardous substances.

Conclusion

Thank you for the opportunity to testify. I welcome any questions the Committee may have.

¹ Centers for Disease Control and Prevention, National Center for Environmental Health, Preventing Lead Exposure in Children, *available at*: <https://www.cdc.gov/lead-prevention/prevention/index.html>; Harvard T.H. Chan School of Public Health, Study finds link between childhood lead exposure and mental illness, (2019), *available at*: <https://www.hsph.harvard.edu/news/hsph-in-the-news/childhood-leadexposure-mental-illness/>; Centers for Disease Control and Prevention, Childhood Lead Poisoning Prevention, Health Effects of Lead Exposure, *available at*: <https://www.cdc.gov/nceh/lead/prevention/health-effects.htm>.

² DC Health, LinkU – Making the Connection, *see* <https://www.youtube.com/watch?v=PcJZ7Ou6cDY>.

³ Findhelp is the company that provides the software and platform. *See* Findhelp, About Us, *available at*: <https://company.findhelp.com/about/>.

⁴ Councilmember Christina Henderson, the District of Columbia Council Committee on Health, Committee Report on B25-0759, Child Behavioral Health Services Dashboard Amendment Act of 2024, (October 22, 2024), *available at*: https://lms.dccouncil.gov/downloads/LIMS/55080/Committee_Report/B25-0759-Committee_Report1.pdf?Id=200066.

⁵ *Id.*

⁶ History provided orally during a training by Ashley Coleman of DC Health.

⁷ HAHSTA LinkU Staff Quick-Start Guide, *available at*: <https://effibarryinstitute.org/resources/hahsta-linku-staff-quick-start-guide/>.

⁸ In late February 2026, DC Health is hosting the first LinkU Working Group that will help support these efforts across agencies. One agency that has integrated LinkU into their work is CFSA. *See* Grandparent Caregivers Program and Close Relative Caregivers Program, Annual Status Report 2024, *available at*: https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/CY24_CFSA_Grandparent_Caregivers_and_Close_Relative_Caregivers_Programs_2024_Annual_Report_%28Final%29_2-24-25.pdf.

⁹ December FY26 Medical Care Advisory Committee (MCAC) Meeting, (December 17, 2026), *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/December_FY26_Medical_Care_Advisory_Committee.pdf.

¹⁰ Councilmember Christina Henderson, the District of Columbia Council Committee on Health, Committee Report on B25-0759, Child Behavioral Health Services Dashboard Amendment Act of 2024, (October 22, 2024), *available at*: https://lms.dccouncil.gov/downloads/LIMS/55080/Committee_Report/B25-0759-Committee_Report1.pdf?Id=200066.

¹¹ *Id.*

¹² LinkU training, *available at*: <https://www.youtube.com/watch?v=PcJZ7Ou6cDY>.

¹³ HealthySteps DC ensures access to behavioral health services in a setting child frequent, their pediatric primary care practice. Children are more likely to go to their primary care provider due to scheduled

well-child visits, thus a primary care provider is well positioned to detect the early onset of behavioral problems. However, a primary care provider may not have the knowledge or skill set to address developmental, behavioral, social, and emotional needs of a child. See HealthySteps, Our Model, available at: <https://www.healthysteps.org/what-we-do/our-model/>.

¹⁴ ZERO TO THREE, HealthySteps: Enhancing Pediatric Care and Support, available at: <https://www.zerotothree.org/our-work/healthysteps/>.

¹⁵ D.C. Law 22-179. Birth-to-Three for All D.C. and Metro for D.C. Dedicated Funding Amendment Act of 2020.

¹⁶ FY2026 DC Health Performance Oversight Responses, response to Q48, available at: <https://lims.dccouncil.gov/Hearings/hearings/2129>.

¹⁷ There are opportunities for sustained financing for HealthySteps in the District. Several other jurisdictions have pursued this type of financing. In January, California launched new dyadic benefits that are modeled after HealthySteps and provide an opportunity to offer services to children and families during a child's pediatric visits. See California Department of Health Care Services, Medi-Cal Children's Initiatives (2022), available at: <https://www.dhcs.ca.gov/services/Documents/DHCS-Childrens-Initiatives.pdf>; First Center for Children's Policy, New Children's Medi-Cal Behavioral Health Benefits 101: Family Therapy and Dyadic Services, available at: <https://first5center.org/blog/new-childrens-medi-cal-behavioral-health-benefits101family-therapy-and-dyadic-services>. Additionally, starting in January, Maryland will have Medicaid enhanced payments for CenteringPregnancy and HealthySteps services. The payments will provide an enhanced \$15 rate per well-child and sick visits for all children birth to age 4 at HealthySteps sites in Maryland (and in DC if children with Maryland Medicaid coverage seek care at DC HealthySteps sites). See Maryland Department of Health, Maryland Medical Assistance Program, Deputy Medicaid Director Letter RE: Coverage of CenteringPregnancy and HealthySteps Services (December 16, 2022), available at: <https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Documents/CenteringPregnancy/PT%2030-23%20Coverage%20of%20CenteringPregnancy%20and%20HealthySteps%20Services.pdf>.

¹⁸ Pay is a huge factor for recruitment and retention – leaving stagnant pay will create turnover. See Hallett E, Simeon E, Amba V, Howington D, McConnell KJ, Zhu JM. Factors Influencing Turnover and Attrition in the Public Behavioral Health System Workforce: Qualitative Study. *Psychiatr Serv.* 2024 Jan 1;75(1):55-63. doi: 10.1176/appi.ps.20220516. Epub 2023 Jun 30. PMID: 37386878; PMCID: PMC10756926; American Journal of Healthcare Strategy, The Realities of Mental Health Staffing: Addressing the Behavioral Health Workforce Shortage, (February 6, 2025), available at: <https://ajhcs.org/podcasts/the-realities-of-mental-health-staffing>. "There are a few factors driving this exodus.

For one, wages aren't keeping up. Ben Caldwell gathered 15 years of data from the U.S. Bureau of Labor Statistics to show therapist salaries rose less than \$10,000 from 2007 to 2021. Meanwhile, soaring inflation has led to cumulative price increases of 56.25%." See *The real cost of low pay for therapists*, Ensora Health, (December 8, 2025), available at: <https://ensorahealth.com/blog/the-cost-of-low-pay-for-therapists/#:~:text=Then%20there's%20crushing%20student%20debt,most%20therapists%20are%20burned%20out>.

¹⁹ Convened by Children's Law Center, the DC HealthySteps Learning Collaborative brings together the leadership from the 4 HealthySteps teams across the District to share successful approaches, collectively discuss challenges and solutions, and work collaboratively to improve HealthySteps implementation across the District of Columbia.

²⁰ D.C. Law 22-179. Birth-to-Three for All D.C. and Metro for D.C. Dedicated Funding Amendment Act of 2020. One particular example of this is that DC Health currently asks HealthySteps sites to report the number of breastfeeding children they serve and their breastfeeding initiation and duration rates. Yes,

early initial research indicated HealthySteps was associated with higher rates (97% in HealthySteps vs 91% in comparison patients) and longer duration of breastfeeding. However, breastfeeding – when a baby started and stopped – is not well documented by pediatric medical providers in a child’s medical record and there is no other data infrastructure to pull this data from. Therefore, trying to pull this number is not easily accomplished and even if it can be found it will not yield accurate data if breastfeeding cannot be ascertained from the medical record. While we understand this information was required in Birth to Three, it is both difficult to obtain and second not a major focus of the current HealthySteps program model.

²¹ Several pieces of the Birth to Three 2018 legislation are not written in a way that accurately reflects the HealthySteps program model. For instance, Section 102-d separates out “(1) Implement HealthySteps” from other activities (e.g., “(4) Screen patients and their families...”, “(5) Provide families with community navigation...”) that are actually subsumed under Implementing HealthySteps. Also, in Section 102-a, there appears to be an additional expectation of pediatric provider grantees that was not included in the DC Health RFP: “(3) co-located lactation support services”. This misalignment of Birth to Three legislation with what grantees are actually providing patients (I.e., the HealthySteps program according to a national model) has resulted in reporting requirements that are irrelevant (I.e., 103-b-(3) lead screening rates, (4) home visiting placements) and impossible to meet because these program staff/providers do not record such information about services they are not providing (I.e., 103-b-(5) unplaced children because home visiting does not have availability, (8)-(10) breastfeeding initiation and duration rates). *See* D.C. Law 22-179. Birth-to-Three for All D.C. and Metro for D.C. Dedicated Funding Amendment Act of 2020.

²² Under 3 DC, Home Visiting, *available at*: <https://under3dc.org/wp-content/uploads/2021/05/U3DC-Home-Visiting-5-11-21.pdf>; District of Columbia Home Visiting Council, *available at*: <http://www.dchomevisiting.org/>.

²³ Health Resources and Services Administration, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, *available at*: <https://mchb.hrsa.gov/programs-impact/maternal-infant-early-childhood-home-visiting-miechv-program>.

²⁴ *Id.*

²⁵ This caused Mary’s Center to terminate 63 families without home visiting services. While we understand the need for competitive RFA processes – the loss of Mary’s Center as a home visiting provider for DC Health is a huge hit to the District. While Mary’s Center continues to operate two other home visiting programs – Nurse Family Partnership and Father-Child Attachment – these programs have more restrictive requirements for eligibility than PAT and HFA. *See* FY2026 DC Health Performance Oversight Responses, response to Q45, *available at*: <https://lims.dccouncil.gov/Hearings/hearings/2129>.

²⁶ Leah Castelaz, Testimony before the District of Columbia Council Committee on Health, (January 18, 2024), *available at*: https://childrenslawcenter.org/wp-content/uploads/2024/01/L.Castelaz_DC-Health-Performance-Oversight-Hearing_1.17.2024_FINAL.pdf.

²⁷ *Id.*

²⁸ *Id.*

²⁹ Victoria Kim and Mary Katherine West, THE STATE OF ADMINISTRATIVE BURDEN FOR DC’S HOME VISITORS, DC Action, (2024), *available at*: <https://wearedcaction.org/wp-content/uploads/The-State-of-Administrative-Burden-for-DCs-Home-Visitors.pdf>.

³⁰ Nisa Hussain, Voices From the Field: The Experiences of the District’s Home Visitors, DC Action, (February 11, 2021), *available at*: <https://wearedcaction.org/publications/voices-from-the-field-the-experiences-of-the-districts-home-visitors/>.

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- ³¹ Paving the Way, DC MAP (Mental Health Access in Pediatrics), *available at*: <https://www.pavingthewaymsi.org/dc-map>; FY2020 DBH Performance Oversight Responses, responses to Q54.
- ³² Leandra Godoy, et al., Behavioral Health Integration in Health Care Settings: Lessons Learned from a Pediatric Hospital Primary Care System, *Journal of Clinical Psychology in Medical Settings* 24, no. 3, 245–58, September 19, 2017, *retrieved from*: <https://doi.org/10.1007/s10880-017-9509-8>.
- ³³ D.C. Act. 20-539 Fiscal Year 2014 Budget Support Act of 2013. Memo on the legislation on file with Children’s Law Center.
- ³⁴ FY2021 DBH Performance Oversight Responses, response to Q45, *available at*: <https://dccouncil.gov/wp-content/uploads/2022/01/dbh.pdf>; Department of Behavioral Health, DC Department of Behavioral Health Awards Children’s National with Contract to Implement the DC Mental Health Access in Pediatrics Project, (March 24, 2025), *available at*: <https://dbh.dc.gov/release/dc-department-behavioral-health-awards-children%E2%80%99s-national-contract-implement-dc-mental>.
- ³⁵ Tami Weerasingha-Cote, Testimony before the District of Columbia Council Committee on Health, (May 24, 2022), *available at*: https://childrenslawcenter.org/wp-content/uploads/2022/06/T-Weerasingha-Cote_DBH-Performance-Oversight-Testimony_1.24.22_updated-5.24.22.pdf; Tami Weerasingha-Cote, Testimony before the District of Columbia Council Committee on Health, (February 1, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/Sharra-Greer_CLC_Performance-Oversight_DBH_General_February-1-2023_final-1.pdf.
- ³⁶ Prior to the transition, the number of consultation requests from primary care settings increased from 96 in FY15 to 1,480 in FY21, showing substantial growth of this program in a short amount of time. Additionally, the number of patient consultations increased from 776 unique patients in FY20 to 1252 unique patients in FY21, representing a 38% increase in unique patients. However, Paving the Way reported 881 referrals in FY23, 819 referrals in FY24, and 759 referrals in FY25 – illustrating both a significant drop between FY21 and a significant drop year over year for Paving the Way. In reporting on the enrolled providers for DC MAP for FY24, FY25, and FY26 shows a consistent decrease of enrolled providers across all categories year over year. Provider types that enroll in DC MAP include psychiatrist, pediatrician, nurse practitioner, behavioral health provider, care coordinator/patient navigator, and family medicine. The only provider that saw an increase was pediatrician from 9 in FY24 to 31 in FY25 but then back down to FY26 to 11 pediatricians. DBH does not report on why providers disenroll, but it does seem raise alarm bells especially when Paving the Way reported they received limited responses to a satisfaction survey and of those responses only 85% providers were very satisfied with the program. *See* FY2025 DBH Performance Oversight Responses, response to Q73, *available at*: <https://lims.dccouncil.gov/Hearings/hearings/21261>; Other numbers are on file with Children’s Law Center.
- ³⁷ We need clarity on the grant and the actual transfer. Based on federal reporting we believe it is the HRSA FY2022 Pediatric Mental Health Care Access (PMHCA) Awards; but also, have seen recent grants for DC Health titled HC0.PMNE. Pediatric Mental Health New Expansion (funding notice in May 2025 and January 2026) which could be the implementation of that grant. *See* Health Resources & Services Administration Maternal & Child Health, FY 2022 Pediatric Mental Health Care Access (PMHCA) Awards, *available at*: <https://mchb.hrsa.gov/programs-impact/programs/pediatric-mental-health-care-access/fy-2022-pediatric-mental-health-care-access-awards>; *See* GBM26-0043 - FY 2026 GRANT BUDGET MODIFICATIONS AS OF JANUARY 16, 2026 and GBM26-0018 - FY 2025 Grant Budget Modification as of May 8, 2025.
- ³⁸ With reduced funds in FY25, the program has downsized to two LICSWs, two LGSW, two care coordinators and two part time psychiatrists. *See* FY2025 DBH Performance Oversight Responses,

response to Q65(f), available at: <https://dccouncil.gov/wp-content/uploads/2025/02/FY-24-Oversight-Index-of-Questions-FINAL.pdf>.

³⁹ This includes all of the licenses administered by the Boards of Professional Counseling, Psychology, and Social Work. There may be a small amount of duplication, for instance, a Licensed Professional Counselor could also be a Professional Art Therapist. See, Department of Health Health Systems and Preparedness Administration FY25 Oversight Questions, Q109c, available at: <https://lims.dccouncil.gov/Hearings/hearings/2129>.

⁴⁰ ⁱⁱ The Board of Medicine does not distinguish between the various medical disciplines in its licensure census.

⁴¹ The Board of Nursing does not distinguish between the various nursing disciplines in its licensure census.

⁴² Chris Gamble, Children’s Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 2, 2025), available at: <https://childrenslawcenter.org/wp-content/uploads/2025/02/DBH-Performance-Oversight-2025-Childrens-Law-Center-Written-Testimony-2.3.25.pdf>.

⁴³ Example: “Please indicate your work setting: Hospital, school, community-based organization, group/solo private practice, other.”

⁴⁴ Example: “What is the age range of patients you serve?”

⁴⁵ Internal Children’s Law Center Data Collection, “GAL Deep Dive,” October 1, 2024 through September 30, 2025.

⁴⁶ *Id.*

⁴⁷ DC Law 26-44. Certificate of Need Improvement Amendment Act of 2025, available at: https://lims.dccouncil.gov/downloads/LIMS/56852/Signed_Act/B26-0025-Signed_Act.pdf?Id=210295.

⁴⁸ Matt P. DeCarlo and Mary Nienow, *Uniquely Biased: How ASWB Exams Violate Psychometric Best Practices*, *Advances in Social Work*, (November 2025), available at: <https://journals.indianapolis.iu.edu/index.php/advancesinsocialwork/article/view/28573>.

⁴⁹ Department of Health Health Systems and Preparedness Administration FY25 Oversight Questions, Q114, available at: <https://lims.dccouncil.gov/Hearings/hearings/2129>.

⁵⁰ Department of Health Health Systems and Preparedness Administration FY25 Oversight Questions, Q111, available at: <https://lims.dccouncil.gov/Hearings/hearings/2129>.

⁵¹ B25-0259, *Social Work License Modernization Amendment Act of 2023*, available at: <https://lims.dccouncil.gov/Legislation/B25-0259>.

⁵² B26-0422, *Interstate Social Work Licensure Compact Act of 2025*, available at: <https://lims.dccouncil.gov/Legislation/B26-0442>.

⁵³ DC Law 23-190. Psychology Interjurisdictional Compact Act of 2020, available at: <https://code.dccouncil.gov/us/dc/council/laws/23-190>.

⁵⁴ DC Law 25-238. Counseling Compact Approval Act of 2024, available at: <https://code.dccouncil.gov/us/dc/council/laws/25-238>.

⁵⁵ This includes companies like BetterHelp and Talkspace.

⁵⁶ Perinatal Mental Health Task Force: Recommendations to Improve Mental Health in the District, January 9, 2024, available at: <https://dhcf.dc.gov/publication/perinatal-mental-health-task-force>.

⁵⁷ Molly Knowles, Aidan P. Crowley, Aditi Vasan, Shreya Kangovi, Community Health Worker Integration with and Effectiveness in Health Care and Public Health in the United States, *Annual Review of Public Health* 2023 44:1, 363-381; Integration of Community Health Workers Improves Care Management Effectiveness, *Health Catalyst*, available at: https://www.healthcatalyst.com/success_stories/community-health-workericmp-partners-healthcare;

Community Health Works, National Academy for State Health Policy, available at: <https://nashp.org/policy/health-care-workforce/community-health-workers/>; DC Health Matters Collaborative, Community Health Needs Assessment, 2022, available at: https://www.dchealthmatters.org/content/sites/washingtondc/2022_CHNA/2022_CHNA_DC_Health_Matters_Collab.pdf; Robertson, H.A.; Biel, M.G.; Hayes, K.R.; Snowden, S.; Curtis, L.; Charlot-Swilley, D.; Clauson, E.S.; Gavins, A.; Sisk, C.M.; Bravo, N.; et al. Leveraging the Expertise of the Community: A Case for Expansion of a Peer Workforce in Child, Adolescent, and Family Mental Health. *Int. J. Environ. Res. Public Health* 2023, 20, 5921. <https://doi.org/10.3390/ijerph20115921>.

⁵⁸ Megan Coffinbarger, et. Al., Risks and Benefits to Community Health Worker Certification, (July 7, 2022), available at: <https://www.healthaffairs.org/content/forefront/risks-and-benefits-community-health-workercertification>.

⁵⁹ Leah Castelaz, Children’s Law Center, Testimony Before the District of Columbia Council Committee on Health, (June 6, 2025), available at: https://childrenslawcenter.org/wp-content/uploads/2025/06/L.Castelaz_CLC-Testimony-Before-COH_DC-Health_Budget-Oversight-FY26_final.pdf.

⁶⁰ DC Health FY2025-2025 Performance Oversight Responses, response to Q135, available at: <https://lims.dccouncil.gov/Hearings/hearings/2129>. “The Healthy Housing Branch is now known as the Division of Indoor Environment.”

⁶¹ DC Health, Healthy Housing Program, available at: <https://dchealth.dc.gov/service/healthy-housing-program-0>. (stating: “... front-line responders refer [families exposed to lead] to DC Health’s Lead and Healthy Housing Division. After an intake process, participants receive a comprehensive home environmental assessment, family education, and case management coordination. Once health and safety threats have been identified and systematically documented, DC Health creates a comprehensive Technical Assistance Report that serves as a time-sensitive roadmap for the correction of identified hazards and details the potential health issues related to those hazards ... The Technical Assistance Report is issued to property owners and tenants, detailing the identified hazards, its associated health risks, work that needs to be completed and the methodology that should be employed in making repairs.”).

⁶² Department of Energy & Environment (DOEE), Childhood Lead Poisoning and Prevention Testing Dashboard, available at: <https://dchealth.dc.gov/page/childhood-lead-poisoning-and-prevention-testing-dashboard>

⁶³ Children’s Law Center (CLC) and other related advocates have requested this program feature during public meetings with the Lead Hazard Elimination and Healthy Home Advisory Committee.

⁶⁴ This was from conversations with agency staff. In DOEE FY24-25 Performance Oversight Responses, the agency reported then transfer of 8 employees. The FY2026 budget reports there are 10 FTEs for this division. DOEE FY24-25 Performance Oversight Responses response to Q4, available at: <https://lims.dccouncil.gov/Hearings/hearings/669>. We could not confirm how many employees DOEE used to have working in this division. We would ask the Committee to clarify this understanding and more importantly follow-up with the agencies on the needed capacity to effectively run this division of DC Health. We are concerned that if the number of employees was cut during the transfer the agency will be less able to perform its duties.

⁶⁵ The Hon. Kathleen Patterson, Office of the District of Columbia Auditor, Testimony Before the District of Columbia Council Committee on Housing and Executive Administration, (March 17, 2021) available at: <https://dcauditor.org/testimony/written-testimony-by-the-hon-kathleen-patterson-d-c-auditor-prepared-for-the-council-committee-on-housing-and-executive-administration-performance-oversight-hearing-on-the-district-of-columbia-ho/>.

⁶⁶ The District Department of Energy and Environment (DOEE) is responsible for enforcing the District’s lead law in specific instances. *See* DC Code § 8-231.11.

⁶⁷ During DOEE’s 2023 Performance Oversight Hearing, Interim Director Jackson explained that one of these two mold inspectors is actually a supervisor in the Licensing and Certification Branch’s mold and radon programs. This staff member is not supposed to be a full-time mold inspector but has been “helping out” to meet the high need for inspections. Committee on Transportation & the Environment, Performance Oversight Hearing, Charles Allen Chair, (February 16, 2023), *available at*: https://dc.granicus.com/MediaPlayer.php?view_id=29&clip_id=8091. *See also*, Council of the District of Columbia, Committee on Transportation & The Environment, Fiscal Year 2023 Committee Budget Report, p. 80, (Apr. 21, 2022), *available at*: https://lms.dccouncil.gov/downloads/LIMS/49081/Committee_Report/B24-0716-Committee_Report9.pdf.