

Birth-to-Three and Beyond: Policy Recommendations to Strengthen Health, Mental Health and the Early Childhood System for DC's Infants, Toddlers, and their Families

Collaborative report by: Children's Law Center, DC Learning Collaborative for Early Childhood Behavioral Health Care in Pediatrics (Collaborative), Early Childhood Innovation Network, Strengthening Families Coalition, and home visiting partners across the District

September 2026



Executive Summary

Over the past decade, the District has made significant investments in infants, toddlers, and families through the landmark Birth-to-Three for All DC Amendment Act of 2018 (“Birth-to-Three”), and related early childhood initiatives. Birth-to-Three established an important framework for supporting healthy development by expanding access to childcare, strengthening the early childhood workforce, and investing in preventive family supports and health services. Birth-to-Three recognized: (1) ages zero to three is a critical time period in need of specific investment;¹ (2) that to best support children ages zero to three, there needs to be a system connecting health, education, and mental wellbeing together; and (3) supporting a child in their earliest years not only requires meeting the child’s needs, but also the needs of their caregiver(s).

In the area of health and mental health, three primary programs have been the focus of Birth-to-Three: 1) HealthySteps – a national, evidence-based model that promotes early childhood development and behavioral health for young children and families in the pediatric primary care office; 2) Healthy Futures, a model of early childhood mental health consultation that builds the capacity of child care providers to support children’s social and emotional development; and 3) Home Visiting, which are voluntary services that connect expectant parents and families with a trained professional who assesses needs, and provides education, support, and connection to community resources. These programs, supported by stakeholders across government, philanthropy, providers, advocates, and families, have expanded equitable access to high-quality services and care.

Building on a strong foundation, the incoming Mayoral Administration and the DC Council have an opportunity to advance transformational outcomes for DC’s youngest residents by creating a visionary and cohesive early childhood system encompassing health, mental health, childcare and economic wellbeing. This is imperative as the window of infancy and early childhood provides optimal opportunities to build healthy brain development and support lifelong physical and mental health. For some young children and families, risks to wellbeing exist and mental health and developmental disorders can occur, even in the early months and years of a child’s life.² However, early mental health is more than the absence of mental health problems. It is the foundation of a child’s emotional well-being, healthy relationships, emotional regulation, resilience, and lifelong development. The earlier we build upon existing strengths and resilience, as well as recognize and address concerns, the better we can optimize each child’s unique potential.³

Overarching Recommendations

A comprehensive early childhood system requires significant investment – not only of financial resources but strategic capital, a unified vision co-created with families, and coordination across many government agencies and community partners. The following are key overarching recommendations:

1) Establish a Vision for a Holistic Early Childhood System.

- **Create infrastructure that prioritizes early childhood across all relevant agencies and establish a vision** for early childhood in the District that is transparent, created with families, data driven, utilizes innovative funding for prevention, strengthens the workforce, creates administrative efficiencies (such as reporting) and is rooted in public-private partnership.
- **Work with stakeholders to design an effective early childhood governance and coordination structure** that has the authority and explicit task of requiring all relevant agencies across the early childhood system (e.g., health, mental health, education, economic security) to work holistically to improve investment, collaboration, and innovation in early childhood. Options could include overhauling the State Early Childhood Development Coordinating Council or identifying other options based on early childhood governance best practices from the national nonpartisan Prenatal-to-3 Policy Impact Center.⁴

2) Prioritize Financing and Policies for Promotion and Prevention. Ensuring a system that incorporates financing for services and programs that promote early childhood health/mental health and prevent illness and/or mitigate severity is critical to strengthening early childhood in the District. A defining challenge of the current early childhood health and mental health system is that health financing infrastructure is largely diagnosis- and treatment-based.

3) Build Beyond Birth-to-Three: While the Birth-to-Three law includes key priorities and important programs, it does not encompass the full spectrum of early childhood health, mental health and developmental services and programs, or the full early childhood system. The programs identified in Birth-to-Three are necessary, but not sufficient. The contributors to this memo, the Early Childhood Innovation Network, DC Learning Collaborative for Early Childhood Behavioral Health Care in Pediatrics, Home Visiting partners, and Strengthening Families Coalition, would be pleased to discuss additional early childhood health and mental health system building opportunities in addition to those identified below.

Policy Recommendations for HealthySteps, Healthy Futures, and Home Visiting

Below are concrete recommendations to advance the impact and reach of HealthySteps, Healthy Futures and Home Visiting, delineated by short term actions (first 100 days) and long-term actions (1-4 years). For a detailed overview of each program, the recommendations and critical considerations, please see pages 5-13.

HealthySteps

First 100 Days

- Restore funding for HealthySteps to be recurring and not one-year, renewable funding (approximately \$1.35 million).

- Increase the local dollar grants to reflect Birth-to-Three legislation requirement of \$300,000 per HealthySteps site per year (an additional, \$1.4 million, with total funding of \$2.7 million; could expand local funding to the ninth HealthySteps site for an additional \$300,000).
- Remove the requirement that HealthySteps sites pay for an external evaluator and instead allocate those funds for an external evaluator⁵ to conduct a multisite evaluation of HealthySteps across the District (\$225,000).⁶
- Amend the Birth-to-Three law to remove Ward restrictions for health centers to receive grants and adjust reporting requirements to align with the HealthySteps National Office annual reporting requirements. This should include working with sites to identify further ways to reduce administrative burden for HealthySteps.

Long-Term and Systemic Changes

- Create a sustainable funding model for HealthySteps, which includes:
 - Continued partnership with the DC Learning Collaborative for Early Childhood Behavioral Health Care in Pediatrics.⁷
 - Conduct a fiscal study for HealthySteps to understand true cost of program implementation within the District.⁸
 - Study current Medicaid reimbursement rates for applicable billing codes that can be utilized by HealthySteps sites and implementation barriers to billing of codes.
 - Identify and advance preventive Medicaid and commercial payer financing mechanisms for early childhood behavioral health and family mental health in primary care.
 - Identify opportunities to build HealthySteps into Managed Care Plans and/or bundled payments so that all health centers can offer HealthySteps, including FQHCs.
 - Determine if the Collaborative Care Services billing codes can be feasibly utilized:
 - Clarify rules for Collaborative Care Services for young children to determine ability to utilize in the District, especially by HealthySteps sites
 - Pilot Collaborative Care Services at a HealthySteps site to assess feasibility with clinic workflows and reimbursement potential
- Build clinical and non-clinical workforce capacity to support current health systems and allow for continued and future growth of HealthySteps which includes:
 - Establish guidance for billing for non-clinical supports through Medicaid.⁹
 - Create certification for community health workers (CHWs) and a path for Medicaid reimbursements for CHWs.
 - Build pathways to expand clinicians with expertise in infant and early childhood mental health.

Healthy Futures

First 100 Days

- Maintain funding for Healthy Futures at current FY27 funding levels (\$3.025 million).
- Healthy Futures should remain at the standalone agency of the Department of Behavioral Health.
- Release the completed implementation evaluation for Healthy Futures from FY2025.

- Assess feasibility to expand Healthy Futures through a plan that addresses each eligible childcare center or provider in the District and the feasibility of expanding to those centers/providers (noting if a center/provider is not interested, why, and if there are opportunities to do further educating or engagement to address their lack of interest).
- Investigate whether Healthy Futures could supplement or replace services for young children delivered by the School-Based Behavioral Health programming.

Long-term and System Changes

- Develop a strategic plan to address the workforce pipeline for ECMHC in the District including leveraging current work in the District (e.g. the Thrive Center for Children, Families, and Communities Certificate in Infant & Early Childhood Mental Health – Clinical Track).¹⁰
- Develop an outcome evaluation for Healthy Futures.

Home Visiting

First 100 Days

- Increase home visiting funding to support grants that allow home visiting programs to increase salaries for home visitors. Conduct cost analysis and align with available federal and local dollars.
- Ensure no further cuts to local home visiting funding in FY27 across the four government agencies (CFSA, OSSE, DHCF, and DC Health).
- Implement DC Law 25-142, Home Visiting Services Reimbursement Act of 2024, which establishes Medicaid reimbursement for home visiting.
- Re-establish the DC Home Visiting Council through the Deputy Mayor of Health and Human Services and ensure it is a requirement across all relevant government partners to participate.
- Direct the Deputy Mayor of Health and Human Services publish the annual home visiting report.

Long-term and System Changes

- Create a strategic, unified vision for home visiting in the District that removes the burden from one agency and better integrates all agencies in the improved implementation of home visiting. DC agencies must include home visiting providers and other stakeholders in this process.
- Reassess proposed legislation “B22-0350 - Home Visiting Services Pilot Program Establishment Act of 2017” to determine if reintroduction would be beneficial to home visiting programs.¹¹
- Improve reporting metrics for home visiting that reduces the administrative burden by aligning with national models and federal grant requirements.
- Establish clear guidance for grant shifts including:
 - Earlier timelines for grant cycles to prevent service gaps and allow for meaningful transition planning for families and staff;
 - A system-level needs and capacity assessment to understand where families can realistically transition when funding changes occur, and use this information to guide funding decisions and timelines; and

- Collaboration with grantees on program closeout, providing early, clear, and supportive guidance that prioritizes continuity of care for families
- Create a more transparent and accessible way to track funding to ensure there is a clear understanding of the availability of funds across private, local, and federal dollars.
- Identify all available home visiting funding and create a cohesive strategy on braiding funding to have the largest impact on DC children and families.
- Identify the barriers to centralized intake and what investments are needed to support implementation.

Detailed Background, Recommendations, and Critical Considerations

The following provides detailed programmatic, policy and financing information and status regarding HealthySteps, Healthy Futures and Home Visiting, including short and long term policy recommendations, and critical considerations.

HealthySteps

HealthySteps is national evidence-based model¹² that integrates behavioral health¹³ into the pediatric setting to support children ages 0-3 and their caregivers. Embedding behavioral health professionals in the pediatric care setting – where families can more readily access care – allows for increased integration of care, earlier identification of behavioral health concerns for both child and caregiver(s), and greater connection to community supports and resources. HealthySteps is primarily a developmental and behavioral health promotion and prevention model – supporting wellbeing, identifying challenges early, and preventing others from happening

It is well documented that HealthySteps leads to improved outcomes in areas where there are persistent inequities for families of color with low incomes – like breastfeeding, early intervention, maternal depression, social emotional development, and well child visit attendance.¹⁴

Since the passage of Birth-to-Three, HealthySteps has grown to be locally funded in eight out of the nine DC sites – Children’s National’s Columbia Heights site is privately funded. [see [Appendix A, HealthySteps Sites in the District](#) for a full table of sites].

The recommendations proposed below are reflective of two substantial gaps in HealthySteps implementation in the District. First, and foremost, HealthySteps funding needs to be stabilized. The proposed FY27 budget cut all local funding for HealthySteps, effectively eliminating the program in the District, as the sites rely on the full grant amount to sustain HealthySteps at their respective primary care sites. The DC Council restored funding for HealthySteps with one-time funding for FY27. This leaves funding for HealthySteps in peril beginning in FY28.

The gap is exacerbated by no clear path forward to secure sustainable funding for HealthySteps despite many years of working with DC agencies and key stakeholders. As noted above,

HealthySteps is a prevention focused model for young children and caregivers with services delivered in the pediatric setting. Traditionally, Medicaid reimburses services with a treatment and diagnosis focus. Some states, including Maryland, have implemented innovative payment pathways to support HealthySteps and preventive dyadic services for young children and families. There are also other innovative non-Medicaid funds that could be leveraged to better support HealthySteps in DC. However, the District must take a holistic approach to establishing a clear funding model that recognizes both opportunities for where Medicaid dollars can work and where other District funds can help fill the gap that Medicaid cannot. There are other examples of where the District does this – for example the funding for school-based behavioral health is a grant of local dollars to ensure coverage of all non-billable aspects of the work. We have to clearly define non-billable aspects of the HealthySteps work (e.g., systems navigation and care coordination to ensure families are connected to and receive services) and ensure there are ways to support these critical services.

The second gap in HealthySteps implementation in the District is the high administrative burden for reporting and data collection. There are several areas that increase the administrative burden on HealthySteps programs: (1) DC Health requires data from HealthySteps sites that is irrelevant or tangentially related to the program’s design and does not measure the intended impact on the families served; (2) DC Health requires monthly reports, quarterly reports, a mid-year report and site visit, and a comprehensive end of the year report and site visit that often duplicates the same data that is submitted to the HealthySteps National Office at ZERO TO THREE; (3) Not all of the data collected by the District is required by the HealthySteps National Office. Moreover, the data collected has not resulted in a comprehensive District-wide evaluation of the outcomes of families who participate in HealthySteps or significantly contributed to the advancement of the program, particularly in terms of financial sustainability or expansion to additional primary care sites. It would be extremely beneficial for DC Health to accept the already recognized fidelity measures and data of this nationally evidence-based program that is required by ZERO TO THREE, and for sites to resolve any implementation challenges with the HealthySteps National Office at ZERO TO THREE which can provide technical assistance and quality improvement support. The goal is to create better learning within HealthySteps by aligning fewer measures with nation/local requirements, measuring outcomes that matter to families, and creating a District-level learning/evaluation infrastructure that feeds data back to sites for continuous improvement.

The recommendations below are reflective of closing these two gaps. HealthySteps either needs full commitment for adequate DC Health grant funding; the implementation of a different sustainability approach that maximizes Medicaid billing and is not based on a fee for service billing model (i.e., Maryland Medicaid previously adopted a \$15 enhanced payment on every well-child and sick visit for all children birth through age 3 at a HealthySteps site); or a hybrid financing approach. Lastly, HealthySteps will function most efficiently with reporting requirements that: align with its preventive model focus and other existing requirements (i.e., HealthySteps National Office), evaluate outcomes, and are regularly utilized to inform and improve implementation of the model.

Recommendations for HealthySteps

First 100 Days

- Restore funding for HealthySteps to be recurring and not one-year, renewable funding (approximately \$1.35 million).
- Increase the local dollar grants to reflect Birth-to-Three legislation requirement of \$300,000 per HealthySteps site per year (an additional, \$1.4 million, with total funding of \$2.7 million; could expand local funding to the ninth HealthySteps site for an additional \$300,000).
- Remove the requirement that HealthySteps sites pay for an external evaluator, and instead allocate those funds for an external evaluator¹⁵ to conduct a multisite evaluation of HealthySteps across the District (\$225,000).¹⁶
- Amend the Birth-to-Three law to remove Ward restrictions for health centers to receive grants, and adjust reporting requirements to align with the HealthySteps National Office annual reporting requirements. This should include working with sites to identify further ways to reduce administrative burden for HealthySteps.

Long-Term and Systemic Changes

- Create a sustainable funding model for HealthySteps, which includes:
 - Continued partnership with the DC Learning Collaborative for Early Childhood Behavioral Health Care in Pediatrics.¹⁷
 - Conduct a fiscal study for HealthySteps to understand true cost of program implementation within the District.¹⁸
 - Study current Medicaid reimbursement rates for applicable billing codes that can be utilized by HealthySteps sites and implementation barriers to billing of codes.
 - Identify and advance preventive Medicaid and commercial payer financing mechanisms for early childhood behavioral health and family mental health in primary care.
 - Identify opportunities to build HealthySteps into Managed Care Plans and/or bundled payments so that all health centers can offer HealthySteps, including FQHCs.
 - Determine if the Collaborative Care Services billing codes can be feasibly utilized:
 - Clarify rules for Collaborative Care Services for young children to determine ability to utilize in the District, especially by HealthySteps sites
 - Pilot Collaborative Care Services at a HealthySteps site to assess feasibility with clinic workflows and reimbursement potential
- Build clinical and non-clinical workforce capacity to support current health systems and allow for continued and future growth of HealthySteps which includes:
 - Establish guidance for billing for non-clinical supports through Medicaid.¹⁹
 - Create certification for community health workers (CHWs) and a path for Medicaid reimbursements for CHWs.
 - Build pathways to expand clinicians with expertise in infant and early childhood mental health.

Critical Considerations

- Medicaid is a critical resource for funding, and, given current Medicaid billing options, it cannot fully cover the cost of HealthySteps.
- Medicaid funding is more precarious under the current federal administration.

Acknowledgement: Thank you to the DC Learning Collaborative for Early Childhood Behavioral Health Care in Pediatrics (Collaborative) and the Early Childhood Innovation Network (ECIN) for their contributions to this section. For further information, please contact Leah Castelaz, (Collaborative) at lcastelaz@childrenslawcenter.org and Sarah Barclay Hoffman, (ECIN) at sbhoffma@childrensnational.org

Healthy Futures

Healthy Futures is a program through the Department of Behavioral Health that provides infant and early childhood mental health consultation²⁰ (IECMHC) in District's child development centers (CDC) and home-based providers. Specifically, IECMHC is a prevention-based approach that pairs a mental health consultant with adults caring for infants and young children. It equips the caregivers to facilitate children's healthy social and emotional development through a variety of supports. IECMH consultants draw upon their clinical skills, mental health training and knowledge of evidence-based strategies to help identify individual and/or program needs and address them collaboratively through the adult caregivers they support.

IECMHC has been shown to improve children's social skills and emotional functioning, promote healthy relationships, reduce challenging behaviors, reduce the number of suspensions and expulsions, improve classroom quality, and reduce provider stress, burnout, and turnover.²¹ Most recently, the District did an evaluation of the Healthy Futures program, but unfortunately the evaluation has not been released to the public.

Healthy Futures expanded utilizing American Rescue Plan Act (ARPA) dollars and then eventually local District dollars to create a Healthy Futures treatment program, as well. The treatment program differs from Healthy Futures in several aspects – currently it utilizes two clinicians working at eight CDCs who are trained in early childhood evidence-based treatments and can provide trauma informed treatment approaches for young children and their families who have complex needs or may be involved with the Child and Family Services Agency.

Since the passage of Birth-to-Three, the Healthy Futures program has grown to 58 CDCs and home-based providers to 101 CDCs and home-based providers. [see [Appendix A, Healthy Future Sites in the District FY23-FY25](#)]. While this exemplifies growth it also highlights gaps in Healthy Futures expansion as originally envisioned in the Birth-to-Three legislation. First, there are many additional CDCs and home-based providers who could benefit from Healthy Futures. Funding for Healthy Futures at one point was sufficient to expand to over 180 CDCs and home-based providers. The expansion did not take place for several reasons: (1) the agency, through budget modifications, chipped away at the expansion dollars; (2) the lack of mechanism to match CDCs and home-based providers with Healthy Future;²² and (3) workforce constraints making it difficult to expand further.

Therefore, the District must address funding and workforce constraints in relation to demand for Healthy Futures in the District.

Notably, Healthy Futures is just one opportunity for the District to implement IECMHC in the District. A continued gap in IECMHC in the District is the lack of integration into the District's school-based behavioral health program which encompasses Pre-K 3 and 4 through grade 12. IECMHC was piloted in select charter preschools.²³ The pilot showed promising results including improvements in classroom mental health climate and social-emotional practices in preschool classrooms. Teachers who participated in consultation reported improved emotional climate in their classrooms.

DBH has struggled to match preschools with a provider – nine Pre-K 3 and 4 schools have never been matched and have no DBH SBBH funded resource and 28 schools that serve preschool through 5th to 8th grade have also never been matched and have no DBH SBBH funded resource. Preschool and younger student populations are unique particularly in the SBBH context particularly because of the billing requirements to sustain funding – many younger populations do not have diagnoses that allow a clinician to bill for their time. DBH could and should fill this gap by deploying IECMHC in schools that serve younger ages – like Pre-K 3 and 4. This would also result in a cost savings given the model of deploying IECMHC.²⁴

Overall, the District must also prioritize adult well-being alongside child support, ensuring that educators and students receive comprehensive resources and capacity to sustain developmental care. According to the U.S. Department of Education, “Educator wellness is a critical component of a healthy school climate and is linked to greater workplace satisfaction, lower absenteeism, and improved child well-being.”

Recommendations for Healthy Futures

First 100 Days

- Maintain funding for Healthy Futures at current FY27 funding levels (\$3.025 million).
- Healthy Futures should remain at the standalone agency of the Department of Behavioral Health.
- Release the completed implementation evaluation for Healthy Futures from FY2025.
- Assess feasibility to expand Healthy Futures through a plan that addresses each eligible childcare center or provider in the District and the feasibility of expanding to those centers/providers (noting if a center/provider is not interested, why, and if there are opportunities to do further educating or engagement to address their lack of interest).
- Investigate whether Healthy Futures could supplement or replace services for young children delivered by the School-Based Behavioral Health programming.

Long-term and System Changes

- Develop a strategic plan to address the workforce pipeline for ECMHC in the District including leveraging current work in the District (e.g. the Thrive Center for Children, Families, and Communities Certificate in Infant & Early Childhood Mental Health – Clinical Track).²⁵

- Develop an outcome evaluation for Healthy Futures.

Critical Considerations

- Healthy Futures is a very strong and well implemented program and must rely on continued local dollar funding.

Acknowledgement: Thank you to the Strengthening Families Coalition (SFC) and the Early Childhood Innovation Network (ECIN) for their contributions to this section. For further information, please contact Leah Castelaz, (SFC) at lcastelaz@childrenslawcenter.org and Sarah Barclay Hoffman, (ECIN) at sbhoffma@childrensnational.org

Home Visiting

Home visiting is a voluntary, free service strategy that connects trained professionals— including nurses, social workers, and parent educators—with expectant parents and families with young children in the comfort of their homes. Unlike clinic-based services, home visiting meets families where they are—reducing barriers such as transportation, childcare, and time constraints.

Home visitors²⁶ build strong, trusting relationships with families and provide individually tailored support, resources, and information. They help parents develop skills to promote their child’s healthy development, navigate community resources, and achieve their own goals for economic self-sufficiency and family well-being.

Research demonstrates that evidence-based home visiting programs produce significant, measurable benefits for children and families. Research shows that home visiting has statistically significant positive effects including in five key maternal and family well-being outcome areas:

1. Maternal coping strategies and parenting behaviors that could be improved through direct interaction between parents and home visitors
2. Maternal mental and behavioral health
3. Parent-child interactions
4. Outcomes related to family conflict, intimate partner violence, and child maltreatment
5. Family economic self-sufficiency.²⁷

Additional research has found that home visiting can reduce child maltreatment, improve child health and development, and generate economic returns that exceed costs by five times for the most disadvantaged families over a 15-year follow-up period.²⁸

Home visiting in the District is spread across four agencies, 14 community-based organizations, and deploying 10 different models – totaling 20 different home visiting programs available for DC families. A comprehensive table can be found below in [Appendix A, Home Visiting Partners in the District](#).

The largest gap in home visiting is exactly this – the programming is spread across a large number of community-based organizations and agencies and utilizes numerous different models for home visiting. This gap has been exacerbated by the ending of the DC Home Visiting Council. The DC

Home Visiting Council ran from 2004 to 2024. At the time of Birth-to-Three the DC Home Visiting Council was seen as one of the strengths of the District's home visiting programs.²⁹ The DC Home Visiting Council acted as an entity that brought together the vast number of home visiting partners to engage in data and reporting – each year the DC Home Visiting Council published a comprehensive annual report – as well as program management, advocacy, and program improvements like creating a centralized intake. The lack of a DC Home Visiting Council has had a disparate impact on the District's home visiting programs.

Moreover, there continues to be common gaps in implementation of home visiting that need to be addressed. First, and foremost, the District lacks a vision for home visiting particularly when it comes to leveraging available federal funding. A primary reason for the spread of home visiting across so many agencies is due to numerous funding streams available including: (1) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) [DC Health]; (2) Early Head Start [OSSE]; and (3) Community-Based Child Abuse Prevention (CBCAP) [CFSA]. Home visiting is also included in DHCF because of the potential for Medicaid to be used to support home visiting programming.

In FY2025, the DC Council passed and funded the DC Law 25-142, Home Visiting Services Reimbursement Act of 2024 which required DHCF to submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to reimburse for home visiting services. DHCF has refused to implement the legislation – going against precedent of following legislation that requires the agency to submit a SPA. Not braiding Medicaid dollars with the other federal dollars is a huge gap in the District.

Furthermore, the current Administration continuously cuts the local dollars for home visiting which can be used to support home visiting programs who do not meet the criteria for federal funds, as well as families who would benefit from home visiting, but also do not meet the criteria for federal funds. The DC Council often is able to find some one-time funding for home visiting. However, one-time dollars are precarious and so long as the home visiting budgets remain uncertain, programs will continue to feel the instability.

Over the last year the home visiting landscape has shifted significantly and has potential to further shift due to available funding. First, in FY2026, 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. Community of Hope and Mamatoto Village continued to receive MIECHV funding from a different RFA. Additionally, MIECHV dollars go to an in-house DC Health home visiting program – DC Safe Care.

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. Despite efforts by Mary's Center, 63 families – half of all families enrolled in HFA and PAT – were discharged from services due to the lack of available home visiting options within the District. These families lost trusted relationships and consistent support during a critical period for parents and young children.

Further, the District is at risk of greater shifts in CFSA, who shared in July 2026 that while they have applied for a CBCAP grant and are waiting to hear from the federal government, the CBCAP funding will be the only available funding for FY2027 for these programs. This means that there will be no local funds available to support CFSA's home visiting programs – a majority of which rely on local dollars to operate. Even if CFSA receives CBCAP funds, the CBCAP funding will not be sufficient to continue to fund all these programs at FY2026 levels.

Another critical gap in home visiting is maintaining the home visiting workforce. The current funding means that often salaries are minuscule (putting some home visitors eligible for the same benefits as the families they are serving).³⁰ Additionally, home visitors endure significant second hand trauma from their work – often taking on the stressors and worries of the families they serve – while trying to balance significant administrative burden. One of the largest strains on the administration of home visiting is the differing data collection requirements by funding streams, program models, and providers, which create challenges in evaluating the effectiveness of services, even across different programs implementing the same models. Streamlining reporting and data collection is key to closing the administrative burden gap for home visitors.

Before the DC Home Visiting Council ended, it published two significant reports that highlight the gaps in home visiting implementation: (1) Voices from the Field: The Experiences of the District's Home Visitors; and (2) The State of Administrative Burden for Dc's Home Visitors.³¹ Having one single entity bringing together the key stakeholders to examine the gaps, bring forth innovative ideas, and promote what is working well is key. We therefore need an administration invested in bringing back the DC Home Visiting Council to serve this vital role.

Recommendations for Home Visiting

First 100 Days

- Increase home visiting funding to support grants that allow home visiting programs to increase salaries for home visitors. Conduct cost analysis and align with available federal and local dollars.
- Ensure no further cuts to local home visiting funding in FY27 across the four government agencies (CFSA, OSSE, DHCF, and DC Health).
- Implement DC Law 25-142, Home Visiting Services Reimbursement Act of 2024, which establishes Medicaid reimbursement for home visiting.
- Re-establish the DC Home Visiting Council through the Deputy Mayor of Health and Human Services and ensure it is a requirement across all relevant government partners to participate.
- Direct the Deputy Mayor of Health and Human Services publish the annual home visiting report.

Long-term and System Changes

- Create a strategic, unified vision for home visiting in the District that removes the burden from one agency and better integrates all agencies in the improved implementation of home visiting. DC agencies must include home visiting providers and other stakeholders in this process.
- Reassess proposed legislation “B22-0350 - Home Visiting Services Pilot Program Establishment Act of 2017” to determine if reintroduction would be beneficial to home visiting programs. ³²
- Improve reporting metrics for home visiting that reduces the administrative burden by aligning with national models and federal grant requirements.
- Establish clear guidance for grant shifts including:
 - Earlier timelines for grant cycles to prevent service gaps and allow for meaningful transition planning for families and staff;
 - A system-level needs and capacity assessment to understand where families can realistically transition when funding changes occur, and use this information to guide funding decisions and timelines; and
 - Collaboration with grantees on program closeout, providing early, clear, and supportive guidance that prioritizes continuity of care for families
- Create a more transparent and accessible way to track funding to ensure there is a clear understanding of the availability of funds across private, local, and federal dollars.
- Identify all available home visiting funding and create a cohesive strategy on braiding funding to have the largest impact on DC children and families.
- Identify the barriers to centralized intake and what investments are needed to support implementation.

Critical Considerations

- Monitor federal funding for home visiting – while under the current administration there have been some increases to home visiting funding in MIECHV programs, programs such as Early Head Start are at risk for cuts.

Acknowledgement: Thank you to the home visiting partners across the District for their contributions to this section. For further information, please contact Leah Castelaz at lcastelaz@childrenslawcenter.org.

Appendix A

HealthySteps Sites in the District (FY25)

Healthy System	Clinic Name	Ward
Children's National	Children's Health Center Anacostia	8
	Columbia Heights	1
	Children's Health Center at THEARC	8
Community of Hope	Family Health and Birth Center	5
Georgetown MedStar	MGUH Pediatrics/Kids Mobile Medical Clinic	Travels Across the District
Unity Healthcare	Anacostia	8
	East of the River Health Center	7
	Minnesota Avenue Health Center	7
	Parkside	7

Healthy Future Sites in the District (FY23-FY25)

FY25	FY24	FY23
2 New Heights CDC	2 New Heights CDC	2 New Heights CDC
Amen Family	Amen Family	Amen Family
Angel's Arena Child Care	Angel's Arena Child Care	Angel's Arena Child Care
Baby Einstein	Baby Einstein	
Barbara Chambers #5	Barbara Chambers #5	Barbara Chambers #5
Barbara Chambers Children Center #2	Barbara Chambers Children Center #2	Barbara Chambers Children Center #2
Barbara Chambers Children Center #3	Barbara Chambers Children Center #3	Barbara Chambers Children Center #3
Barbara Chambers Children Center #4	Barbara Chambers Children Center #4	Barbara Chambers Children Center #4
Barbara Chambers Children's Center	Barbara Chambers Children's Center	Barbara Chambers Children's Center
Bell Teen and CDC	Bell Teen and CDC	Bell Teen and CDC
Bert Family Child Care	Bert Family Child Care	Bert Family Child Care
Bethel Christian Fellowship Early CDC	Bethel Christian Fellowship Early CDC	Bethel Christian Fellowship Early CDC
Bethel Christian Fellowship Infant - Center	Bethel Christian Fellowship Infant Center	Bethel Christian Fellowship Infant Center
Big Mama's Children Center	Big Mama's Children Center	Big Mama's Children Center
Blandi's	Blandi's	Blandi's

Board of Child Care***	Board of Child Care^^	
Bright Beginnings*	Bright Beginnings	Bright Beginnings
Bright Start Brentwood	Bright Start Brightwood	Bright Start Brightwood
Bright Start CDC	Bright Start CDC	Bright Start CDC
Bright Start Child Childcare & Preschool	Bright Start Child Childcare & Preschool	Bright Start Child Childcare & Preschool
Bright Start NOMA	Bright Start NOMA	Bright Start NOMA
CentroNia	CentroNia	CentroNia
CentroNia @ Bunker Hill	CentroNia @ Bunker Hill	
CentroNia @ Stevens	CentroNia @ Stevens	CentroNia @ Stevens
CentroNia @ Upshur Street	CentroNia @ Upshur Street	CentroNia @ Upshur Street
Children's Hut	Children's Hut	Children's Hut
CommuniKids I- Tenley	CommuniKids I- Tenley	CommuniKids I- Tenley
CommuniKids VI – Van Ness	CommuniKids VI – Van Ness	CommuniKids VI – Van Ness
CommuniKids VIII – Glover Park	CommuniKids VIII – Glover Park	CommuniKids VIII – Glover Park
Community Educational Research Group, Inc. – Good Hope Rd	Community Educational Research Group, Inc. – Good Hope Rd	Community Educational Research Group, Inc. – Good Hope Rd
Community Educational Research Group – 50th St	Community Educational Research Group – 50th St	Community Educational Research Group – 50th St
Community Educational Research Group – Minnesota Ave	Community Educational Research Group – Minnesota Ave	Community Educational Research Group – Minnesota Ave
Creative Minds	Creative Minds	
Dawn to Dusk	Dawn to Dusk	Dawn to Dusk
Dawn to Dusk Child Dev. Center II	Dawn to Dusk Child Dev. Center II	Dawn to Dusk Child Dev. Center II
Easter Seals	Easter Seals	Easter Seals
Easter Seals DC EHS	Easter Seals DC EHS	Easter Seals DC EHS
Educare IDEA	Educare IDEA	Educare IDEA
Educare of Washington, DC*	Educare of Washington, DC	Educare of Washington, DC
Edward C. Mazique Parent Child Center, Inc @ the Ruth E. Rucker Bldg.*	Edward C. Mazique Parent Child Center, Inc @ the Ruth E. Rucker Bldg.	Edward C. Mazique Parent Child Center, Inc @ the Ruth E. Rucker Bldg.

Embassy Row CDC		
Estrellitas Montessori	Estrellitas Montessori	Estrellitas Montessori
Everstand	Everstand (Board of Child Care)	
First Rock Baptist CDC	First Rock Baptist CDC	First Rock Baptist CDC
Gap Community Children Center	Gap Community Children Center	Gap Community Children Center
God is Good Child Development Home	God is Good Child Development Home	God is Good Child Development Home
	Happy Faces Early Learning Academy	Happy Faces Early Learning Academy
Home Away From Home	Home Away From Home	Home Away From Home
Home Away from Home, Too	Home Away from Home, Too	Home Away from Home, Too
House of Ruth/Kids Space	House of Ruth/Kids Space	House of Ruth/Kids Space
Ideal Child Care Development Center #1	Ideal Child Care Development Center #1	Ideal Child Care Development Center #1
Ideal Child Care Development Center #2	Ideal Child Care Development Center #2	Ideal Child Care Development Center #2
Jubilee Jumpstart	Jubilee Jumpstart	Jubilee Jumpstart
KD's Discovery CDC		
Kennedy Institute	Kennedy Institute	Kennedy Institute
Kiddie Academy	Kiddie Academy	Kiddie Academy
Kiddie Academy of DC West End	Kiddie Academy of DC West End	Kiddie Academy of DC West End
Kiddie University		
Kiddies Inc.	Kiddies Inc.	
Kids Are People Too II	Kids Are People Too II	Kids Are People Too II
Kids Are People Too V	Kids Are People Too V	Kids Are People Too V
Kids Are Us Learning Center	Kids Are Us Learning Center	Kids Are Us Learning Center
KU Kids Deanwood, LLC	KU Kids Deanwood, LLC	KU Kids Deanwood, LLC
Little Blessings, LLC	Little Blessings, LLC	Little Blessings, LLC
Love First CDC	Love First CDC	Love First CDC
Loving Care	Loving Care	Loving Care
Loving Care Day Nursery, Inc.	Loving Care Day Nursery, Inc.	Loving Care Day Nursery, Inc.

LTH Infants and Toddlers	LTH Infants and Toddlers	LTH Infants and Toddlers
Mana Bilingual CDC 2	Mana Bilingual Child Development - Center 2	Mana Bilingual Child Development - Center 2
Martha's Table - The Commons*	Martha's Table - The Commons	Martha's Table - The Commons
Martha's Table – Maycroft	Martha's Table – Maycroft	Martha's Table – Maycroft
	Meriam Academy, LLC	Meriam Academy, LLC
Miriam's Growing Seeds	Miriam's Growing Seeds	Miriam's Growing Seeds
Ms. P's Unique Development	Ms. P's Unique Development	Ms. P's Unique Development
National Children's Center*	National Children's Center	National Children's Center
Our Children First	Our Children First	Our Children First
Paramount CDC	Paramount CDC	Paramount CDC
Point of Care	Point of Care	Point of Care
Promoting Love and Wisdom	Promoting Love and Wisdom	Promoting Love and Wisdom
Reggio's Treehouse - HHS/ED Children 's Center	Reggio's Treehouse - HHS/ED Children 's Center	
Reggio's Treehouse - HUD		
Reggio's Treehouse -TeleTots	Reggio's Treehouse – TeleTots	
Reggio's Treehouse Commerce Dept	Reggio's Treehouse Commerce - Department Child Care Center	
Rehoboth Baptist Church Day Care	Rehoboth Baptist Church Day Care	Rehoboth Baptist Church Day Care
Rosemount Center*	Rosemount Center	Rosemount Center
Saint Phillip's Child Development Center	Saint Phillip's Child Development Center	Saint Phillip's Child Development Center
	Saint Timothy Episcopal CDC	Saint Timothy Episcopal CDC
Spanish Education Development Center	Spanish Education Development Center	Spanish Education Development Center
St Albans	St Albans	St Albans
St. Timothy's		
Sunshine Early Learning Center*	Sunshine Early Learning Center	Sunshine Early Learning Center
The Learning Curve CDC	The Learning Curve CDC	The Learning Curve CDC
The Learning Curve CDC III	The Learning Curve CDC III	The Learning Curve CDC III

The Learning Curve CDC IV	The Learning Curve CDC IV	The Learning Curve CDC IV
Tiny Tots	Tiny Tots	Tiny Tots
Two Birds N St	Two Birds N St	Two Birds N St
Two Birds Tenleytown	Two Birds Tenleytown	Two Birds Tenleytown
UPO @ Anacostia High School	UPO @ Anacostia High School	UPO @ Anacostia High School
UPO @ Atlantic Garden	UPO @ Atlantic Garden Early	UPO @ Atlantic Garden Early
UPO @ Azeeze Bates	UPO @ Azeeze Bates	UPO @ Azeeze Bates
UPO @ Ballou High School	UPO @ Ballou High School	UPO @ Ballou High School
UPO @ Coolidge High School		
UPO @ CW Harris	UPO @ CW Harris	
UPO @ Edgewood CDC	UPO @ Edgewood Child Development Center	UPO @ Edgewood Child Development Center
UPO @ Frederick Douglass	UPO @ Frederick Douglass	UPO @ Frederick Douglass
UPO @ Ketcham Elementary School	UPO @ Ketcham Elementary School	UPO @ Ketcham Elementary School
UPO @ Paradise Early Childhood -Center	UPO @ Paradise Early Childhood Center	UPO @ Paradise Early Childhood Center
UPO @ Roosevelt Senior High	UPO @ Roosevelt Senior High	UPO @ Roosevelt Senior High
		CentroNia @ Cardozo
		CommuniKids V – The Church
		CommuniKids IV- UDC
		ABC Child Development Center
		Chantelle's
		Love and Care CDC LLC
		Infancia Feliz
		Newlen Early Childhood School Readiness Center
		Associates for Renewal in Education, Inc.
		Newlen Early Childhood School Readiness Center II
		Edward C. Mazique @ Tyler House

	Board of Child Care
	Shining Star
	Shining Star II
	Bright Horizon
	Kiddies Kollege
	Blessing
	UPO @ Eagle Academy Public Charter School
	UPO @ Malcolm X Elementary School

Home Visiting Partners in the District*

*noting the [unknown] shows the need for more consistent, centralized data collection

Organization	Model	Evidence-based Model (EVBP) or Other Model (Non-EVBP; Home Grown)	Primary Population	Capacity (# of families served)	Relevant Agency	Funding Source	Funding Total in FY25
Bright Beginnings	Parents as Teachers	EVBP	Expectant parents and families with children up to 3 years old experiencing homelessness	20 families at a time	OSSE	Early Head Start (federal); Private	[unknown]
Center for Non-profit advancement (Love More Movement)	Home Visiting/Trauma-informed	Non-EVBP	Families in Ward 6 and 7, East of the Anacostia River	[unknown]	CFSA	Local	\$100,000
CentroNia	Creative Curriculum and March of Dimes	Non-EVBP	Expectant parents and families with children up to 3 years old who have low incomes or experience	56 families at a time	OSSE	Early Head Start (federal)	[unknown]

			multiple overlapping adversities				
Community Family Life Services	Nurturing Skills for Families	Non-EVBP	Returning citizens reunified or seeking to reunify with children and parents experiencing homelessness or domestic violence	50 families annually	CFSA	Local	\$210,000
Community of Hope	Healthy Families America	EVBP	Expectant parents and families with a child no older than 3 months upon enrollment living in Wards 7 or 8 or homeless who are experiencing a high number of stressors.	37 families at a time	DC Health	MIECHV (federal)	\$315,000
	Parents as Teachers	EVBP	Expectant parents and families with children 5 and under living in wards 5, 7, 8 or who are experiencing homelessness and experiencing a high number of stressors	65 families at a time	DC Health	Local	\$300,000
DC Health	SafeCare Augmented	EVBP	SafeCare is delivered across 18 weekly home visits, which typically last 60 minutes each.	120 families annually	DC Health	MIECHV (federal)	\$767,409

			SafeCare can be delivered to any family with a child between the ages of birth and 5 years old, with no other inclusion or exclusion family characteristics necessary for enrollment.				
Family Place (CSC)	Home Instruction for Parents of Preschool Youngsters (HIPPY)	EVBP	Spanish-speaking immigrant and displaced families with low incomes that have children ages 2-4 years old	75 families annually	CFSA	CBCAP (federal); Local	\$175,000
Generation Hope	Parents as Teachers	EVBP	Teen parents in college at a 2- or 4-year university with children 5 and under	45 families annually	N/A	Private	[unknown]
Georgetown	Parents as Teachers – Parenting Support Program	Non-EVBP**	Parents with developmental and intellectual disability or experience in the child welfare system who are expecting or have children 5 years old and under, or parents who are typically developing and whose children may be at risk for	36 families at a time	DC Health	Local	\$300,000

			or with developmental delay or disability				
	Parents as teachers – Parenting Support Early Intervention	EVBP	[unknown]	[unknown]	DC Health	MIECHV (federal)	\$315,000
Healthy Babies Project Inc.	Growing Great Kids, Nurturing Parent	EVBP	Pregnant teens and parenting youth and families experiencing homelessness with children 3 years old and under	60 families annually	OSSE	Early Head Start (federal); Private	[unknown]
Lutheran Social Services	Parents as Teachers	EVBP	[unknown]	[unknown]	DC Health	MIECHV (federal)	\$315,000
Mamatoto Village	Mother's Rising	Non-EVBP**	Medicaid-eligible pregnant and parenting people less than 12 weeks postpartum	290 families at a time	*DC Health received dollars for evaluation of the model (MIECHV Dollars)	Medicaid and Private Foundation Grants	[unknown]
Martha's Table	Parents as Teachers	EVBP	Low-income expectant parents or families with children under 3 years old who live in wards 7 or 8	18 families at a time	OSSE	Early Head Start (federal)	[unknown]
Mary's Center	Father-Child Attachment Program: Attachment Program 24/7 Dad Curriculum and Parents As Teachers	Non-EVBP	Any caregiving father or father figure with a child 5 and under who resides in the District	50 families annually	CFSA	Local	\$210,000

	Nurse Family Partnership	EVBP	First-time pregnant people within the first 28 weeks of gestation in the District (working with them until age 2)	100 families at a time	DHCF	Local	\$625,000
Rosemount	Parents as Teachers	EVBP	Expectant parents and families that have low incomes, with children 3 years old and under	77 families at a time	OSSE	Early Head Start (Federal)	[unknown]
United Planning Organization (UPO)	Parents as Teachers	EVBP	Expectant families that have low incomes, are experiencing homelessness, are in foster care, or are receiving public assistance, with children under 3 years old	84 families at a time	OSSE	Early Head Start (Federal)	[unknown]
	Parents as Teachers	EVBP	[unknown]	[unknown]	DC Health	MIECHV (federal)	\$315,000

** has been undergoing research to become an evidence-based practice

¹ Age 0-3 is when a child's brain is growing at a high speed forming over one million new neural connections every second, and laying the core base for future learning, health, and behavior. See ZERO TO THREE, Why 0-3, *available at*: <https://www.zerotothree.org/why-0-3/>; Center on the Developing Child, Harvard University, Why Early Matters, *available at*: <https://developingchild.harvard.edu/>; American Academy of Pediatrics, Promoting Safe, Secure, Nurturing Relationships, (2025), *available at*: <https://www.aap.org/en/patient-care/early-childhood/early-relational-health/promoting-safe-secure-nurturing-relationships/?srsltid=AfmBOoo5ILeca5nd6TBkEsRwPkzEpt20UjGWorqybFgQL4-LTt5A459K>; American Academy of Pediatrics, Early Relational Health, *available at*: <https://www.aap.org/en/patient-care/early-childhood/early-relational-health/>; American Academy of Pediatrics, Early Childhood, *available at*: <https://www.aap.org/en/patient-care/early-childhood/>.

² ZERO TO THREE'S What do mental health issues in young children look like? Available at: [What do mental health issues in young children look like? | ZERO TO THREE](#)

³ZERO TO THREE's Infant and Early Childhood Mental Health (IECMH) Guiding Principles, *available at*: <https://www.zerotothree.org/resource/zero-to-threes-infant-and-early-childhood-mental-health-iecmh-guiding-principles/>.

⁴ Available at: <https://pn3policy.org/early-childhood-governance/#lessons-learned>

⁵ Maintaining evaluation outside the agency is important – independent evaluation can bring objectivity and expertise, providing an unbiased assessment of the progress and impacts.

⁶ Based on current funding set aside for evaluation, nine sites multiple by \$25,000 to compensate an evaluator.

⁷ The DC DC Learning Collaborative for Early Childhood Behavioral Health Care in Pediatrics is a collective of the leaders of the HealthySteps site led by Children's Law Center.

⁸ California recently underwent a study to identify challenges, strategies and best practices to achieve sustainability for HealthySteps as informed by learning collaboratives, individualized TA sessions, and financial modeling exercises. These efforts to support the financial sustainability of HealthySteps sites in California included federally qualified health centers (FQHCs), community clinics (non-FQHCs), private practices, and other settings and was led by the HealthySteps National Office and Health Management Associates (HMA). See Case Study Report: Lessons Learned from HealthySteps Technical Assistance in California, (February 11, 2026), *available at*: <https://www.healthmanagement.com/insights/briefs-reports/case-study-report-lessons-learned-from-healthysteps-technical-assistance-in-california/>.

⁹ A Path Forward recommendation, "Establish mechanisms to adequately reimburse decentralized care coordination services provided by clinical and nonclinical professionals in settings where families frequent and trust." See *A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, page 61, (2021), *available at*: <https://childrenslawcenter.org/our-impact/health/behavioral-health/a-path-forward-for-dcs-public-behavioral-health-system/>.

¹⁰ "The Online Certificate in Infant & Early Childhood Mental Health is a comprehensive program for professionals seeking to deepen their clinical knowledge and experience working with parents and young children. Participants will have the opportunity to review, discuss, and synthesize cutting-edge materials and learn from luminaries in the infant mental health field." See Thrive Center for Children, Families, and Communities, Certificate in Infant & Early Childhood Mental Health – Clinical Track, *available at*: <https://thrivecenter.georgetown.edu/iecmh-certificate-clinical-track/>.

¹¹ B22-0350 - Home Visiting Services Pilot Program Establishment Act of 2017.

¹² ZERO TO THREE, HealthySteps, *available at*: <https://www.healthysteps.org/>.

¹³ This role is a child development specialist, called a HealthySteps Specialist (HSS), who is integrated into primary care visits, meaning both the child development specialist and the pediatrician are in the room together. In general, HealthySteps seeks to take a multi-generational approach to family care, including infant health, maternal health and parenting, and family needs. An HHS uses their expertise to deliver a multi-tier service approach – Tier 1, universal services, Tier 2, short-term supports, and Tier 3, comprehensive services). Across the three Tiers an HSS offers developmental, behavioral, social, and emotional screenings to assess if a child is reaching developmental milestones. Specialists can provide support to a family by answering questions and facilitating the development of attachment, self-regulation skills, and family resiliency. Additionally, the HHS can provide guidance and referrals to families who need additional services.

¹⁴ HealthySteps Advance Health Equity, (2021), *available at*: https://www.healthysteps.org/wp-content/uploads/2021/07/HealthySteps_Advances_Health_Equity.pdf.

¹⁵ Maintaining evaluation outside the agency is important – independent evaluation can bring objectivity and expertise, providing an unbiased assessment of the progress and impacts.

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²⁰ "Infant and early childhood mental health consultants are highly-trained licensed or license-eligible professionals with specialized knowledge in childhood development, the effects of stress and trauma on families, the importance of

attachment for young children, and the impacts of adult mental health on developing children. Unlike other mental health professionals, IECMH consultants do not [typically] provide direct mental health treatment to young children or the adults who surround them. Instead, the consultant works *indirectly* by developing relationships with the adults in young children's lives to build adults' capacity to support children's healthy social and emotional development – early and before formalized intervention is needed.” See Center of Excellence for Infant and Early Childhood Mental Health Consultation, *IECMHC Basics*, available at: <https://www.iecmhc.org/about/>.

²¹ Center of Excellence for Infant and Early Childhood Mental Health Consultation, *IECMHC Basics*, available at: <https://www.iecmhc.org/about/>.

²² According to DBH's FY24 oversight responses, 85 eligible CDCs and home providers were not receiving Healthy Futures services and supports. Of those, 44 had been contacted but indicated they were not interested in services. But this has not been followed up on since. See DBH, FY2024 Oversight Responses, response to Q62, available at: <https://lims.dccouncil.gov/Hearings/hearings/637>.

²³ Fight for Children funded GUCCHD to pilot IECMH at a Charter Pre-K program. It was very successful and resulted in a manual that many other states and communities have found useful. It also developed evaluation tools in the appendix. See Georgetown University Center for Child and Human Development (GUCCHD), *The Georgetown Manual for School-Based Early Childhood Mental Health Consultation Services*, (2016), available at: iecmhc.org/documents/FCC_Manual_2020_Proof2.pdf.

²⁴ For example, the nine preschools with no DBH SBBH funded resource if allowed to leverage ECMHC could be covered by 2 clinicians – approximately a 75% savings to cover nine schools with a more effective model. The model allows less clinicians to cover more schools while retaining effective and necessary behavioral health supports in the preschool setting. This would allow more schools to access DBH funded resources and better support SBBH. Currently SBBH is funded at \$120,000 per grant – so if all nine preschools received a grant it would cost \$1,080,000 but since they only need 2 clinicians (\$240,000) there is approximately \$840,000 in savings for SBBH. ECMHC are able to cover more schools because of the model.

²⁵ “The Online Certificate in Infant & Early Childhood Mental Health is a comprehensive program for professionals seeking to deepen their clinical knowledge and experience working with parents and young children. Participants will have the opportunity to review, discuss, and synthesize cutting-edge materials and learn from luminaries in the infant mental health field.” See Thrive Center for Children, Families, and Communities, Certificate in Infant & Early Childhood Mental Health – Clinical Track, available at: <https://thrivecenter.georgetown.edu/iecmh-certificate-clinical-track/>.

²⁶ A home visitor is a trained professional—such as a nurse, social worker, or early childhood specialist—who visits expectant parents and families with young children to provide free, voluntary education, coaching, and resource connections.

²⁷ Health Resources & Services Administration, New HHS Study Finds Home Visiting Services Improves Family Wellbeing, (September 11, 2025), available at: <https://www.hrsa.gov/about/news/press-releases/positive-home-visiting-by-kindergarten>.

²⁸ *Id.*

²⁹ See Office of the District of Columbia Auditor, Status Report on Home Visiting in the District of Columbia, (March 23, 2017), available at: <https://dcauditor.org/report/status-report-on-home-visiting-in-the-district-of-columbia/>.

³⁰ In FY25 the average home visitor salary was \$51,000 and could be as low as \$45,000. See FY2025 Department of Health Performance Oversight Responses, response to Q44, available at: <https://lims.dccouncil.gov/Hearings/hearings/2129>.

³¹ Voices from the Field: The Experiences of the District's Home Visitors, (February 11, 2021), available at: <https://weareedaction.org/publications/voices-from-the-field-the-experiences-of-the-districts-home-visitors/>; The State of Administrative Burden for DC's Home Visitors, (August 2024), available at: <https://under3dc.org/wp-content/uploads/The-State-of-Administrative-Burden-for-DCs-Home-Visitors.pdf>.

³² B22-0350 - Home Visiting Services Pilot Program Establishment Act of 2017.