COUNCIL OF THE DISTRICT OF COLUMBIA
Office of the Budget Director

Jennifer Budoff
Budget Director

TO: **The Honorable Phil Mendelson**
Chairman, Council of the District of Columbia

FROM: **Jennifer Budoff**
Budget Director, Council of the District of Columbia

DATE: **April 26, 2023**

SUBJECT: **Certification of the Draft Report and Recommendations of the Committee on Health on the Fiscal Year 2024 Budget and Financial Plan for Agencies Under Its Purview**

This is to certify that the Office of the Budget Director has reviewed the Draft Report and Recommendations of the Committee on Health on the Fiscal Year 2024 Budget and Financial Plan for Agencies Under Its Purview, circulated at 2:32 pm on April 25, 2023, and found it to be balanced and compliant with Council Rule 703(b).

If you have any questions in this regard, please do not hesitate to call me at 724-5689.

Jennifer Budoff
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COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
CHRISTINA HENDERSON, CHAIRPERSON

FISCAL YEAR 2024 COMMITTEE BUDGET REPORT

TO: Members of the Council of the District of Columbia

FROM: Councilmember Christina Henderson
Chairperson, Committee on Health

DATE: April 26, 2023

SUBJECT: Report and Recommendations of the Committee on Health on the Fiscal Year 2024 Budget for Agencies Under Its Purview

The Committee on Health ("Committee"), having conducted hearings and received testimony on the Mayor's proposed operating and capital budgets for Fiscal Year 2024 ("FY 2024") for the agencies under its purview, reports its recommendations for review and consideration by the Committee of the Whole. The Committee also comments on several sections in the Fiscal Year 2024 Budget Support Act of 2023, as proposed by the Mayor, and proposes several new sections.

TABLE OF CONTENTS

I. SUMMARY 3

A. Executive Summary 3
B. FY 2024 Agency Operating Budget 6
C. FY 2024 Agency Operating Budget by Program 8
D. FY 2024 Agency Full-Time Equivalents 20
E. FY 2024 - 2029 Agency Capital Budgets 21
F. Transfers In from Other Committees 22
G. Transfers Out to Other Committees 22
H. Revenue Adjustments 23
I. Funding of Legislation 23
J. Summary of Committee Budget Recommendations 23

II. AGENCY FISCAL YEAR 2024 BUDGET RECOMMENDATIONS 24

A. Introduction 24
B. Department of Health (HC0) 27
C. Department of Behavioral Health (RM0) 46
D. Department of Health Care Finance (HT0) 65

E. Office of the Deputy Mayor for Health and Human Services (HG0) 79
F. Not-For-Profit Hospital Corporation & Subsidy (HX0) 83
G. Health Benefit Exchange Authority (HI0) 86
III. BUDGET SUPPORT ACT RECOMMENDATIONS 90
A. Recommendations on Mayor's Proposed Subtitles 90
1. Title V, Subtitle A. Public Health Laboratory 90
2. Title V, Subtitle B. Medicaid Hospital Provider Reimbursement 92
B. Recommendations for New Subtitles 93
1. Title V, Subtitle X. School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023 94
2. Title V, Subtitle X. First-Time Mothers Home Visiting Program 96
3. Title V, Subtitle X. Substance Abuse and Behavioral Health Targeted Outreach Pilot 97
4. Title V, Subtitle X. Department of Health Care Finance Reporting Requirements 98
IV. COMMITTEE ACTION AND VOTE 101
V. ATTACHMENTS 104

I. SUMMARY

A. EXECUTIVE SUMMARY

This report of the Committee on Health on the Fiscal Year 2024 Proposed Budget for the agencies within its jurisdiction was developed after several months of hearings, testimony, meetings, and other forms of public engagement. The summary below highlights many of the Committee's notable investments in the FY 2024 budget, including the approval of proposed investments by the Mayor.

The Committee's recommended budget makes critical investments to:

Improve Access to Critical Health Care and Services

- Ensures on-time completion and opening of hospital opening in Ward 8 by approving Cedar Hill Regional Medical Center one-year advance investment of **$10,000,000** to account for inflationary increases and supply chain delays of medical equipment
- Expands access to diagnosis and treatment of infertility by providing **$750,000 in local funds, with $940,000 in federal matching funds,** to implement the Expanding Access to Fertility Treatment Amendment Act of 2023, which would expand Medicaid and Alliance coverage for the diagnosis and medication treatment of infertility and fund the study of expanding coverage to IVF and fertility preservation services
- Provides critical animal rescue and animal control services for the District by restoring **$2,000,000** for the Animal Care and Control contract
- Approves **$300,000** of the Mayor's one-time enhancement for senior dental services
- Ensures individuals with HIV/AIDS or cancer have stable housing and appropriate medical care by restoring a **$250,000** grant to Joseph's House to provide nursing care and housing support to individuals critically ill with HIV/AIDS or cancer
- Accepts a transfer from the Committee on Transportation and the Environment of **$170,000** to require dementia training for direct care workers, implementing the Dementia Training for Direct Care Workers Act of 2019

Increase Support for Behavioral Health and Substance Abuse Treatment

- Addresses the gap in access to behavioral health services by providing **$325,000** for the School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023
- Accepts a transfer from the Committee on Public Works and Operations of **$200,000** and provides an additional **$400,000**, for a total enhancement of **$600,000** for the Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2023 that pilots the effectiveness of an influx of direct support, relationship development, and resource brokering for individuals in need of substance abuse and behavioral health services at three locations in Wards 1, 5, and 7
- Addresses pivotal staffing shortages by designating **$100,000** for retention and hiring bonuses to attract and retain qualified staff for the Children and Adolescent Mobile Psychiatric Service (ChAMPS) staff
- Enhances academic support, youth development, health and wellness, and family engagement in Ward 8 by transferring **$100,000** to the Committee on Recreation, Libraries,

and Youth Affairs for a grant to Horton's Kids through the Department of Parks and Recreation.

Strengthen the Public Health Workforce

- Increases the pipeline of talented healthcare professionals in the District by allocating **$1,419,000** to fund L24-0313, the High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022, thereby creating a High Need Healthcare Career Scholarship and Supports program and adding **one FTE** to implement the program
- Enhances the licensing process for healthcare professionals by restoring **2.25 FTEs** to the Health Licensing Professional Boards Division at DC Health
- Increases critical food safety inspections for restaurants, cafeterias, and other food establishments in the District by restoring **one FTE** to the Food Safety Division at DC Health
- Increases opportunities for small food entrepreneurs by partially funding B25-0068, the Street Vendor Advancement Amendment Act of 2023. **Two new FTEs at DC Health** will create and enforce a new permit for Microenterprise Home Kitchens for small businesses making prepared food in their homes

Improve Perinatal and Children's Health

- Accepts a transfer from the Committee on Public Works and Operations to increase evidence-based home visiting for low-income, Medicaid eligible, first-time mothers through a grant of **$225,000** to Department of Health Care Finance
- Increases distribution of diapers, formula, and other essential supplies for infants by investing **$400,000** in recurring funds as a grant to the DC Diaper Bank
- Ensures more consistent staffing at School Health Suites by restoring **$2,000,000** for the Children's School Services grant to implement a new staffing model and address the high vacancy rate for school nurses
- Enhances healthy meals and nutrition education in schools by transferring **$822,367** to the Committee of the Whole for the Healthy Schools Fund at the Office of the State Superintendent for Education to be spent on school garden grants, nutrition education grants, and school cafeteria equipment and training grants

Addresses the Social Determinants of Health

- Accepts a transfer from the Committee on Transportation and the Environment to increase access to healthy food by restoring the Council's **$375,000** one-time enhancement for the Healthy Food Access Grants at DC Health, including: **$150,000** for the Healthy Corners Program; **$25,000** for Home Delivered Meals; and $**200,000** for Produce Plus, and accepts the Mayor's proposed one-time enhancement of **$324,066** for Joyful Food Markets
- Encourages activity and independence for individuals living in Assisted Living Facilities and Certified Residential Facilities by allocating **$269,280** for a $30 increase of personal needs allowances (PNAs) to cover personal expenses.
- Encourages increased medical respite care for individuals experiencing homelessness by providing **$55,000** to the Department of Health Care Finance to produce a report on opportunities to expand Medicaid coverage for medical respite care.
- Helps low-income tenants remain in their homes by transferring **$500,000** to the Committee on Housing to restore the Emergency Rental Assistance Program

- Restores critical funding for public libraries, which serve as cultural and resource centers for District residents, by restoring **$433,410** for the DC Public Library Revenue Generating Fund for featured author, musical, and other cultural events as well as exhibitions primarily at the MLK Library thus attracting individuals downtown, and **$629,442** for custodial maintenance for DC Public Library for regular cleaning, pest control, and landscape services at all branch locations
- Enhances Access to Justice Initiatives at Office of Victim Services and Justice Grants by transferring **$350,000** to the Committee on the Judiciary and Public Safety for that purpose
- Promotes public safety and modernizes traffic enforcement programs by transferring **$50,000** to the Committee on Public Works and Operations to fund self-releasing boots, bringing the total to $900,000 for this program

B. FY 2024 Agency Operating Budget

Fund Type	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee's FY 2024 Recommendation	Committee Percent Change
Department of Behavioral Health						
DEDICATED TAXES	$0	$200,000	$0	$0	$0	(100.00%)
FEDERAL GRANT FUND	$38,271,832	$55,041,715	$54,525,365	$0	$54,525,365	(0.94%)
FEDERAL MEDICAID PAYMENTS	$2,713,504	$2,742,751	$3,316,674	$0	$3,316,674	20.93%
FEDERAL PAYMENTS	$5,079,315	$10,158,064	$9,613,592	$0	$9,613,592	(5.36%)
LOCAL FUND	$288,570,879	$305,681,032	$314,330,360	($3,615,468)	$310,714,892	1.65%
INTRA-DISTRICT	$14,282,761	$0	$0	$0	$0	0.00%
PRIVATE DONATIONS	$5,002	$36,000	$93,000	$0	$93,000	158.33%
PRIVATE GRANT FUND	$214,926	$486,290	$255,000	$0	$255,000	(47.56%)
SPR FUNDS	$1,604,020	$2,673,080	$3,009,823	$0	$3,009,823	12.60%
TOTAL GROSS FUNDS	**$350,742,239**	**$377,018,932**	**$385,143,814**	**($3,615,468)**	**$381,528,346**	**1.20%**
Department of Health						
FEDERAL GRANT FUND	$186,955,135	$158,594,599	$173,799,377	$0	$173,799,377	9.59%
FEDERAL PAYMENTS	$4,956,065	$5,000,000	$5,000,000	$0	$5,000,000	0.00%
LOCAL FUND	$89,218,502	$98,469,027	$90,893,861	$3,868,905	$94,762,766	(3.76%)
INTRA-DISTRICT	$10,810,090	$0	$0	$0	$0	0.00%
PRIVATE GRANT FUND	$240,869	$0	$0	$0	$0	0.00%
SPR FUNDS	$20,134,541	$21,891,637	$22,308,969	$0	$22,308,969	1.91%
TOTAL GROSS FUNDS	**$312,315,202**	**$283,955,264**	**$292,002,208**	**$3,868,905**	**$295,871,113**	**4.20%**
Department of Health Care Finance						
DEDICATED TAXES	$98,736,598	$105,105,077	$114,535,958	$0	$114,535,958	8.97%
FEDERAL GRANT FUND	$4,918,520	$5,174,115	$4,550,493	$0	$4,550,493	(12.05%)
FEDERAL MEDICAID PAYMENTS	$3,072,184,089	$2,663,283,088	$3,180,056,342	$940,000	$3,180,996,342	19.44%
FEDERAL PAYMENTS	$0	$2,000,000	$0	$0	$0	(100.00%)

Fund Type	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee's FY 2024 Recommendation	Committee Percent Change
LOCAL FUND	$843,270,232	$954,955,220	$986,913,175	($1,706,569)	$985,206,606	3.17%
INTRA-DISTRICT	$93,009,075	$0	$0	$0	$0	0.00%
PRIVATE GRANT FUND	$0	$365,701	$100,000	$0	$100,000	(72.66%)
SPR FUNDS	$2,020,706	$5,643,542	$8,805,546	$0	$8,805,546	56.03%
TOTAL GROSS FUNDS	**$4,114,139,219**	**$3,736,526,743**	**$4,294,961,514**	**($766,569)**	**$4,294,194,945**	**14.92%**
Health Benefit Exchange Authority						
ENTERPRISE AND OTHER FUNDS	$30,194,256	$35,684,055	$37,552,148	$0	$37,552,148	5.24%
TOTAL GROSS FUNDS	**$39,657,848**	**$35,684,055**	**$37,552,148**	**$0**	**$37,552,148**	**5.24%**
Not-for-Profit Hospital Corporation						
ENTERPRISE AND OTHER FUNDS	$0	$155,000,000	$155,000,000	$0	$155,000,000	0.00%
TOTAL GROSS FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**	**0.00%**
Not-for-Profit Hospital Corporation Subsidy						
LOCAL FUND	$22,000,000	$15,000,000	$15,000,000	$0	$15,000,000	0.00%
TOTAL GROSS FUNDS	**$22,000,000**	**$15,000,000**	**$15,000,000**	**$0**	**$15,000,000**	**0.00%**
Office of the Deputy Mayor for Health and Human Services						
LOCAL FUND	$2,095,724	$2,861,218	$2,588,900	($111,338)	$2,477,562	(13.41%)
INTRA-DISTRICT	$213,733	$0	$0	$0	$0	0.00%
TOTAL GROSS FUNDS	**$2,309,458**	**$2,861,218**	**$2,588,900**	**($111,338)**	**$2,477,562**	**(13.41%)**
GRAND TOTAL	**$4,842,763,966**	**$4,606,046,211**	**$5,182,248,582**	**($624,470)**	**$5,181,624,112**	**12.50%**

C. FY 2024 AGENCY OPERATING BUDGET BY PROGRAM

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
1000 - AGENCY MANAGEMENT						
1010 - PERSONNEL	$1,727,342	$1,842,289	$1,933,524	$0	$1,933,524	4.95%
1015 - TRAINING AND EMPLOYEE DEVELOPMENT	$272,183	$608,322	$604,166	$0	$604,166	(0.68%)
1017 - LABOR RELATIONS	$390,005	$518,584	$506,298	$0	$506,298	(2.37%)
1030 - PROPERTY MANAGEMENT	$972,847	$1,264,637	$1,012,036	$0	$1,012,036	(19.97%)
1040 - INFORMATION TECHNOLOGY	$5,619,100	$5,499,720	$6,548,434	$0	$6,548,434	19.07%
1050 - FINANCIAL MANAGEMENT-AGENCY	$2,292,493	$2,176,073	$2,653,009	$0	$2,653,009	21.92%
1088 - CLAIMS ADMINISTRATION	$721,505	$794,542	$818,323	$0	$818,323	2.99%
1091 - OFFICE OF ADMINISTRATION OPERATIONS	$12,171,348	$13,827,730	$14,550,358	$0	$14,550,358	5.23%
1092 - RECORDS MANAGEMENT	$875,291	$782,863	$815,427	$0	$815,427	4.16%
TOTAL PROGRAM FUNDS	**$24,999,309**	**$27,314,759**	**$29,441,574**	**$0**	**$29,441,574**	**7.79%**
100F - DBH FINANCIAL OPERATIONS						
110F - DBH BUDGET OPERATIONS	$731,268	$1,123,878	$1,395,339	$0	$1,395,339	24.15%
120F - DBH ACCOUNTING OPERATIONS	$862,339	$991,126	$787,171	$0	$787,171	(20.58%)
130F - DBH FISCAL OFFICER	$209,949	$362,955	$312,564	$0	$312,564	(13.88%)
TOTAL PROGRAM FUNDS	**$1,803,556**	**$2,477,958**	**$2,495,073**	**$0**	**$2,495,073**	**0.69%**
1800 - BEHAVIORAL HEALTH AUTHORITY						
1810 - OFC OF THE DIRECTOR/ CHIEF EXEC OFFICER	$1,901,957	$2,501,440	$2,708,261	$0	$2,708,261	8.27%
1820 - CONSUMER AND FAMILY AFFAIRS	$1,177,984	$1,323,344	$993,354	$0	$993,354	(24.94%)
1885 - OFFICE OF OMBUDSMAN	$297,827	$292,428	$302,307	$0	$302,307	3.38%

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
1888 - LEGAL SERVICES	$918,208	$1,003,112	$1,040,560	$0	$1,040,560	3.73%
1889 - LEGISLATIVE AND PUBLIC AFFAIRS	$565,571	$1,261,275	$996,094	($32,266)	$963,828	(23.58%)
TOTAL PROGRAM FUNDS	**$4,861,546**	**$6,381,599**	**$6,040,576**	**($32,266)**	**$6,008,310**	**(5.85%)**
3800 - ST. ELIZABETHS HOSPITAL						
3805 - OFFICE OF THE CHIEF EXECUTIVE	$469,174	$252,661	$255,207	$0	$255,207	1.01%
3810 - OFFICE OF CLINICAL AND MEDICAL SVS - SEH	$22,688,238	$23,207,304	$21,153,193	$0	$21,153,193	(8.85%)
3815 - ENGINEERING AND MAINTENANCE - SEH	$4,238,182	$5,911,932	$4,853,078	$0	$4,853,078	(17.91%)
3820 - FISCAL AND SUPPORT SERVICES - SEH	$208,092	$699,201	$951,917	$0	$951,917	36.14%
3828 - QUALITY AND DATA MANAGEMENT	$1,434,517	$1,489,682	$1,571,602	$0	$1,571,602	5.50%
3830 - HOUSEKEEPING - SEH	$3,227,387	$2,924,550	$2,788,853	$0	$2,788,853	(4.64%)
3835 - MATERIALS MANAGEMENT - SEH	$1,327,373	$1,634,175	$1,586,638	$0	$1,586,638	(2.91%)
3845 - NURSING - SEH	$54,948,858	$45,611,480	$46,290,762	$0	$46,290,762	1.49%
3850 - NUTRITIONAL SERVICES SEH	$3,554,616	$3,789,756	$4,375,449	$0	$4,375,449	15.45%
3860 - SECURITY AND SAFETY - SEH	$5,262,205	$4,761,344	$4,741,694	$0	$4,741,694	(0.41%)
3865 - TRANSPORTATION AND GROUNDS - SEH	$685,763	$769,916	$667,042	$0	$667,042	(13.36%)
3870 - OFF OF THE CHIEF OF STAFF - SEH	$1,200	$110,067	$110,067	$0	$110,067	0.00%
TOTAL PROGRAM FUNDS	**$98,089,445**	**$91,162,067**	**$89,345,501**	**$0**	**$89,345,501**	**(1.99%)**
3875 - OFF OF THE CHIEF OPERATING OFFICER - SEH	$962,702	$908,222	$815,462	$0	$815,462	(10.21%)
3880 - OFFICE OF CHIEF CLINICAL OFFICER-SEH	$12,308,421	$12,242,775	$12,805,160	($199,596)	$12,605,564	2.96%
4900 - ACCOUNTABILITY						
4905 - OFFICE OF ACCOUNTABILITY	$275,400	$109,115	$117,215	$0	$117,215	7.42%

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
4910 - INVESTIGATIONS	$436,292	$525,337	$561,097	$0	$561,097	6.81%
4920 - LICENSURE	$580,643	$586,898	$606,246	$0	$606,246	3.30%
4930 - CERTIFICATION	$1,153,871	$1,082,254	$943,177	$0	$943,177	(12.85%)
4940 - PROGRAM INTEGRITY	$1,515,798	$1,174,857	$1,183,750	$0	$1,183,750	0.76%
TOTAL PROGRAM FUNDS	**$3,962,004**	**$3,478,460**	**$3,411,485**	**$0**	**$3,411,485**	**(1.93%)**
5800 - CLINICAL SERVICES DIVISION						
5810 - OFFICE OF THE CHIEF CLINICAL OFFICER	$6,508,272	$3,247,995	$2,706,701	$0	$2,706,701	(16.67%)
5830 - BEHAVIORAL HEALTH SERVICES	$447,509	$7,000	$115,681	$0	$115,681	1552.59%
5836 - BEHAVIORAL HEALTH SERVICES - PHARMACY	$1,070,521	$810,039	$202,510	$0	$202,510	(75.00%)
5840 - COMPREHENSIVE PSYCH EMER PROG-CPEP	$8,444,369	$5,145,770	$5,174,478	$0	$5,174,478	0.56%
5842 - HOMELESS OUTREACH / MOBILE CRISIS - CPEP	($44,161)	$2,000	$0	$0	$0	(100.00%)
5880 - FORENSICS	$4,376,571	$4,739,017	$4,734,130	$0	$4,734,130	(0.10%)
5890 - ASSESSMENT AND REFERRAL CENTER (ARC)	$1,869,614	$173,899	$180,634	$0	$180,634	3.87%
TOTAL PROGRAM FUNDS	**$23,750,737**	**$14,125,720**	**$13,114,134**	**$0**	**$13,114,134**	**(7.16%)**
5900 - SYSTEM TRANSFORMATION						
6500 - ADULT/TRANSITIONAL YOUTH SERVICES						
6501 - ADULT/TRANSITIONAL YOUTH SERVICES ADMIN	$126,385	$1,449,045	$465,356	$0	$465,356	(67.89%)
6502 - BEHAVIORAL HEALTH SERVICES MH/SUD	$9,272,600	$3,201,388	$3,048,535	$0	$3,048,535	(4.77%)
6503 - GOVT OPERATED SVCS 35 K ST ADULT CLINIC	$0	$2,893,517	$2,783,877	$0	$2,783,877	(3.79%)
6504 - PROVIDER RELATIONS	$1,046,225	$1,348,639	$1,252,045	$0	$1,252,045	(7.16%)
6505 - CO-LOCATED SERVICES	$578,366	$276,173	$289,175	$0	$289,175	4.71%
6506 - RESIDENTIAL SUPPORT & CONTINUITY OF SVCS	$623,788	$583,934	$582,907	$0	$582,907	(0.18%)

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
6507 - HOUSING SUPPORT SERVICES	$30,847,874	$28,397,179	$29,637,309	($873,690)	$28,763,619	1.29%
6508 - COMMUNITY RESPONSE TEAM	$5,924,495	$9,051,625	$7,937,853	$0	$7,937,853	(12.30%)
6509 - STATE OPIOID RESPONSE PROGRAM	$27,973,585	$25,698,023	$29,847,071	$0	$29,847,071	16.15%
6510 - ASSESSMENT & REFERRAL CENTER	$94,202	$2,021,089	$2,092,632	$0	$2,092,632	3.54%
6511 - ACCESS HELPLINE	$1,991,079	$2,402,116	$2,987,375	$0	$2,987,375	24.36%
6512 - SPECIALTY SERVICES	$3,595,081	$7,847,516	$7,416,635	$0	$7,416,635	(5.49%)
6513 - SUBSTANCE USE DISORDER TREATMENT SVCS	$11,340,129	$11,063,584	$10,580,628	$573,852	$11,154,480	0.82%
6514 - MHRS LOCAL ONLY	$9,727,552	$10,954,477	$10,954,476	$0	$10,954,476	(0.00%)
6515 - BEHAVIORAL HEALTH REHAB. - LOCAL MATCH	$35,046,405	$43,240,769	$61,000,966	($3,100,000)	$57,900,966	33.90%
6516 - GAMBLING ADDICTION TREATMENT & RESEARCH	$0	$200,000	$0	$0	$0	(100.00%)
TOTAL PROGRAM FUNDS	**$138,527,633**	**$150,629,075**	**$170,876,838**	**($3,399,838)**	**$167,477,000**	**11.19%**
6600 - CHILD/ADOLESCENT/FAMILY SERVICES						
6601 - CHILD/ADOLESCENT/FAMILY SERVICES ADMIN	$1,987,090	$1,751,148	$907,705	$0	$907,705	(48.17%)
6610 - BEHAVIORAL HEALTH SERVICES MH/SUD	$1,333,901	$1,532,467	$1,378,285	$0	$1,378,285	(10.06%)
6615 - SUD PREVENTION & TREATMENT	$303,168	$2,499,412	$1,267,195	$0	$1,267,195	(49.30%)
6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES	$26,680,996	$37,901,894	$38,014,743	$325,000	$38,339,743	1.16%
6625 - CRISIS SERVICES	$350,673	$1,866,544	$1,366,544	$100,000	$1,466,544	(21.43%)
6630 - COURT ASSESSMENT	$529,351	$2,169,514	$1,630,847	$0	$1,630,847	(24.83%)
6635 - EARLY CHILDHOOD SERVICES	$3,118,115	$3,643,591	$2,988,895	$0	$2,988,895	(17.97%)
6640 - SPECIALTY SERVICES	$619,831	$1,098,238	$1,166,899	($100,000)	$1,066,899	(2.85%)
6645 - GOVERNMENT OPERATED SERVICES-HOWARD ROAD	$0	$208,494	$216,507	$0	$216,507	3.84%

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
6650 - EVIDENCE BASED PRACTICES (EBP)	$0	$1,750,375	$1,493,111	($233,824)	$1,259,287	(28.06%)
TOTAL PROGRAM FUNDS	**$34,923,126**	**$54,421,677**	**$50,430,731**	**$91,176**	**$50,521,907**	**(7.17%)**
6700 - POLICY, PLANNING, & EVALUATION ADMIN						
6701 - DATA & PERFORMANCE MEASUREMENT	$0	$2,331,349	$2,062,300	$0	$2,062,300	(11.54%)
6702 - STRATEGIC PLANNING & POLICY	$847,895	$401,057	$409,361	$0	$409,361	2.07%
6703 - TRAINING INSTITUTE	$3,063,347	$1,052,433	$1,272,418	($74,944)	$1,197,474	13.78%
6704 - BEHAVIORAL HEALTH BLOCK GRANT PROGRAM	$3,875,901	$10,091,781	$2,623,198	$0	$2,623,198	(74.01%)
TOTAL PROGRAM FUNDS	**$7,787,143**	**$13,876,620**	**$6,367,278**	**($74,944)**	**$6,292,334**	**(54.66%)**
TOTAL AGENCY FUNDS	**$344,032,480**	**$370,443,433**	**$378,333,503**	**($3,515,670)**	**$374,817,833**	**1.18%**
Department of Health						
1000 - AGENCY MANAGEMENT SUPPORT						
1010 - PERSONNEL	$1,333,662	$1,507,892	$1,742,355	$0	$1,742,355	15.55%
1017 - LABOR MANAGEMENT	$156,145	$156,933	$180,829	$0	$180,829	15.23%
1020 - CONTRACTING AND PROCUREMENT	$748,505	$661,470	$785,676	$0	$785,676	18.78%
1030 - PROPERTY MANAGEMENT	$12,683,927	$19,313,004	$19,639,133	$0	$19,639,133	1.69%
1040 - INFORMATION TECHNOLOGY	$6,562,339	$3,587,150	$4,165,806	$0	$4,165,806	16.13%
1055 - RISK MANAGEMENT	$123,302	$121,644	$132,064	$0	$132,064	8.57%
1060 - LEGAL	$2,253,597	$2,625,559	$2,716,132	$0	$2,716,132	3.45%
1080 - COMMUNICATIONS	$726,545	$895,294	$956,599	$0	$956,599	6.85%
1087 - LANGUAGE ACCESS	$96,504	$100,000	$100,000	$0	$100,000	0.00%
1090 - PERFORMANCE MANAGEMENT	$14,840,660	$1,862,431	$1,700,763	$0	$1,700,763	(8.68%)
TOTAL PROGRAM FUNDS	**$39,525,186**	**$30,831,376**	**$32,119,357**	**$0**	**$32,119,357**	**4.18%**
100F - AGENCY FINANCIAL OPERATIONS						
110F - AGENCY FISCAL OFFICER OPERATIONS	$1,027,999	$1,197,291	$1,272,746	$0	$1,272,746	6.30%

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
120F - ACCOUNTING OPERATIONS	$1,055,106	$1,294,438	$1,329,845	$0	$1,329,845	2.74%
130F - ACFO	$353,723	$337,420	$358,470	$0	$358,470	6.24%
140F - AGENCY FISCAL OFFICER	$280,781	$499,332	$510,535	$0	$510,535	2.24%
TOTAL PROGRAM FUNDS	**$2,717,609**	**$3,328,480**	**$3,471,596**	**$0**	**$3,471,596**	**4.30%**
2500 - HLTH EMERG PREPAREDNESS AND RESP.ADMIN						
2540 - PUBLIC HEALTH EMERGENCY PREPAREDNESS	$3,194,461	$2,401,278	$1,502,138	$0	$1,502,138	(37.44%)
2550 - PUBLIC HEALTH EMERG. OPS. AND PGM SUPT	$473,070	$773	$462,117	$0	$462,117	59717.14%
2560 - EPIDEMIOLOGY DISEASE SURVL. AND INVESTIG	$340,287	$362,328	$339,532	$0	$339,532	(6.29%)
2570 - EMERGENCY MEDICAL SERVICES REGULATION	$212,814	$292,209	$201,301	$0	$201,301	(31.11%)
2580 - SENIOR DEPUTY DIRECTOR	$7,187,596	$4,680,418	$3,919,363	$0	$3,919,363	(16.26%)
TOTAL PROGRAM FUNDS	**$11,408,228**	**$7,737,007**	**$6,424,452**	**$0**	**$6,424,452**	**(16.96%)**
3000 - HIV/AIDS HEPATITIS STD AND TB ADMIN						
3010 - HIV/AIDS SUPPORT SERVICES	$2,045,683	$1,635,515	$2,047,423	$0	$2,047,423	25.19%
3015 - HIV/AIDS POLICY AND PLANNING	$1,176,477	$3,222,744	$3,430,210	$0	$3,430,210	6.44%
3020 - HIV HEALTH AND SUPPORT SERVICES	$31,044,082	$32,126,750	$39,975,052	$0	$39,975,052	24.43%
3030 - HIV/AIDS DATA AND RESEARCH	$2,339,063	$2,822,906	$4,165,821	$0	$4,165,821	47.57%
3040 - PREVENTION AND INTERVENTION SERVICES	$11,335,794	$11,741,234	$10,849,079	$250,000	$11,099,079	(5.47%)
3060 - DRUG ASSISTANCE PROGRAM (ADAP)	$11,216,066	$11,972,161	$9,081,291	$0	$9,081,291	(24.15%)
3070 - GRANTS AND CONTRACTS MANAGEMENT	$1,500,414	$1,082,592	$1,918,229	$0	$1,918,229	77.19%
3080 - STD CONTROL	$2,721,785	$3,361,771	$3,191,638	$0	$3,191,638	(5.06%)
3085 - TUBERCULOSIS CONTROL	$1,778,638	$1,636,062	$1,751,308	$0	$1,751,308	7.04%

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
3090 - HIV/AIDS HOUSING AND SUPPORTIVE SERVICES	$11,711,282	$13,823,136	$13,664,395	$0	$13,664,395	(1.15%)
TOTAL PROGRAM FUNDS	**$76,869,285**	**$83,424,871**	**$90,074,448**	**$250,000**	**$90,324,448**	**8.27%**
4500 - HEALTH REGULATION AND LICENSING ADMIN.						
4200 - HEALTH PROFESSIONAL LICENSE ADMIN	$9,289,690	$9,542,138	$10,184,256	$1,669,122	$11,853,378	24.22%
4515 - FOOD DRUG RADIATION AND COMM. HYGIENE	$11,680,330	$14,055,628	$11,875,724	$2,258,177	$14,133,901	0.56%
4530 - HEALTH CARE FACILITIES REGULATION	$5,307,985	$7,942,154	$8,045,422	$170,000	$8,215,422	3.44%
TOTAL PROGRAM FUNDS	**$26,278,004**	**$31,539,920**	**$30,105,402**	**$4,097,299**	**$34,202,701**	**8.44%**
7000 - OFFICE OF HEALTH EQUITY						
7010 - MULTI SECTOR COLLABORATION	$601,690	$491,387	$567,539	$0	$567,539	15.50%
7020 - COMM BASED PART. RSRCH AND PLCY EVAL.	$116,548	$225,499	$231,663	$0	$231,663	2.73%
7030 - HEALTH EQUITY PRACTICE AND PGM IMPLEMENT	$3,220	$87,759	$102,390	$0	$102,390	16.67%
TOTAL PROGRAM FUNDS	**$721,459**	**$804,645**	**$901,593**	**$0**	**$901,593**	**12.05%**
8200 - CTR FOR POLICY, PLANNING AND EVALUATION						
8240 - EPI DISEASE SURVEY & INVESTIGATION	$1,143,002	$1,909,491	$2,254,080	$0	$2,254,080	18.05%
8250 - RESEARCH EVALUATION AND MEASUREMENT	$35,992,441	$21,424,803	$24,329,152	$0	$24,329,152	13.56%
8260 - STATE CENTER HEALTH STATISTICS	$15,921,012	$5,606,144	$5,074,580	$0	$5,074,580	(9.48%)
8270 - STATE HEALTH PLANNING AND DEVELOPMENT	$1,110,652	$1,788,038	$1,582,930	$0	$1,582,930	(11.47%)
TOTAL PROGRAM FUNDS	**$54,167,108**	**$30,728,477**	**$33,240,742**	**$0**	**$33,240,742**	**8.18%**
8500 - COMMUNITY HEALTH ADMINISTRATION						
8502 - CANCER AND CHRONIC DISEASE PREVENTION	$9,484,659	$9,990,357	$9,710,496	$0	$9,710,496	(2.80%)

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
8505 - HEALTH CARE ACCESS BUREAU	$28,454,818	$11,364,178	$11,800,158	($2,211,148)	$9,589,010	(15.62%)
8506 - FAMILY HEALTH BUREAU	$35,397,007	$44,251,281	$37,868,174	$1,750,000	$39,618,174	(10.47%)
8510 - SUPPORT SERVICES	$1,807,335	$8,903,530	$9,481,382	$0	$9,481,382	6.49%
8511 - PERINATAL AND INFANT HEALTH	$295,484	$93,422	$326,381	$0	$326,381	249.36%
8513 - NUTRITION AND PHYSICAL FITNESS	$24,146,320	$20,957,721	$21,789,173	$375,000	$22,164,173	5.76%
TOTAL PROGRAM FUNDS	**$99,965,700**	**$95,560,488**	**$90,975,764**	**($86,148)**	**$90,889,616**	**(4.89%)**
TOTAL AGENCY FUNDS	**$312,315,049**	**$283,955,264**	**$292,002,208**	**$3,868,905**	**$295,871,113**	**4.20%**
Department of Health Care Finance						
1000 - AGENCY MANAGEMENT						
1010 - PERSONNEL	$1,518,285	$2,230,954	$2,047,874	$0	$2,047,874	(8.21%)
1015 - TRAINING AND DEVELOPMENT	$0	$24,013	$16,809	$0	$16,809	(30.00%)
1020 - CONTRACTING AND PROCUREMENT	$2,200,538	$2,197,640	$1,875,735	$0	$1,875,735	(14.65%)
1030 - PROPERTY MANAGEMENT	$2,866,361	$4,297,612	$4,533,618	$0	$4,533,618	5.49%
1040 - INFORMATION TECHNOLOGY	$7,521,753	$16,240,802	$19,410,559	$0	$19,410,559	19.52%
1060 - LEGAL	$981,706	$1,577,506	$1,633,025	$0	$1,633,025	3.52%
1080 - COMMUNICATIONS	$567,589	$1,436,639	$1,219,551	$0	$1,219,551	(15.11%)
1085 - CUSTOMER SERVICE	$3,019,151	$4,818,357	$4,700,046	$0	$4,700,046	(2.46%)
1087 - LANGUAGE ACCESS	$0	$10,000	$36,000	$0	$36,000	260.00%
1090 - PERFORMANCE MANAGEMENT	$18,267,369	$14,614,363	$15,389,233	$0	$15,389,233	5.30%
TOTAL PROGRAM FUNDS	**$36,942,751**	**$47,447,885**	**$50,862,451**	**$0**	**$50,862,451**	**7.20%**
100F - AGENCY FINANCIAL OPERATIONS						
110F - BUDGETING OPERATIONS	$619,728	$770,760	$740,233	$0	$740,233	(3.96%)
120F - ACCOUNTING OPERATIONS	$3,171,451	$4,996,634	$7,133,253	$0	$7,133,253	42.76%
140F - AGENCY FISCAL OFFICER	$345,255	$342,538	$356,386	$0	$356,386	4.04%
TOTAL PROGRAM FUNDS	**$4,136,435**	**$6,109,932**	**$8,229,872**	**$0**	**$8,229,872**	**34.70%**

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
2000 - HEALTHCARE DELIVERY MANAGEMENT						
2002 - MANAGED CARE MGT	$7,308,942	$11,919,846	$12,819,010	$0	$12,819,010	7.54%
2003 - PREVENTIVE AND ACUTE CARE	$1,030,292	$1,234,750	$1,564,887	$0	$1,564,887	26.74%
2004 - DIV OF QUALITY AND HEALTH OUTCOMES	$2,248,496	$3,268,061	$3,166,714	$0	$3,166,714	(3.10%)
2007 - CLINICIANS, RX AND ACUTE PROVIDER SVS	$7,173,737	$9,830,275	$9,861,474	$0	$9,861,474	0.32%
2010 - HEALTH CARE DELIVERY MGT SUPPORT SVCS	($1,032,177)	$1,372,160	$1,486,607	$0	$1,486,607	8.34%
TOTAL PROGRAM FUNDS	**$16,729,289**	**$27,625,093**	**$28,898,692**	**$0**	**$28,898,692**	**4.61%**
200L - LONG TERM CARE PROGRAM						
201L - LONG TERM CARE SUPPORT SERVICES	$11,817,479	$23,022,944	$20,934,246	$0	$20,934,246	(9.07%)
210L - OVERSIGHT	$1,659,449	$1,725,290	$1,807,223	$0	$1,807,223	4.75%
220L - OPERATIONS	$1,819,717	$1,879,279	$1,816,335	$0	$1,816,335	(3.35%)
230L - INTAKE AND ASSESSMENT	$1,075,685	$1,111,731	$1,133,956	$0	$1,133,956	2.00%
TOTAL PROGRAM FUNDS	**$16,372,329**	**$27,739,244**	**$25,691,760**	**$0**	**$25,691,760**	**(7.38%)**
3000 - HEALTHCARE POLICY AND PLANNING						
3001 - POLICY UNIT MANAGEMENT	$627,264	$815,713	$899,139	$0	$899,139	10.23%
3003 - DATA ANALYSIS	$746,856	$150,000	$215,100	$0	$215,100	43.40%
3004 - MEMBER MANAGEMENT	$1,027,375	$1,693,349	$1,301,808	$0	$1,301,808	(23.12%)
3010 - HEALTH CARE POLICY AND PLANNING SUPPORT	($392,586)	$2,624,904	$4,456,582	$55,000	$4,511,582	71.88%
TOTAL PROGRAM FUNDS	**$2,008,909**	**$5,283,966**	**$6,872,630**	**$55,000**	**$6,927,630**	**31.11%**
300A - DCAS PROGRAM MANAGEMENT ADMINISTRATION						
310A - PROGRAM MANAGEMENT	$1,171,179	$2,503,580	$3,106,084	$0	$3,106,084	24.07%
320A - PROJECT MANAGEMENT	$99,182	$10,467,997	$8,626,369	$0	$8,626,369	(17.59%)
330A - ORGANIZAIONAL CHANGE	$7,515,222	$9,270,560	$13,477,387	$0	$13,477,387	45.38%

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
340A - INFORMATION TECHNOLOGY MANAGEMENT	$40,194,309	$50,821,269	$55,099,725	($3,355,849)	$51,743,876	1.82%
TOTAL PROGRAM FUNDS	**$48,979,891**	**$73,063,407**	**$80,309,565**	**($3,355,849)**	**$76,953,716**	**5.32%**
5000 - HEALTH CARE FINANCE						
5001 - MEDICAID PROVIDER PAYMENT	$3,694,247,893	$3,276,749,506	$3,835,890,836	$1,612,280	$3,837,503,116	17.11%
5002 - MEDICAID PUBLIC PROVIDER PAYMENTS	$80,147,462	$73,359,100	$75,211,595	$0	$75,211,595	2.53%
5003 - ALLIANCE PROVIDER PAYMENTS	$157,084,195	$127,276,202	$117,199,057	$297,000	$117,496,057	(7.68%)
TOTAL PROGRAM FUNDS	**$3,931,479,550**	**$3,477,384,808**	**$4,028,301,488**	**$1,909,280**	**$4,030,210,768**	**15.90%**
6000 - HEALTH CARE OPERATIONS						
6001 - MEDICAID INFORMATION SYSTEMS	$42,487,850	$52,170,216	$51,036,289	$0	$51,036,289	(2.17%)
6006 - DIV. OF PUBLIC AND PRIVATE PROVIDER SVS	$2,950,943	$3,257,002	$3,221,722	$0	$3,221,722	(1.08%)
6010 - HEALTH CARE OPERATIONS SUPPORT	($1,079,770)	$482,849	$444,909	$0	$444,909	(7.86%)
TOTAL PROGRAM FUNDS	**$44,359,023**	**$55,910,067**	**$54,702,920**	**$0**	**$54,702,920**	**(2.16%)**
8000 - HEALTH CARE REFORM AND INNOVATION						
8002 - AFFORDABLE CARE REFORM AND GRANTS DEV.	$6,885,462	$6,829,252	$2,437,404	$625,000	$3,062,404	(55.16%)
8010 - HC REFORM AND INNOVATIVE SUPPORT SVS	$6,260,639	$9,133,090	$8,654,733	$0	$8,654,733	(5.24%)
TOTAL PROGRAM FUNDS	**$13,146,101**	**$15,962,342**	**$11,092,137**	**$625,000**	**$11,717,137**	**(26.60%)**
9960 - YR END CLOSE						
TOTAL AGENCY FUNDS	**$4,114,139,219**	**$3,736,526,743**	**$4,294,961,514**	**($766,569)**	**$4,294,194,945**	**14.92%**
Health Benefit Exchange Authority						
1000 - AGENCY MANAGEMENT						
1010 - PERSONNEL	$354,081	$360,624	$377,369	$0	$377,369	4.64%
1020 - CONTRACTS AND PROCUREMENT	$669,785	$581,146	$651,920	$0	$651,920	12.18%

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
1030 - PROPERTY MANAGEMENT	$1,291,296	$1,446,442	$1,506,499	$0	$1,506,499	4.15%
1040 - INFORMATION TECHNOLOGY	$176,336	$153,192	$158,883	$0	$158,883	3.71%
1060 - LEGAL SERVICES	$848,742	$1,134,199	$1,278,375	$0	$1,278,375	12.71%
1090 - PERFORMANCE MANAGEMENT	$5,563,621	$2,298,607	$2,392,033	$0	$2,392,033	4.06%
TOTAL PROGRAM FUNDS	**$14,371,273**	**$5,974,210**	**$6,365,078**	**$0**	**$6,365,078**	**6.54%**
100F - AGENCY FINANCIAL OPERATIONS						
110F - BUDGET OPERATIONS	$200,454	$200,318	$207,584	$0	$207,584	3.63%
120F - ACCOUNTING OPERATIONS	$198,550	$200,318	$207,584	$0	$207,584	3.63%
140F - AGENCY FISCAL OFFICER	$343,686	$405,858	$413,879	$0	$413,879	1.98%
TOTAL PROGRAM FUNDS	**$742,689**	**$806,495**	**$829,047**	**$0**	**$829,047**	**2.80%**
5000 - CONSUMER EDUCATION AND OUTREACH PROGRAM						
5010 - CONSUMER EDUC. AND OUTREACH SUPPORT SVC	$1,339,300	$1,266,130	$1,340,759	$0	$1,340,759	5.89%
5020 - MARKETING AND COMMUNICATION	$532,229	$965,576	$972,946	$0	$972,946	0.76%
5040 - NAVIGATORS COUNSELORS AND IPA	$999,100	$1,000,000	$1,050,000	$0	$1,050,000	5.00%
TOTAL PROGRAM FUNDS	**$2,870,629**	**$3,231,707**	**$3,363,705**	**$0**	**$3,363,705**	**4.08%**
7000 - MARKETPLACE INNOVATION POLICY AND OPS						
7010 - CONTACT CENTER	$2,034,669	$4,220,103	$3,906,947	$0	$3,906,947	(7.42%)
7020 - PLAN MANAGEMENT	$2,212,530	$2,353,981	$2,235,723	$0	$2,235,723	(5.02%)
7030 - ELIGIBILITY AND ENROLLMENT	$855,719	$1,339,206	$1,785,931	$0	$1,785,931	33.36%
7040 - MEMBER SERVICES	$1,527,074	$1,782,832	$1,977,168	$0	$1,977,168	10.90%
7050 - DATA ANALYTICS AND REPORTING	$132,369	$177,574	$182,253	$0	$182,253	2.64%
7060 - S.H.O.P OPERATIONS	$2,591,482	$3,451,930	$3,680,894	$0	$3,680,894	6.63%
TOTAL PROGRAM FUNDS	**$9,353,844**	**$13,325,626**	**$13,768,917**	**$0**	**$13,768,917**	**3.33%**
8000 - IT RELATED OPERATIONS						
8010 - IT RELATED OPERATIONS	$12,319,413	$12,346,018	$13,225,400	$0	$13,225,400	7.12%

Activity	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	Committee % Change (FY24 Committee vs FY23 Approved)
TOTAL PROGRAM FUNDS	**$12,319,413**	**$12,346,018**	**$13,225,400**	**$0**	**$13,225,400**	**7.12%**
TOTAL AGENCY FUNDS	**$39,657,848**	**$35,684,055**	**$37,552,148**	**$0**	**$37,552,148**	**5.24%**
Not-for-Profit Hospital Corporation						
1000 - NOT FOR PROFIT HOSPITAL CORPORATION						
1001 - NOT FOR PROFIT HOSPITAL CORPORATION	$0	$155,000,000	$155,000,000	$0	$155,000,000	0.00%
TOTAL PROGRAM FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**	**0.00%**
TOTAL AGENCY FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**	**0.00%**
Not-for-Profit Hospital Corporation Subsidy						
1000 - NOT FOR PROFIT HOSPITAL CORP. SUBSIDY						
1100 - NOT FOR PROFIT HOSPITAL CORP. SUBSIDY	$22,000,000	$15,000,000	$15,000,000	$0	$15,000,000	0.00%
TOTAL PROGRAM FUNDS	**$22,000,000**	**$15,000,000**	**$15,000,000**	**$0**	**$15,000,000**	**0.00%**
TOTAL AGENCY FUNDS	**$22,000,000**	**$15,000,000**	**$15,000,000**	**$0**	**$15,000,000**	**0.00%**
Office of the Deputy Mayor for Health and Human Services						
1000 - AGENCY MANAGEMENT						
1090 - PERFORMANCE MANAGEMENT ACTIVITY	$1,920,119	$2,343,376	$2,183,229	($111,338)	$2,071,891	(11.59%)
TOTAL PROGRAM FUNDS	**$1,920,119**	**$2,343,376**	**$2,183,229**	**($111,338)**	**$2,071,891**	**(11.59%)**
2000 - HUMAN SUPPORT SERVICES						
2010 - AGENCY OVERSIGHT AND SUPPORT	$328,799	$517,841	$405,671	$0	$405,671	(21.66%)
TOTAL PROGRAM FUNDS	**$328,799**	**$517,841**	**$405,671**	**$0**	**$405,671**	**(21.66%)**
TOTAL AGENCY FUNDS	**$2,309,458**	**$2,861,218**	**$2,588,900**	**($111,338)**	**$2,477,562**	**(13.41%)**
GRAND TOTAL	**$4,836,054,054**	**$4,599,470,713**	**$5,175,438,271**	**($524,672)**	**$5,174,913,599**	**12.51%**

D. FY 2024 Agency Full-Time Equivalents

Fund Type	FY 2022 Actuals	FY 2023 Approved	Mayor's FY 2024 Proposed	Committee Variance	Committee FY 2024 Approved	% Change (FY24 Committee vs FY23 Approved)
Department of Behavioral Health						
LOCAL FUND	1,104.78	1,225.90	1,203.79	0.00	1,203.79	(1.80%)
FEDERAL PAYMENTS	55.00	55.00	54.00	0.00	54.00	(1.82%)
FEDERAL GRANT FUND	75.57	147.53	150.02	0.00	150.02	1.69%
FEDERAL MEDICAID PAYMENTS	3.44	3.50	7.19	0.00	7.19	105.43%
SPR FUNDS	13.05	16.50	16.50	0.00	16.50	0.00%
INTRA-DISTRICT FUNDS	59.88	0.00	0.00	0.00	0.00	*0.00%*
TOTAL FTE	**1,311.72**	**1,448.43**	**1,431.50**	**0.00**	**1,431.50**	**(1.17%)**
Department of Health						
LOCAL FUND	148.24	188.10	190.38	6.25	196.63	4.53%
FEDERAL GRANT FUND	309.96	425.20	455.85	0.00	455.85	7.21%
PRIVATE GRANT FUND	0.47	0.00	0.00	0.00	0.00	*0.00%*
SPR FUNDS	121.89	144.11	143.36	0.00	143.36	(0.52%)
INTRA-DISTRICT FUNDS	4.66	0.00	0.00	0.00	0.00	*0.00%*
TOTAL FTE	**585.22**	**757.41**	**789.59**	**6.25**	**795.84**	**5.07%**
Department of Health Care Finance						
LOCAL FUND	101.52	172.08	165.04	0.00	165.04	(4.09%)
DEDICATED TAXES	4.10	6.52	8.17	0.00	8.17	25.31%
FEDERAL GRANT FUND	0.00	2.00	0.00	0.00	0.00	(100.00%)
FEDERAL MEDICAID PAYMENTS	146.74	182.09	177.84	0.00	177.84	(2.33%)
SPR FUNDS	12.25	16.15	15.60	0.00	15.60	(3.41%)
INTRA-DISTRICT FUNDS	3.63	0.00	0.00	0.00	0.00	*0.00%*
TOTAL FTE	**268.24**	**378.84**	**366.65**	**0.00**	**366.65**	**(3.22%)**
Health Benefit Exchange Authority						
ENTERPRISE AND OTHER FUNDS	103.69	117.00	123.00	0.00	123.00	5.13%
TOTAL FTE	**103.69**	**117.00**	**123.00**	**0.00**	**123.00**	**5.13%**
Not-for-Profit Hospital Corporation						
ENTERPRISE AND OTHER FUNDS	0.00	0.00	0.00	0.00	0.00	*0.00%*
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	***0.00%***
Not-for-Profit Hospital Corporation Subsidy						
LOCAL FUND	0.00	0.00	0.00	0.00	0.00	*0.00%*
TOTAL FTE	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	***0.00%***
Office of the Deputy Mayor for Health and Human Services						
LOCAL FUND	14.92	14.75	13.75	(1.00)	12.75	(13.56%)
INTRA-DISTRICT FUNDS	3.65	0.00	0.00	0.00	0.00	*0.00%*
TOTAL FTE	**18.57**	**14.75**	**13.75**	**(1.00)**	**12.75**	**(13.56%)**
GRAND TOTAL	**2,287.44**	**2,716.43**	**2,724.49**	**5.25**	**2,729.74**	**0.49%**

E. FY 2024 - 2029 AGENCY CAPITAL BUDGETS

Owner Agency	Old Project No	Project Title	Scenario	Existing Balances	FY 2024 Planned Allotment	FY 2025 Planned Allotment	FY 2026 Planned Allotment	FY 2027 Planned Allotment	FY 2028 Planned Allotment	FY 2029 Planned Allotment	FY 2024-FY 2029 Total Planned Allotment
HT0-DEPARTMENT OF HEALTHCARE FINANCE	UMV01C	SAINT ELIZABETHS MEDICAL CENTER	Mayor's Prop. FY24-FY29 CIP	0	125,500,000	0	0	0	0	0	125,500,000
			Existing Balances	141,849,463	0	0	0	0	0	0	0
	DIM01C	ENTERPRISE DATA INTEGRATION SYSTEM/MEDIC	Mayor's Prop. FY24-FY29 CIP	0	860,810	0	0	0	0	0	860,810
			Existing Balances	12,709,546	0	0	0	0	0	0	0
	CM103C	CLINICAL CASE MANAGEMENT SYSTEM REFRESH	Mayor's Prop. FY24-FY29 CIP	0	200,000	0	0	0	0	0	200,000
			Existing Balances	200,000	0	0	0	0	0	0	0
	MPM05C	MEDICAID DATA WAREHOUSE- GO BOND	Existing Balances	2,582,613	0	0	0	0	0	0	0
	CM102C	REPLACE CASE MANAGEMENT SYSTEM	Existing Balances	1,113,405	0	0	0	0	0	0	0
	PBM01C	PHARMACY BENEFIT MANAGER SYSTEM REFRESH	Existing Balances	360,000	0	0	0	0	0	0	0
	UMC02C	UNITED MEDICAL CENTER IMPROVEMENTS	Existing Balances	3,049,433	0	0	0	0	0	0	0
	MES12C	MES - FEDERAL MATCH	Existing Balances	28,198,642	0	0	0	0	0	0	0
	PDM01C	PROVIDER DATA MANAGEMENT SYSTEM REFRESH	Existing Balances	400,000	0	0	0	0	0	0	0
	MES23C	DCAS RELEASE 3	Existing Balances	10,456,867	0	0	0	0	0	0	0
	MPM03C	MMIS UPGRADED SYSTEM	Existing Balances	81,246,691	0	0	0	0	0	0	0
HT0-DEPARTMENT OF HEALTHCARE FINANCE Total				**282,166,661**	**126,560,810**	**0**	**0**	**0**	**0**	**0**	**126,560,810**
RM0-DEPARTMENT OF BEHAVIORAL HEALTH	RM0SCC	SECOND STABILIZATION AND SOBERING CENTER	Mayor's Prop. FY24-FY29 CIP	0	9,500,000	0	0	0	0	0	9,500,000
	DB202C	THERMAL DOCKING STATION SYSTEM	Existing Balances	1,755,000	0	0	0	0	0	0	0
	XA655C	AVATAR UPGRADE	Existing Balances	10,721	0	0	0	0	0	0	0
	HX703C	DBH FACILITIES SMALL CAPITAL IMPROVEMENT	Existing Balances	626,184	0	0	0	0	0	0	0
	HX201C	ST. ELIZABETHS GENERAL IMPROVEMENTS (HX2	Existing Balances	1	0	0	0	0	0	0	0
	HX805C	VEHICLE ACQUISITION-DBH	Existing Balances	30,161	0	0	0	0	0	0	0
	HX999C	SERVER ROOM AND DATA WAREHOUSE	Existing Balances	1,000,000	0	0	0	0	0	0	0
	HX990C	FACILITY UPGRADES	Existing Balances	12,874,327	0	0	0	0	0	0	0
	HX992C	ST. ELIZABETHS HOSPITAL EHR CAP IMPROVME	Existing Balances	226,570	0	0	0	0	0	0	0
	DB203C	INTERCOM SYSTEM	Existing Balances	655,000	0	0	0	0	0	0	0
	HX993C	PHARMACY MEDICINE DISPENSING UPGRADE (PY	Existing Balances	184,400	0	0	0	0	0	0	0
	HX998C	HVAC MODERNIZATION AT SAINT ELIZABETHS H	Existing Balances	1,825,000	0	0	0	0	0	0	0
	HX995C	ELECTRONIC HEALTH RECORD SYSTEMS REPLACE	Existing Balances	3,283,986	0	0	0	0	0	0	0
	HX501C	NEW MENTAL HEALTH HOSPITAL	Existing Balances	62,500	0	0	0	0	0	0	0
	HX997C	FLOORING REPLACEMENT	Existing Balances	699,944	0	0	0	0	0	0	0
RM0-DEPARTMENT OF BEHAVIORAL HEALTH Total				**23,233,793**	**9,500,000**	**0**	**0**	**0**	**0**	**0**	**9,500,000**
HC0-DEPARTMENT OF HEALTH	HFL24C	FLEET REPLACEMENT	Mayor's Prop. FY24-FY29 CIP	0	493,483	239,028	246,199	253,585	348,257	841,112	2,421,665
	HC102C	DC ANIMAL SHELTER RENOVATION & EXPANSIO	Existing Balances	4,162,500	0	0	0	0	0	0	0
	FSH01C	FOOD SAFETY AND HYGIENE INSPECTION SERVI	Existing Balances	250,000	0	0	0	0	0	0	0
	RA840C	APRA PATIENT RECORDS SYSTEM	Existing Balances	16,751	0	0	0	0	0	0	0
	NAS23C	FUTURE DC HEALTH ANIMAL SHELTER	Existing Balances	4,500,000	0	0	0	0	0	0	0
HC0-DEPARTMENT OF HEALTH Total				**8,929,251**	**493,483**	**239,028**	**246,199**	**253,585**	**348,257**	**841,112**	**2,421,665**
Grand Total				**314,329,705**	**136,554,293**	**239,028**	**246,199**	**253,585**	**348,257**	**841,112**	**138,482,475**

F. TRANSFERS IN FROM OTHER COMMITTEES

Sending Committee	*Amount*	*FTEs*	*Receiving agency*	*Program*	*Purpose*	*Recurring or One-Time*
Public Works and Operations	$ 225,000		Department of Health Care Finance	8000/8002/0050	To fund BSA Subtitle: First time home visiting grants to DHCF	One Time
Public Works and Operations	$ 200,000		Department of Behavioral Health	6500/6513/0050	To fund BSA Subtitle Substance Abuse Targeted Outreach Pilot at T Street Plaza and Ward 5 Location	One Time
Transportation and the Environment	$ 150,000		Department of Health	8500/8513/0050	Restore Healthy Food Access Grants to FY2023 levels--Healthy Corners	One Time
Transportation and the Environment	$ 25,000		Department of Health	8500/8513/0050	Restore Healthy Food Access Grants to FY2023 levels--Nutritional Home Delivery of Meals	One Time
Transportation and the Environment	$ 200,000		Department of Health	8500/8513/0050	Restore Healthy Food Access Grants to FY2023 levels--Produce Plus	One Time
Transportation and the Environment	$ 170,000		Department of Health	4500/4530/0041	DC Health implementation of legislatively required dementia training for direct care workers	One Time
Total	$ 970,000					

G. TRANSFERS OUT TO OTHER COMMITTEES

Receiving Committee	*Amount*	*FTEs*	*Receiving agency*	*Program*	*Purpose*	*Recurring or One-Time*
Business and Economic Development	$ 50,000		Department of Insurance, Securities and Banking	2000/2080/0041	Implementation of B25-034 Expanding Access to Fertility Treatment Amendment Act of 2022 pending approval by Council: DISB Counsel and Actuary Study	One Time
Recreation Libraries and Youth Affairs	$ 433,410		District of Columbia Public Library	6160 Special Purpose Revenue Fund	Restore Mayor's Sweep of SPR DCPL Revenue Generating Fund	One Time
Recreation Libraries and Youth Affairs	$ 21,425		District of Columbia Public Library	L400/L410/0020	Restore Mayor's cut to custodial maintenance DCPL	Recurring
Recreation Libraries and Youth Affairs	$ 608,017		District of Columbia Public Library	L400/L410/0020	Restore Mayor's cut to custodial maintenance DCPL	Recurring
Housing	$ 500,000		Department of Human Services	5000/5014/0050	To enhance the FY24 amount for the Emergency Rental Assistance Program	One Time
Judiciary and Public Safety	$ 350,000		Office of Victim Services and Justice Grants	3000/3010/0050	To enhance Access to Justice Initiatives at the Office of Victim Services and Justice Grants	One Time
Recreation Libraries and Youth Affairs	$ 100,000		Department of Parks and Recreation	1000/1020/0050	To provide a one-time grant to the organization Horton's Kids, which serves Ward 8 students, including mental health supports, high impact tutoring, and violence intervention	One Time
Committee of the Whole	$ 621,747		OSSE	E500/E505/0050	To partially restore reductions to the Healthy Schools Fund	One Time
Committee of the Whole	$ 200,620		OSSE	E500/E505/0050	To partially restore reductions to the Healthy Schools Fund	Recurring
Public Works and Operations	$ 50,000		Department of Public Works	5000/5010/0041	To fund self-release boots at the Department of Public Works	One Time
Total	$ 1,822,367					

H. REVENUE ADJUSTMENTS

Agency	*Fund Type*	*Amount*	*Description*	*Legislation*

I. FUNDING OF LEGISLATION

Bill, Law, or Subtitle #	*Status*	*Agency*	*Attributes*	*FY 2024 Amount*	*FTEs*
L24-313 High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022	Law Effective March 10, 2023, subject to Appropriations	DC Health	4500/4200/0041 4500/4200/0011 4500/4200/0014	$1,419,789	1.0
L23-201 Dementia Training for Direct Care Workers Act of 2019	Law Effective April 2, 2021, subject to Appropriations	DC Health	4500/4530/0041	$170,000	0.0
B25-68 Street Vendor Advancement Amendment Act of 2023	Under Mayoral Review	DC Health	4500/4515/0012	$174,960	2.0
B25-034 Expanding Access to Fertility Treatment Amendment Act of 2023	Under Council Review	Department of Health Care Finance	5000/5003/F600/0050 500/5001/F020/0050	$1,640,000 ($940,000 federal)	0.0
FY 2024 Budget Support Act of 2023, Title V, Subtitle X. School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023	Proposed in BSA	Department of Behavioral Health	6600/6620/0050	$325,000	0.0
FY 2024 Budget Support Act of 2023, Title V, Subtitle X. First-Time Mothers Home Visiting Program	Proposed in BSA	Department of Health Care Finance	8000/8002/R420/50	$225,000	0.0
FY 2024 Budget Support Act of 2023, Title V, Subtitle X. Substance Abuse and Behavioral Health Targeted Outreach Pilot	Proposed in BSA	Department of Behavioral Health	6500/6513/0050	$600,000	0.0
FY 2024 Budget Support Act of 2023, Title V, Subtitle X. Department of Health Care Finance Reporting Requirements	Proposed in BSA	Department of Health Care Finance	3000/3010/0041	$55,000	0.0

J. SUMMARY OF COMMITTEE BUDGET RECOMMENDATIONS

Please see Attachment A for a spreadsheet detailing all the changes made to agencies under the committee's purview.

II. AGENCY FISCAL YEAR 2024 BUDGET RECOMMENDATIONS

A. INTRODUCTION

The Committee on Health is responsible for responsible for matters concerning health, including environmental health; the regulation of health occupations and professions, and health care inspectors; and joint jurisdiction with the Committee on Hospital and Health Equity on matters and agencies within the purview of the Committee on Hospital and Health Equity.

The following agencies are within the jurisdiction of the Committee:

- Department of Health
- Department of Behavioral Health
- Department of Health Care Finance
- Office of the Deputy Mayor for Health and Human Services
- Not-for-Profit Hospital Corporation (United Medical Center)
- DC Health Benefit Exchange Authority

The Committee also oversees the following Boards and Commissions. These entities do not have their own budget chapters, but many have dedicated funding within the agencies listed above:

- Advisory Committee on Acupuncture
- Advisory Committee on Anesthesiologist Assistants
- Advisory Committee on Clinical Laboratory Practitioners
- Advisory Committee on Naturopathic Medicine
- Advisory Committee on Physician Assistants
- Advisory Committee on Polysomnography
- Advisory Committee on Surgical Assistants
- Boards of Allied Health
- Board of Audiology and Speech-Language Pathology
- Board of Behavioral Health
- Board of Chiropractic
- Board of Dentistry
- Board of Dietetics and Nutrition
- Board of Long-Term Care Administration
- Board of Marriage and Family Therapy
- Board of Massage Therapy
- Board of Medicine
- Board of Nursing
- Board of Occupational Therapy
- Board of Optometry
- Board of Pharmacy

- Board of Physical Therapy
- Board of Podiatry
- Board of Professional Counseling
- Board of Psychology
- Board of Respiratory Care
- Board of Social Work
- Board of Veterinary Medicine
- Cedar Hill Hospital on the St. Elizabeth's Campus
- Commission on Health Disparities
- Commission on Health Equity
- Commission on HIV/AIDS
- Committee on Metabolic Disorders
- Council on Physical Fitness, Health, and Nutrition
- Food Policy Council
- Health Information Exchange Policy Board
- Health Literacy Council
- Medicaid Reserve
- Mental Health Planning Council
- Metropolitan Washington Regional Ryan White Planning Council
- Perinatal and Infant Health Advisory Committee
- Statewide Health Coordinating Council

The Committee is chaired by Councilmember Christina Henderson. The other members of the Committee are Councilmembers Charles Allen, Vincent C. Gray, Brianne K. Nadeau, and Zachary Parker.

The Committee held performance and budget oversight hearings for the agencies under its purview on the following dates:

Performance Oversight Hearings	
February 1, 2023	DC Health Benefit Exchange Authority; Department of Behavioral Health (public witnesses only)
February 9, 2023	Not-for-Profit Hospital Corporation – United Medical Center; Department of Behavioral Health (government witnesses only)
February 16, 2023	Deputy Mayor for Health and Human Services; Department of Health Care Finance
February 28, 2023	Board of Medicine; Board of Nursing; Board of Pharmacy; Board of Psychology; Board of Social Work
March 2, 2023	Department of Health

Budget Oversight Hearings	
March 30, 2023	DC Health Benefit Exchange Authority Not-for-Profit Hospital Corporation – United Medical Center Department of Behavioral Health (public witnesses only)
April 5, 2023	Department of Health Care Finance Deputy Mayor for Health and Human Services
April 6, 2023	Department of Behavioral Health (government witnesses only)
April 10, 2023	Department of Health (public witnesses only)
April 12, 2023	Department of Health (government witnesses only)

The Committee received important comments from members of the public during these hearings. Copies of witness testimony are included in this report as *Attachments C through G*. A video recording of the hearings can be obtained through the Office of Cable Television or at *oct.dc.gov*. The Committee continues to welcome public input on the agencies and activities within its purview.

B. DEPARTMENT OF HEALTH (HC0)

1. AGENCY MISSION & OVERVIEW

The District of Columbia Department of Health (DC Health) promotes health, wellness, and equity across the District, and protects the safety of residents, visitors, and those doing business in our nation's capital.

The Department of Health provides programs and services with the ultimate goal of reducing the burden of disease and improving opportunities for health and well-being for all District residents and visitors. DC Health does this through a number of mechanisms that center around prevention, promotion of health, expanding access to health care, and increasing health equity. The department provides public health management and leadership through policy, planning, and evaluation; fiscal oversight; human resource management; grants and contracts management; information technology; government relations; risk management; communication and community relations; legal oversight; and facilities management. The DC Health performance plan is based on three priority areas: (1) health and wellness promotion, (2) promoting health equity, and (3) public health systems enhancement.

The Department of Health operates through the following 9 divisions:

Health Emergency Preparedness and Response Administration (HEPRA) – provides regulatory oversight of Emergency Medical Services and ensures that DOH and its partners are prepared to respond to citywide medical and public health emergencies, such as those resulting from terrorist attacks, large accidents, or natural events such as weather-related emergencies.

This division contains the following 5 activities:

- Public Health Emergency Preparedness
- Public Health Emergency Operations and Program Support
- Epidemiology Disease Surveillance and Investigation
- Emergency Medical Services Regulation
- Office of the Senior Deputy Director

HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) – partners with health and community-based organizations to provide HIV/AIDS, hepatitis, STD, and TB prevention and care services. Services include prevention tools and interventions, medical care and supportive services, housing services for persons living with HIV/AIDS, HIV counseling and testing, and data and information on disease-specific programs and services. Furthermore, the administration provides information on the impact of these diseases on the community as well as education, referrals, and intervention services. The AIDS Drug Assistance Program (ADAP) provides drugs at no cost to eligible District residents who are HIV-positive or have AIDS. HAHSTA administers the District's budget for HIV/AIDS, hepatitis, STD, and TB programs; provides grants to service providers; provides direct

services for TB and STDs; monitors programs; and tracks the rates of HIV, hepatitis, STDs, and TB in the District of Columbia.

This division contains the following 10 activities:

- HIV/AIDS Support Services
- HIV/AIDS Policy and Planning
- HIV Health and Support Services
- HIV/AIDS Data and Research
- Prevention and Intervention Services
- AIDS Drug Assistance Program (ADAP)
- Grants and Contracts Management
- Sexually Transmitted Disease (STD) Control
- Tuberculosis Control
- HIV/AIDS Housing and Supportive Services

Health Regulation and Licensing Administration (HRLA) – is comprised of the Office of Health Professional Licensing Boards, the Office of Health Care Facilities, the Office of Food, Drug, Radiation and Community Hygiene, and HRLA Support services.

This division contains the following 3 activities:

- Office of Health Professional License Administration
- Office of Food, Drug, Radiation and Community Hygiene Regulation
- Office of Health Care Facilities Regulation

Office of Health Equity (OHE) – works to address the root cause of health disparities, beyond health care, and health behaviors by supporting projects, policies and research that will enable every resident to achieve their optimal level of health. The Office achieves its mission by informing, educating, and empowering people about health issues and facilitating multi-sector partnerships to identify and solve community health problems related to the social determinants of health. As the newest division of DC Health, this Office is charged with providing leadership to the evidence-based paradigm and practice change effort essential to promoting and achieving health equity, including practitioners not only within DC Health, but across District government, as well as with other public, private and non-profit entities, including community residents.

This division contains the following 3 activities:

- Multi Sector Collaboration
- Community Based Participatory Research and Policy Evaluation
- Health Equity Practice and Program Implementation

Center for Policy, Planning, and Evaluation (CPPE) – is responsible for developing an integrated public health information system to support health policy decisions, state health planning activities, performance analysis, and direction setting for department programs;

health policy, health planning and development; health research and analysis; vital records; disease surveillance and outbreak investigation; and planning, directing, coordinating, administering, and supervising a comprehensive Epidemiology and Health Risk Assessment program, which involves federal, state, county, and municipal functions.

This division contains the following 4 activities:

- Epidemiology Disease Surveillance and Investigation
- Research, Evaluation, and Measurement
- State Center for Health Statistics
- State Health Planning and Development

Community Health Administration (CHA) – promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of mortality and morbidity in the District. CHA focuses on nutrition and physical fitness promotion; cancer and chronic disease prevention and control; access to quality health care services, particularly medical and dental homes; and the health of families across the lifespan. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change.

This division contains the following 6 activities:

- Cancer and Chronic Disease Prevention
- Health Care Access Bureau
- Family Health Bureau
- Support Services
- Perinatal and Infant Health
- Nutrition and Physical Fitness

Public Health Laboratory – provides testing of biological and chemical samples that relate to public health and safety, such as infectious diseases, hazardous chemicals, or biological contamination, up to and including biological or chemical terrorist attacks. This is a new division of DC Health being proposed in the FY2024 budget.

This division contains the following 2 activities:

- Administrative and Support Services
- Laboratory Services

Agency Management – provides for administrative support and the required tools to achieve operational and programmatic results. This division is standard for all agencies using performance-based budgeting.

Agency Financial Operations – provides comprehensive and efficient financial management services to, and on behalf, of District agencies so that the financial integrity of

the District of Columbia is maintained. This division is standard for all agencies using performance-based budgeting.

2. COMMITTEE BUDET RECOMMENDATIONS

a. Fiscal Year 2024 Operating Budget Recommendations

The Mayor's FY 2024 proposed operating budget for DC Health is $292,002,208, which represents a 2.8% increase compared with the approved FY 2023 budget. This is largely due to the transfer of the Public Health Laboratory from the Department of Forensic Sciences to DC Health, including the Laboratory's 31.0 FTEs, and an increase of federal grant funds of $15,204,778 and 30.6 FTEs. The FY 2024 funding supports a total of 789.6 FTEs at DC Health, a 4.2% increase from the FY 2023 approved level.

Public Health Laboratory

The Mayor's proposed FY 2024 Budget Support Act of 2023 transfers the Public Health Laboratory (PHL) from the Department of Forensic Sciences (DFS) to DC Health. This would align the District with 45 other states whose public health laboratories are located within their public health agencies. During the budget hearing, DC Health has testified that this transfer will allow DC Health to better respond to public health emergencies and creates efficiencies in funding, since most federal funding for the PHL must come through DC Health to be transferred through MOUs to DFS. Under this new model, DC Health will keep the federal funding in house. Although the Committee is generally supportive of the transfer, it urges the Executive to resolve several outstanding issues related to the transition.

Currently, the PHL is part of the combined Forensic Sciences and Public Health Laboratory at DFS, located in a state-of-the-art facility that opened in 2012.[1] After this transition, the PHL would remain in the facility, but be under the oversight and management of DC Health. The stated purpose of co-locating these laboratories in 2012 was to "improve efficiency, delivery, and customer service" and to increase efficiencies around operations, facilities, equipment, security, and other shared costs. The Committee is concerned that there has been very little discussion within DC Health and between DC Health and DFS about what this transition will mean. In its pre-hearing written responses, DC Health stated that it will be conducting an organizational assessment for the PHL and exploring how to use the PHL to support other agency activities. The Committee urges the agency to include in its assessment an analysis of the best way to coordinate with DFS going forward on aspects of the colocation of facilities, including related to shared equipment, fixed facility and security costs, and how the laboratories will interact with each other going forward.

Further, the proposed budget includes the transfer of $4.69 million and 31 FTEs for the PHL from DFS to DC Health, including 12 vacant FTEs. This high vacancy rate for a state public health laboratory is concerning, particularly because DC Health has been given no additional

[1] Shelow, Taitia. "D.C. Facility Consolidates Public Health, Medical Examiner, and Forensic Sciences." *Tradeline*, (Oct. 2013), *available at*: https://www.tradelineinc.com/reports/2013-10/dc-facility-consolidates-public-health-medical-examiner-and-forensic-sciences (accessed Apr. 24, 2023).

administrative resources for recruiting and hiring for these vacant positions, retaining the current staff, or providing other supports like IT assistance. These administrative challenges will be more complex given the location of the PHL separate from the rest of the agency. DFS is also retaining 9 FTEs from the PHL that are funded by the federal Department of Homeland Security's (DHS) BioWatch program, until DHS signs off on the transfer of the positions. This division of PHL staff and supervisors across two agencies will likely cause additional confusion. The Committee urges DC Health to include in its organizational assessment a thorough organizational strategy and chart, and recommendations for recruiting and retaining high quality PHL staff. To this end, the Committee is amending the proposed BSA subtitle to include a reporting requirement for DC Health to provide the final organizational assessment to Council, with detailed plans for the staffing and operations of the PHL.

The Committee was surprised to learn that the Mayor swept most of the salary and fringe funding ($1,006,440 out of $1,398,686) from the 12 vacant FTEs within the PHL being transferred to DC Health. Although DC Health testified that the PHL will have no disruptions to operations, this sweep seems to illustrate that the Mayor believes the transition will lead to significant delays in filling vacancies and a general slowdown of operations. Given that the Mayor acknowledges that these positions will not likely be filled in FY 2024, **the Committee recommends a reduction of the remaining $392,246 in recurring funding for Program 8600 Public Health Laboratory, Activity 8620 Laboratory Services, CSG 11, to increase vacancy savings.**

DC Health's FY 2024 proposed budget includes the transfer of $4.9M of federal grant funding to DFS through MOUs for the PHL. At the budget oversight hearing, DC Health testified that this transfer will not be required now that the PHL is being transferred to DC Health. DC Health provided the correct accounting lines for this federal grant funding, and the Council Budget Office will move the funding to the correct line before the budget is finalized.

Health Professional Licensing Boards

The Health Regulation and Licensing Administration within DC Health oversees the District's Health Professional Licensing Boards, including establishing the qualifications and process for health professionals to be licensed in the District. The Committee regularly hears from health professionals who are frustrated with the licensing process, complaining that it takes too long or requires documentation that is difficult or impossible to procure from other states. The Committee applauds DC Health staff on their efforts to improve the online portal and the process for health professional licensure but believes the agency does not have the adequate staff to ensure timely processing of applications. This is why the Committee added 10 FTEs to support the licensing boards in the FY2023 approved budget. During the performance oversight hearings, DC Health also acknowledged that this office is underfunded, requesting additional FTEs including:

- 3-4 Health Licensing Specialists (HLS) that would focus solely on compliance and discipline which would allow their colleagues the opportunity to focus completely on licensure;
- A dedicated customer service team of specialists;
- A Business Analyst (BA) for all of Health Professional Boards; and

- Additional staff for the three Behavioral Health Boards: the Board of Social Work, the Board of Psychology, and the Board of Professional Counseling.

The FY 2024 proposed budget does not add any of these staffing requests and instead cuts three vacant positions (2.25 FTEs), one of which this Committee added last year, from the Health Professional Licensing Boards:

- Grade 12 Complaint Coordinator (Supports all boards)
- Grade 12 Supervisory Health Licensing Specialist (Supports Board of Medicine)
- Grade 12 Investigator (Supports all boards)

As the District considers other ways of incentivizing more health professionals to become licensed in DC, such as entering regional or national licensing compacts and amending examination requirements for social workers, it is particularly essential that the staff tasked with overseeing these licenses is adequately staffed. **Therefore, the Committee recommends an enhancement in recurring local funds of $203,869 in CSG 11 and $45,464 in CSG 14 for Program 4500 Health Regulation and Licensing Admin., Activity 4200 Health Professional License Admin, to restore salaries and fringe benefits for the 2.25 FTEs to help with processing health professional licensing applications.** Specifically, this restores positions 106919 Complaint Coordinator; 42425 Health Services Program Coordinator; and 92179 Investigator.

The Committee also recommends the following enhancements in recurring funding for Program 4500 Health Regulation and Licensing Admin, Activity 4200 Health Professional License Admin, to fully fund L24-0313, the High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022: $1,300,000 in CSG 41, $97,947 in CSG 11, and $21,842 in CSG 14. This legislation creates a High Need Healthcare Career Scholarship and Supports program available for costs related to education, training, transportation, and examinations. The program would preference District residents, those who agree to be educated in the District, and those who demonstrate a desire to reside in the District. The Act requires that those who benefit from this program must commit to working in the healthcare industry in the District for at least two years. The Act lists specific careers that would be designated as a high-need healthcare career eligible for participation for this scholarship, but also allows the Mayor the flexibility needed to add or remove listed health care careers.

The Committee urges DC Health to implement the legislation in a timely manner. According to the Financial Impact Statement for the legislation,[2] funding will be used to pay for credentialing expenses for 150 nursing assistive personnel, 25 emergency medical technicians (EMT), and 25 Paramedics. DC Health will continue to add individuals to the program over a three-year span with a targeted total of 600 nursing assistive personnel, 75 EMTs, and 75

[2] Lee, Glen. "Memorandum to Chairman Mendelson: Fiscal Impact Statement – Bill 24-903, High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022." (Nov. 15, 2022) *available at*: https://lims.dccouncil.gov/downloads/LIMS/51036/Other/B24-0943-FIS_-_High_Need_Healthcare_Career_Scholarship.pdf (accessed Apr. 24, 2023).

paramedics by fiscal year 2026. DC Health also needs to hire a program specialist to administer the program.

	FY 2024	FY 2025	FY 2026	FY 2027	Total
Health Professional Recruitment Fund Enhancement	$1,300	$1,675	$1,675	$0	$4,650
Salary	$91	$92	$94	$96	$373
Fringe	$19	$20	$21	$22	$82
Total	$1,410	$1,788	$1,790	$118	$5,105

Table provided via email by Kevin Lang, Office of the Chief Financial Officer, April 5, 2023.

Food Safety

The Food Division (FD) within DC Health's Health Regulation and Licensing Administration regulates food services that are provided in commission merchants, delicatessens, bakeries, candy manufacturers, grocery stores, retail markets, ice cream manufacturers, restaurants, wholesale markets, mobile vendors, cottage food businesses, and hotel kitchens. FD is responsible for inspecting the approximately 6,500 food establishments in the District for routine inspections as well as responding to complaints. At the FY 2022 performance oversight hearing, DC Health testified that the 16 FTEs allocated for FD are insufficient for conducting the required food safety inspections, and that in FY 2022 the Division only conducted the required annual inspection for about one third (2,374) of food establishments. DC Health also testified that FD sanitarian positions are some of the hardest positions to fill at the agency, given the specialized experience needed and the requirement of night and weekend hours.

Instead of providing recruiting or retention incentives for these positions, the Mayor's FY 2024 proposed budget sweeps two of FD's vacant FTEs, bringing the total workforce for this Division to just 14 FTEs. When asked about this cut, DC Health responded that the agency will have to select which food establishments to inspect, prioritizing high risk establishments, like nursing home cafeterias and sushi restaurants, but skipping convenience stores and establishments with primarily fried food. The need to prioritize establishments in this manner raises equity concerns, given that food establishments in predominantly low-income neighborhoods generally offer more packaged and fried food, and also raises significant food safety concerns for all District residents. The Committee recognizes that at the current staff-to-inspection ratio, it would require doubling of FD's workforce from 14 to 28 FTEs to conduct all of the required inspections. Given the difficulty of hiring for these positions, the Committee does not believe the agency could hire that many additional positions in one fiscal year, but does encourage the agency to gradually increase the capacity in this Division, as well as explore technology and systems improvements to increase efficiencies. Further, the Committee urges the agency to work with DC Human Resources to utilize hiring incentives for these positions. **To kickstart this gradual expansion of this Division's capacity, the Committee recommends an enhancement in recurring local funds of $67,995 in CSG 11 and $15,222 in CSG 14 for Program 4500 Health Regulation and Licensing Administration, Activity 4515 Food Drug Radiation And Comm. Hygiene, to restore the salary and fringe benefits for the position 0039467 Sanitarian.**

The Committee is also pleased to fund the portion of the Fiscal Impact Statement for DC Health to implement B25-0068, the Street Vendor Advancement Amendment Act of 2023. This legislation is a landmark victory for street vendors who have struggled to operate legally for decades in the District, often facing harassment from regulators and law enforcement. Among other changes, the legislation creates a new permit within DC Health for Microenterprise Home Kitchens for small businesses making prepared food in their homes. The Financial Impact Statement for the legislation stated that DC Health would require two FTEs to create and enforce this new permit. **The Committee therefore recommends an enhancement in recurring funding of $135,975 in CSG 12 and $39,025 in CSG 14 for Program 4500 Health Regulation and Licensing Admin, Activity 4515 Food Drug Radiation And Comm. Hygiene to add 2 FTEs to partially fund B25-68, the Street Vendor Advancement Amendment Act of 2023.**

Animal Care and Control Services

The Mayor's FY 2024 proposed budget significantly reduces funding for animal rescue and control services in the District which is under the purview of DC Health. First, it sweeps the remaining fund balance for two capital projects: HC102C – DC Animal Shelter Renovation & Expansion ($4,162,500) and NAS23C – Future DC Health Animal Shelter ($4,500,000). Second, it reduces the animal care and control contract to $2.8 million, $3 million less than the FY 2023 amount of $5.8 million.

The Committee was surprised to see DC Health list the "DC Animal Shelter Renovation & Expansion" in its Capital Budget "Recent Accomplishments," when in fact the agency has made very little progress in building a new shelter in the last several years. In FY 2023, the Mayor allocated $4.5M to build a new animal shelter to replace the current shelter site on New York Ave NE. The current animal is old, crowded, and in disrepair, and advocates and the contractor have long been asking for a new shelter. The District has struggled to find a site for the new shelter—in FY 2023, it appeared the District had identified a site at 6500 Blair Road NE, but plans for that site fell through. This year, the Executive seemed confused about whether it had identified a new site, with DC Health including in its pre-hearing written responses a detailed description of a new site on New York Ave NE, but later clarifying that there was no new site identified. The current contractor, Humane Rescue Alliance (HRA), has offered to work with the District to develop HRA's property on Oglethorpe St. NW, but the District has yet to show interest in that proposal. The Mayor's proposed sweep of the capital funds means that even if a new site is identified, there is now no capital funding for building a new shelter. Further, the Mayor proposes sweeping the capital funding to make renovations for the existing shelter. During the budget oversight hearing, Chairperson Henderson asked DC Health who would be liable if the roof on the existing shelter were to collapse. DC Health acknowledged that if the roof was damaged or there were other major renovations needed, they now have no way to make them. What was even more concerning was that DC Health admitted they recently sent a crew to assess the roof after a strong windstorm in the region. The Committee urges the Executive to prioritize identifying a new site and adding back funds to the capital project in FY 2025.

The Mayor also proposes significant reductions in FY 2024 to the Animal Shelter labor hours competitive contract, which has been held by Humane Rescue Alliance (formerly Washington Humane Society) for 43 years. The FY 2024 proposed contract funding is $2,785,523,

approximately $3 million less than the FY 2023 contracted amount of $5,934,581, and the FY 2024 Option Period Amount of $5,900,000.[3] HRA reports that this cut would force them to lay off 30 staff members, or 50% of their total staff, and significantly reduce their services for District residents and animals. At the budget oversight hearing, the DC Health Agency Fiscal Officer testified that the agency had proposed a $4.9 million contract to the Mayor's Budget Office, but that only $2.8 million was ultimately allocated. The contract for the Animal Shelter has not fallen under $4.5M since FY 2019, as shown in this table provided by DC Health:

Humane Rescue Alliance (HRA) Invoices Paid		
Fiscal Year	Invoices Paid	Months Invoiced
FY19*	$3,761,087	12
FY20	$4,970,663	12
FY21	$4,531,599	12
FY22	$5,007,217	12
FY23 through 3/24/23	$2,493,239	6

**This amount was significantly lower due to several vacant positions at HRA.*

The Committee is concerned that in trying to balance priorities in a tight fiscal year, the Mayor has reduced core services that affect the health and safety of District residents. A compromised animal rescue and control program does not just impact animals (although the resulting harm to animals would be severe); it also puts District residents at higher risk of animal bites and attacks that could go unaddressed and be repeated. The Committee urges the Executive to allocate sufficient recurring funding for this contract so that HRA is able to adequately protect District residents and animals. **The Committee recommends an enhancement of $2,000,000 in recurring funds for Program 4500 Health Regulation and Licensing Admin., Activity 4515 Food Drug Radiation And Comm. Hygiene, CSG 41 to restore the Mayor's the Animal Care and Control contract so align the contract amount with FY 2020 - FY 2022 levels.**

Sexual Health and HIV/AIDS

Although the majority of the funding for the District's HIV/AIDS, Hepatitis, STD and TB Administration is federal funding ($82.13M of the $90.07M total budget), the District also uses local dollars to invest in prevention, education, treatment, and recovery that fall outside of federal grant allocations.

Until 2019, DC Health provided a locally funded grant for in-person, school-based Sexual Health Peer Education. This program stopped during the COVID-19 pandemic and there is currently no funding for the program. But as middle school and high school youth participate in more in-person activities again, the need for peer-led sexual education will become increasingly crucial. According to a recent Young Women's Project Sexual Health Survey of 600 students from 22 schools, 84% of high school students in the District received less than one hour of sex education

[3] CA25-0055 – Proposed contract with Washington Human Society, d.b.a. Humane Rescue Alliance, *available at*: https://lims.dccouncil.gov/Legislation/CA25-0055 (accessed Apr. 24, 2023).

in 2022.[4] Further, of the 24% of teens who reported being sexually active, only 46% reported using a condom in their last encounter (down from 57% in 2019). At performance oversight and budget hearings, the Committee heard from high school students who are not aware of any condom distribution happening at their schools. DC Health reports that they are working through an MOU with OSSE to fund a sexual health peer educator program. The Committee urges DC Health and OSSE to ensure that this program reaches as many middle and high school campuses as possible, particularly in schools with high STD and pregnancy rates.

The Mayor's FY 2024 proposed budget does not restore the one-time enhancement of $250,000 to Joseph's House. At the budget oversight hearing, the Executive Director of Joseph's House, Kowshara Thomas, testified that residents with advanced HIV disease are referred to Joseph's House. About 90% of them have experienced chronic homelessness and a history of trauma, substance abuse, and mental illness. Joseph's House provides safe housing and 24-hour nursing and personal care, as well as assistance to access benefits, address trauma and addictions, and find appropriate housing after discharge. As one of the only dedicated respite centers in DC, Joseph's House provides a unique level of intensive and personal care to clients, the majority of whom are from Wards 5, 7, and 8. Joseph's House had formerly received federal Ryan White funding from DC Health, but new administrative requirements made it impossible for Joseph's House to continue receiving that funding. **The Committee recommends an enhancement of $250,000 in one time funding for Program 3000 HIV/AIDS Hepatitis STD And TB Admin, Activity 3040 Prevention and Intervention Services, CSG 50 to restore the Mayor's proposed sweep of the grant for Joseph's House.**

Healthy Food Access

Although the overall food insecurity rate in the District has recovered to near pre-pandemic levels at 11%, this generalized data hides the continued elevated food insecurity rates of Black and Latinx residents in the District. According to the DC Food Policy Council, households with children, and seniors, remain at a higher risk of food insecurity than the general population. DC Health plays a critical role in addressing food insecurity and increasing healthy food access in the District. DC Health administers several federal nutrition assistance programs, including:

- The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC);
- The Commodity Supplemental Food Program (CSFP), also known as Grocery Plus, for low-income seniors;
- The Supplemental Nutrition Assistance Program Education (SNAP-Ed), which provides nutrition education to populations eligible for SNAP benefits; and
- the Senior and WIC Farmers Market Nutrition Programs.

Young Women's Project. "YWP Sexual Health & Wellness Survey: Preliminary Results." (Dec. 26, 2022) *available at*: https://docs.google.com/document/d/1MOuwMBVfKRLt1V3ToH8dKiNHONwQhL_jMQ7XyHKWzNg/edit (accessed Apr. 24, 2023).

DC Health also administers several locally funded nutrition assistance programs, including:

- Produce Plus, which provides low-income DC residents with $40 per month to purchase local produce at farmers markets;
- Healthy Corners, which empowers small businesses in underserved neighborhoods to sell nutritious, affordable food, and provides a $5 SNAP match at several locations;
- Joyful Food Markets, which hosts monthly free markets at 53 elementary schools in Wards 7 and 8; and
- Home Delivered Meals, which provides medically tailored meals to homebound DC residents with chronic diseases, including HIV/AIDS, cancer, and diabetes.

This year and in FY 2024, these programs are particularly important as federal pandemic-related boosts to the Supplemental Nutrition Assistance Program (or SNAP) ended in February 2023, causing decreases in benefits of $90 for individuals and $250 or more for families, even as food prices continue to rise. This decrease impacted 134,000 District residents who rely on SNAP, who are now at higher risk of food insecurity. Yet, the Mayor's FY 2024 proposed budget does not restore the majority of the one-time funding allotted for these programs and invests no additional funding to address food insecurity in the District.

At the March 24, 2023 Committee of the Whole Public Briefing on the FY 2024 Budget, the Executive could only provide one example of new funding to address food insecurity: capital funding to support the construction of a new grocery store in Ward 7. The Executive's position that funding new grocery stores alone will address food insecurity is misguided, both because grocery stores take years to open, and because many District residents cannot afford to shop at the grocery stores across the street from where they live. Food insecurity is a symptom of poverty, unemployment, and rising costs of living, and must be addressed as such. **The Committee therefore recommends restoring the one-time enhancements for several Local Nutrition Assistance grant programs within Program 8500 Community Health Administration, Activity 8513 Nutrition and Physical Fitness, CSG 50:**

- **$150,000 for Healthy Corners;**
- **$25,000 for Home Delivered Meals; and**
- **$200,000 for Produce Plus.**
- ***Note: The Mayor restored the $324,066 one-time enhancement for Joyful Food Markets.***

The Committee was happy to hear that DC Health successfully applied to use $156,000 of federal funding through the U.S. Department of Agriculture's Local Food Purchasing Agreement to enhance Grocery Plus boxes of shelf-stable food for low-income seniors with fresh produce, an effort initially piloted with ARPA funding in FY 2022. DC Health testified at the budget oversight hearing that this funding will be sufficient to provide fresh produce to all Grocery Plus customers (approximately 5,400 seniors) for the next three years, starting in FY 2024.

Home Visiting

The Committee heard from a significant number of individuals at the performance oversight and budget oversight hearings for DC Health testifying on the challenges of recruiting and retaining home visiting program staff for the programs that receive grant funding through DC Health. The Mayor's FY 2024 proposed budget does not restore $150,000 of one-time funding for home visiting programs for first-time mothers, but the spending for the rest of the program remains consistent. The chart below details the allocations for the home visiting grants over the last several fiscal years:

DC Health Home Visiting Grantee	**Fiscal Year 2021**	**Fiscal Year 2022**	**Fiscal Year 2023**	**Proposed Fiscal Year 2024**
Mary's Center for Maternal and Child Health - HFA/PAT*	$ 1,879,748.62	$ 1,834,147.00	$ 1,641,369.00	TBD
Mary's Center for Maternal and Child Health - First Time Mothers	$ 150,000.00	$ 150,000.00	$ 150,000.00	Not funded
Community of Hope - Parents as Teachers	$ 355,000.00	$ 355,000.00	$ 300,000.00	TBD
Georgetown University - Parents as Teachers	$ 357,019.00	$ 357,019.00	$ 339,515.00	TBD
Georgetown University - Evaluation	$ 167,800.00	$ 167,798.00	$ 154,651.00	TBD
MAMATOTO	$ 238,499.00	$ 311,899.00	$ 300,000.00	TBD
TOTAL	**$ 3,148,066.62**	**$ 3,175,863.00**	**$ 2,885,535.00**	**$ 3,295,785.00**

**Healthy Families America/Parents as Teachers*

DC Health testified that it provides grant funding to the programs, but does not set the salaries for program staff or dictate what the funding goes towards. While the Committee acknowledges that DC Health does not set salaries for grantees, it also recognizes that DC Health's grant application process creates pressure for grantees to stretch their services to cover as many people as possible, often to the detriment of underpaid program staff. The Committee urges the agency to take this concern seriously and consider ways to work with grantees to reduce turnover and increase compensation for these essential workers.

The Committee plans to explore in the next year how Department of Health Care Finance (DHCF) could incorporate evidence-based home visiting programs into the Medicaid program. Although this likely would not take effect until at least FY 2025, the Committee believes it is beneficial to start funding some evidence-based home visiting programs through DHCF grants. Thus, the Committee proposes transferring the First Time Mothers Home Visiting Grant to DHCF (please see more details in the DHCF Chapter).

School Nurse Program

DC Health awards a non-competitive grant to Children's School Services (CSS) to provide school nurses for the District's 178 school health suites and approximately 90,000 public school

children. The FY 2024 proposed budget for CSS is $23,133,727, a decrease of $4,500,000 from FY 2023. The school nursing program is burdened by the national nurse workforce shortage that has impacted our healthcare system. High vacancy rates mean that 40% of participating health suites do not have full-time in-person coverage, and even full-time nurses are often temporary and cannot develop relationships in the school community. The FY 2023 supplemental budget sweeps $2 million from the school nursing grant due to projected underspending due to high vacancy rates, and the Executive explains the FY 2024 proposed reduction also as adjusting for the high vacancy rates and nursing shortage, which likely would not be resolved in the next fiscal year.

However, DC Health and CSS are planning to roll out a new staffing model for school year 2023-2024 aimed at addressing the high vacancy rates in the program. The new model, which is still in development and undergoing stakeholder engagement, would essentially create clusters of four schools close in geography that share 2 nurses and 2-3 school health associates, who can provide acute first aid and basic care under the supervision of a licensed nurse. The Committee is generally supportive of this model as it believes this will increase coverage in school health suites, while also providing a healthcare workforce pipeline for young professionals exploring future healthcare careers. However, the Committee is deeply concerned that the FY 2024 proposed funding level will inhibit CSS' implementation of the new model, including the hiring of new school health associates. CSS Executive Director Dr. Andrea Boudreaux testified at the budget oversight hearing that CSS would need the FY 2023 grant funding to remain consistent for CSS to implement the new staffing model. DC Health shared in an Internal presentation to the Committee on Health that the new model would require CSS to hire 128 new School Health Associates, but does not build in additional HR support.

The Committee would like to provide sufficient resources for DC Health and CSS to be able to make significant progress in implementing this new model in the 2023-24 school year. **Although the Committee cannot restore the full $4.5 million reduction, the Committee recommends an enhancement of $2,000,000 in recurring funding for Program 8500 Community Health Administration, Activity 8506 Family Health Bureau, CSG 50, which will enable CSS to hire for more than half of the 128 planned new School Health Associate positions.**

Dementia Training for Direct Care Providers

Approximately 10,000 residents in the District are living with Alzheimer's Disease and approximately 14,000 residents are taking care of loved ones with Alzheimer's. Alzheimer's disproportionately affects women and people who identify as African American and Hispanic. In 2020, the Council passed the Dementia Training for Direct Care Workers Act requiring dementia training for direct care workers, but the law has not yet been implemented because DC Health's Health Regulation & Licensing Administration has not adopted regulations. DC Health reports that the regulations are in the final review phase and should be published before the end of FY 2023. The FY 2022 budget included $170,000 in DC Health's budget to implement the law be requiring direct care providers to receive sufficient dementia care training, but the funds were never spent because the regulations had yet to be published.

Therefore, the Committee is pleased to accept a transfer from the Committee on Transportation and the Environment in the amount of $170,000 to require dementia training

for direct care workers, implementing the Dementia Training for Direct Care Workers Act of 2019.

Howard Centers for Excellence

The Howard Centers for Excellence (COE) was created to develop innovative, measurable, and sustainable programs, educational curricula, outreach initiatives, and clinical research focused on health disparities, focused on five areas: 1) Sickle Cell Disease, 2) Oral Health, 3) Trauma and Violence Prevention, 4) Behavioral Health, and 5) Women's Health. The District provided COE a $30.8 million operating investment to develop and operationalize COE. The funding was allocated as follows:

- Centers of Excellence Infrastructure: $10 million will be allocated to staff, equipment, and facility build out over first two years to operationalize the Centers
- Sickle Cell Disease: $4.5 million over the funding period
- Women's Health: $4.8 million over the funding period
- Oral Health: $ 6.0 million over the funding period
- Trauma and Violence Prevention: $3.0 million over the funding period
- Behavioral Health: $2.5 million over the funding period

Thus far, the District has allocated a total of $26.96 million to COE over four fiscal years, and COE has spent $4.94 million of those funds, to date. During the budget process, the Committee has been perplexed as DC Health officials struggled to describe the work of the COE and its deliverables or impact over the last three fiscal years. Although the Committee understands that the COVID-19 pandemic delayed some of the programmatic initiatives, there still do not seem to be significant deliverables coming out of COE.

In the COE FY 2024 Plan Summary provided by COE and DC Health to the Committee, COE describes that of the $12,558,517 allocated in FY 2023, $6,569,995.78 is being used to support programs in FY 2023, and the remaining $5,988,521.02 will be used in FY 2023 and FY 2024 to implement key infrastructure projects such as the build out of the sickle cell disease day hospital, hire clinical and support staff for the day hospital, and increase staffing within the community telepsychiatry program. The DC Health FY 2024 proposed budget adds an additional $2,211,148 in local funds and $3,787,795 in non-lapsing funds to the COE. After multiple requests for spending plans for these funds, the Committee is skeptical that there is a firm spending plan for these funds, and given historical spending levels, does not foresee COE spending this entire amount. The 3,787,795 in non-lapsing funds in FY 2024 combined with half of the $5,988,521.02 in non-lapsing funds for FY 2023-2024, combined, provides COE a total of $6,782,955.51 for its FY 2024 spending, nearly double what it spent in FY 2022. The Committee believes this funding level gives COE the capacity to scale at a realistic, ambitious pace. **Therefore, the Committee recommends a reduction of $2,211,148 in recurring funding for Program 8500 Community Health Administration, Activity 8505 Health Care Access Bureau, CSG 50, to reduce the local grant funding for Howard Center of Excellence.**

Funding for Howard University Centers of Excellence

Funding	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Budget - **Local**	$ 4,200,000	$ 4,200,000	$ 3,787,795	$ 2,211,148
Budget - **ARPA**	$ -	$ -	$ 8,372,500	$ -
Budget - **Non-Lapsing Account**			$ 398,222	$ 3,787,795
TOTAL	**$ 4,200,000**	**$ 4,200,000**	**$ 12,558,517**	**$ 5,998,943**
YTD - Expenditures	**$ -**	**$ (3,801,778)**	**$ (1,134,124)**	

Smoking Cessation Fund

The Smoking Cessation Fund is a non-lapsing fund that collects revenue from taxes on cigarette sales in the District. In FY 2023, the Fund currently has a balance of $432,017. DC Health reports that they had previously lacked authorization to use these funds, which is why they have never spent them in the past. The agency just received authorization to spend down the funds, but has no current spending plan. **The Committee therefore recommends a reduction of $289,451 from the Smoking Cessation Fund due to annual underspending and will look forward to seeing the agency develop a spending plan for the remaining $142,466 and FY 2024 expected revenue.**

Senior Dental Services

The Mayor's FY 2024 proposed budget allocates $550,000 in one-time funding to support dental services for seniors. This is an increase from the FY 2023 approved budget of $500,000 for this program. This funding goes to support Community of Hope's dental services for low-income seniors, which the organization has been operating since 2019. The funding is designed to support approximately 250 seniors with either no dental insurance or insufficient insurance that does not cover more advanced dental procedures, like implants. While the Committee is supportive of this program, it was surprised to learn that as of March 31, 2023, the program had only served 33 seniors. If these trends continue, the program would serve less than 70 seniors in FY 2023, well under the estimate of 250 seniors. **Therefore, the Committee proposes a reduction of $250,000 in one-time funding in FY 2024, which still leaves $300,000 for this grant program.**

b. Fiscal Year 2024 - 2029 Capital Budget Recommendations

The Mayor's proposed FY 2024 – FY 2029 capital budget request for DC Health is $2,422,000. This represents a decrease of $2,308,000, or 48.8%, from the FY 2023 – FY 2028 Capital Plan. The FY 2024 – FY 2029 Capital Plan includes only one capital project, HC0-HFL24-Fleet Replacement, which will purchase new vehicles for Food Safety and Rodent Control. All vehicles being replaced are over 10 years old and have endured wear and tear and significant city mileage. The tables below provided by DC Health in the pre-hearing written responses show how many vehicles DC Health plans to purchase each year, and the approximate cost of the vehicles.

Agency	Category	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	TOTALS
		Mayors Budget	Mayors Budget	Mayors Budget	Mayors Budget	Mayors Budget	Mayors Budget	Mayors Budget
DOH	LIGHT DUTY	11	6	4	7	9	20	57
	MEDIUM DUTY	1	-	1	-		1	3
	HEAVY DUTY AND OFF ROAD	1		1	-		1	3
		13	6	6	7	9	22	63

DPW FY24 Fleet Assessment	
$38,678	LIGHT DUTY
$158,433	MEDIUM DUTY
$257,695	HEAVY DUTY AND OFF ROAD

COMMITTEE POLICY RECOMMENDATIONS

1. *Identify strategies to encourage more social workers to enter the field and fill critical vacancies.*

There is a shortage of social workers in the District, which has resulted in heavy caseloads and burnout for those in the field. DC is home to a large number of low-income residents who face a wide range of social and economic challenges, including poverty, unemployment, housing insecurity, and access to quality healthcare. As a result, there is an urgent need for skilled social workers who can provide a wide range of services, from direct client care to case management and community engagement. However, despite the need, many social workers in DC face significant challenges, including low salaries, high caseloads, and limited access to training and professional development opportunities.

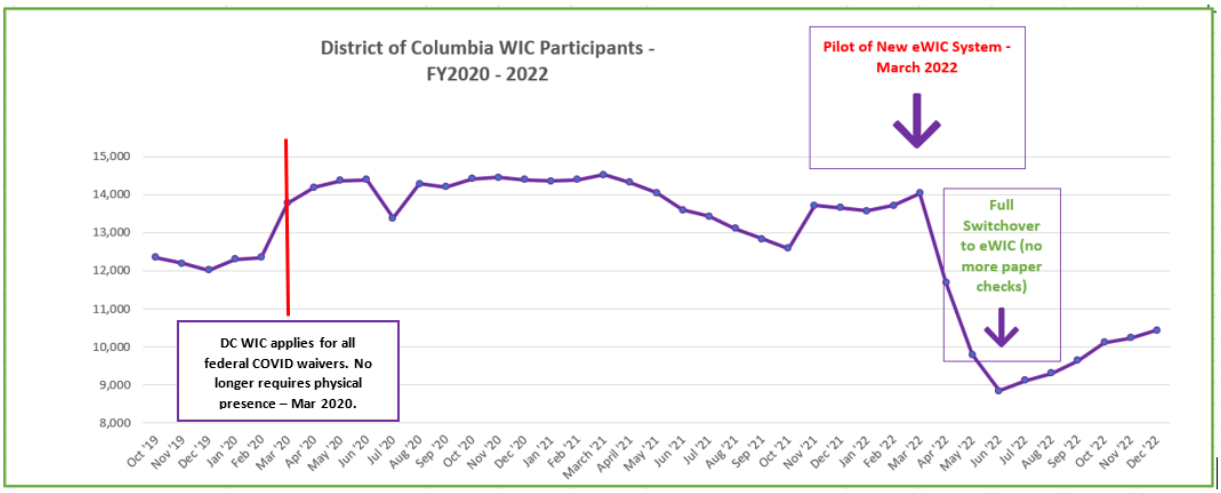
The Committee encourages DC Health and the Board of Social Work to recognize their roles as not only the regulatory and licensing body for social workers, but also as an entity that should facilitate and encourage more social workers to enter the field as a strategy to improve public health. This could include amending the exam requirements for social workers, which currently serve as a significant barrier to entry for many aspiring social workers, particularly those from historically marginalized communities; increasing funding and support for social work education and training programs; and working with non-profit organizations to increase salaries, benefits, or recruitment/retention benefits for social workers. The Committee has a keen interest in increasing the number of talented, passionate social workers in the District and looks forward to working with the agency on this topic going forward.

2. *Identify and invest in strategies to increase enrollment in the Special Supplemental Nutrition Program for Women, Infants, and Children.*

The most recent federal enrollment data for WIC shows that in 2020, approximately 14,000 out of 24,100 eligible residents were enrolled in WIC, a 58% participation rate. Since then, WIC enrollment steeply declined, as seen in the graph below, dipping under 9,000 enrollees during the switchover to electronic WIC (eWIC) benefits and away from paper checks. Although, over time, the transition to eWIC will facilitate the use of WIC benefits by beneficiaries, the initial transition

caused confusion and also required all WIC customers to attend in-person nutrition counseling appointments at WIC clinics.

DC Health is already making efforts to increase WIC enrollment, including through a data sharing agreement with TANF and Medicaid to simplify enrollment; extended weekend and weeknight hours at Program sites; and expanding digital options for enrollment and appointment scheduling. The Committee is eager to work with the DC Health WIC team to identify further ways to increase WIC enrollment and to identify funding where needed to pilot new strategies.



3. *Implement B25-0068, the Street Vendor Advancement Amendment Act of 2023, and identify other ways to decrease red tape for small food entrepreneurs in the District.*

The Committee appreciated DC Health's willingness to collaborate on an amendment to the Street Vendor Advancement Amendment Act of 2023 to create a new microenterprise home kitchen permit process for street vendors preparing food in their home kitchens. As noted above, the Committee has funded the 2 FTEs that DC Health needs to implement the legislation, according to the Fiscal Impact Statement. With these resources, the Committee urges DC Health to develop the required regulations in a timely and thoughtful manner, ensuring any regulatory requirements reflect food science best practices while being realistic for small scale food producers. The Committee also urges the agency to work collaboratively with street vendors to develop an application system that is not overly cumbersome and is accessible in the diverse languages spoken by the street vendor community, including, at the least, Spanish and Amharic.

The Committee also encourages DC Health to consider other regulatory changes that the agency could make to streamline the permitting and licensing process for DC food entrepreneurs, including cottage food businesses, food trucks, and brick and mortar establishments, who often find the DC Health permitting process costly and unnecessarily restrictive. The Committee looks forward to working with the agency to identify strategies to both ensure food safety while not hampering the efforts of District residents to start their own businesses and preserve the District's rich and diverse food culture.

4. *Develop and disseminate a plan for addressing COVID-19 seasonal peaks and new variants.*

The Committee appreciates the dedicated efforts of DC Health to address the COVID-19 pandemic, including previous vaccine and booster rollouts and the operation of the Ward COVID Centers during the peak of the public health emergency. The Committee also agrees with DC Health that this is the right time to scale back costly operations like the COVID centers, particularly as the federal public health emergency ends and the city has experienced many months of low COVID rates and hospital admissions.

That said, the Committee urges DC Health to develop and disseminate to the public a detailed, concrete plan for continuing to monitor local COVID rates and for preparing for seasonal surges and new variants of COVID-19. At the performance and budget oversight hearings, the Committee heard from residents with health conditions that put them at continued high risk of complications from COVID-19. These residents expressed concern that DC Health had not committed to reporting on COVID-19 wastewater monitoring, and that without the DC Health COVID dashboard, these residents were losing a crucial tool that helped them plan for when to be in public spaces. Similarly, the Committee has heard from many residents concerned about the closing of the Ward COVID Centers. Although the Committee agrees with DC Health that continuing to operate these costly Centers, which cost roughly $500,000 per month and were not highly used outside of the release of new boosters, does not make sense, the Committee has yet to hear a clear plan from DC Health about alternatives to these Centers.

In the pre-hearing written responses, DC Health described COVID-19 Walk-In Vaccination Access pilots at the Ward 8 Urgent Care Center and two Safeway locations, but these locations seem difficult to scale up in the event of a seasonal surge or new booster. DC Health also mentioned that it was working with pharmacies and primary care medical homes on Pediatric Vaccine Access, but not details were provided on how many sites and plans to scale when needed. Lastly, DC Health is providing grants to CBOs to increase vaccinations for hard-to-reach populations, and providing limited at-home vaccination options. The Committee applauds all of these efforts, but urges the agency to provide more specifics to the public so residents are clear on their options for accessing vaccines, PCR testing, at-home rapid testing, and masks.

5. *Improve the timeliness of publication of reports and updated data.*

A core component of a public health agency is research, data analysis, and reporting on key indicators of public health in its jurisdiction. Yet over performance and budget oversight, the Committee has been struck by how many DC Health reports are significantly delayed or lost in the internal review process. The Committee acknowledges that aspects of the Executive report development process fall outside of DC Health's control, including delays by the Office of Contracting and Procurement, delays from contractors, and delays from the Deputy Mayor and Executive Office of the Mayor. However, the Committee urges DC Health to identify ways to streamline the processes within its control and publish reports in a timelier manner.

Timely DC Health reports are crucial for the Council, research and advocacy organizations, and healthcare industries to make informed decisions. In the absence of these reports, the Committee has heard from researchers relying on five-year-old data to study childhood asthma,

long-term care advocates lacking data on how many more nursing beds are needed to meet the needs of our aging population, and Death with Dignity advocates struggling to understand the impact of this important law.

After Chairperson Henderson asked about them at hearings and in a letter to the Office of the City Administrator, several DC Health reports were finally published, including the Death with Dignity 2021 Data Summary and the Perinatal Health and Infant Mortality Report 2019-2020.

Despite Chairperson Henderson asking for them repeatedly, the following reports are still outstanding:

- Long Term Care Facilities and Services Report on the supply and demand of long term care facilities and services in the District. According to Mark Miller, the Long Term Care Ombudsman, this report has been completed for a year but has not been published;
- Healthcare Workforce Task Force Report/Recommendations on recommended strategies and investments necessary to address current supply and demand challenges in the healthcare workforce. The Task Force completed its recommendations in early February 2023; and
- DC Calling All Sectors Initiative (CASI) Report (DC Health) on addressing housing insecurity during pregnancy, based on a research project that ended in summer 2022.

C. DEPARTMENT OF BEHAVIORAL HEALTH (RM0)

1. AGENCY MISSION & OVERVIEW

The mission of the Department of Behavioral Health (DBH) is to support prevention, treatment, resiliency, and recovery for District residents with mental health and substance use disorders through the delivery of high-quality, integrated services.

DBH will: (1) ensure that every individual seeking services is assessed for both mental health and substance use disorder needs, (2) increase the capacity of the provider network to treat co-occurring disorders, (3) establish and measure outcomes for individuals with co-occurring mental health and substance use disorders as well as single illnesses with recovery as the goal, and (4) enhance provider monitoring to ensure high quality service.

DBH operates through the following 9 divisions:

Behavioral Health Authority – plans for and develops mental health and substance use disorders (SUD) services; ensures access to services; monitors the service system; supports service providers by operating DBH's Fee for Service (FFS) system; provides grant or contract funding for services not covered through the FFS system; regulates the providers within the District's public behavioral health system; and identifies the appropriate mix of programs, services, and supports necessary to meet the behavioral health needs of District residents.

This division contains the following 5 activities:

- Office of the Director/Chief Executive Officer
- Consumer and Family Affairs
- Office of Ombudsman
- Legal Services
- Legislative and Public Affairs

Saint Elizabeth's Hospital (SEH) – provides inpatient psychiatric, medical, and psycho-social person-centered treatment to adults to support their recovery and return to the community. The hospital's goal is to maintain an active treatment program that fosters individual recovery and independence as much as possible. The hospital is licensed by the District's Department of Health and meets all the conditions of participation promulgated by the federal Centers for Medicare and Medicaid Services.

This division contains the following 14 activities:

- Office of the Chief Executive
- Office of Clinical and Medical Services – SEH
- Engineering and Maintenance – SEH
- Fiscal and Support Services – SEH
- Quality and Data Management

- Housekeeping – SEH
- Materials Management – SEH
- Nursing Services – SEH
- Nutritional Services – SEH
- Security and Safety – SEH
- Transportation and Grounds – SEH
- Office of the Chief of Staff – SEH
- Office of the Chief Operating Officer – SEH
- Office of the Chief Clinical Officer – SEH

Accountability Division – oversees provider certification, mental health community residence facility licensure, program integrity, quality improvement, major investigations, incident management, claims audits, and compliance monitoring. Issues annual Medicaid and local repayment demand letters, annual quality reviews, and annual provider scorecards.

This division contains the following 5 activities:

- Office of Accountability
- Incident Management and Investigations
- Licensure
- Certification
- Program Integrity

Clinical Services Division – provides person-centered, culturally competent outpatient psychiatric treatment and supports to children, youth, and adults to support their recovery; and coordinates disaster and emergency mental health programs.

This division contains the following 7 activities:

- Office of the Chief Clinical Officer
- Behavioral Health Services
- Behavioral Health Services – Pharmacy
- Comprehensive Psychiatric Emergency Program (CPEP)
- Homeless Outreach/Mobile Crisis (CPEP)
- Forensics
- Assessment and Referral Center (ARC)

Adult/Transitional Youth Services Administration – develops, implements and monitors a comprehensive array of prevention, early intervention and community-based behavioral health services and supports for children, youth, and their families that are culturally and linguistically competent; and supports resiliency, recovery and overall well-being for District residents who have mental health and substance use disorders.

This division contains the following 16 activities:

- Adult/Transitional Youth Services Administration

- Behavioral Health Services MH/SUD
- Government Operated Services 35 K Street Adult Clinic
- Provider Relations
- Co-Located Services
- Residential Support and Continuity of Services
- Housing Support Services
- Community Response Team
- State Opioid Response Program (SOR)
- Assessment and Referral Center
- Access Helpline
- Specialty Services
- Substance Use Disorder Treatment Services
- Mental Health Rehabilitation Services (MHRS) Local Only
- Behavioral Health Rehab - Local Match
- Gambling Addiction Treatment and Research

Child/Adolescent/Family Services – develops, implements and monitors a comprehensive array of prevention, early intervention and community-based behavioral health services and supports for children, youth, and their families that are culturally and linguistically competent; and supports resiliency, recovery and overall well-being for District residents who have mental health and substance use disorders.

This division contains the following 10 activities:

- Child/Adolescent/Family Services Administration
- Behavioral Health Services MH/SUD
- SUD Prevention and Treatment
- School Based Behavioral Health Services
- Crisis Services
- Court Assessment
- Early Childhood Services
- Specialty Services
- Government Operated Services-Howard Road
- Evidence Based Practice (EBP)

Policy, Planning, and Evaluation Administration – aggregates and analyses data to evaluate performance; develops strategic plans and programmatic regulations, policies and procedures; develops and implements learning opportunities to advance system change; identifies needs, resources and strategies to improve performance.

This division contains 4 activities:

- Data and Performance Measurement
- Strategic Planning and Policy
- Training Institute
- Behavioral Health Block Grant Program

Agency Management – provides for administrative support and the required tools to achieve operational and programmatic results. This division is standard for all agencies using performance-based budgeting.

Agency Financial Operations – provides comprehensive and efficient financial management services to, and on behalf of, District agencies so that the financial integrity of the District of Columbia is maintained. This division is standard for all agencies using performance-based budgeting.

2. COMMITTEE BUGET RECOMMENDATIONS

a. Fiscal Year 2024 Operating Budget Recommendations

The Mayor's FY 2024 proposed operating budget for the Department of Behavioral Health is $385,143,814, which represents a 2.2% increase in operating funds, compared with the approved FY 2023 budget. This is largely due to increases in the State Opioid Response Program and the Behavioral Health Local Match for Medicaid. The funding supports 1,431.5 Full-Time Equivalents (FTEs), a 1.2% decrease from the FY 2023 approved level.

Opioid Response

In 2017, the District launched its Live.Long.DC. campaign in response to the growing opioid epidemic. According to the CDC, the District currently ranks first in all drug overdoses and second in opioid overdose deaths per capita. According to the Office of the Chief Medical Examiner (OCME), in 2022, there were 448 opioid-related fatal overdoses with an average of 27 deaths per month. The OCME also reported that in 2022, 96% of overdoses involved fentanyl, representing a significant increase since 2017. Fentanyl is a powerful synthetic opioid drug that is used medically for pain relief, particularly in cancer patients. It is about 50-100 times more potent than morphine, which means that even a small amount can cause respiratory depression and potentially fatal overdose. Furthermore, OCME reported that 85% of those who died from opioid overdoses in the District were Black residents. As part of the government's response, DBH has increased the availability of naloxone and fentanyl testing strips. Naloxone is available in many pharmacies and locations across the District at no cost to residents. Various agencies and contractors distribute fentanyl testing strips to District residents. The distribution of more than 150,000 naloxone kits has resulted in the reversal of more than 2,600 overdoses in 2022 alone. While the Committee is encouraged by DBH's commitment to addressing the opioid crisis in the District, it is concerned that the FY 2024 proposed budget and the proposed programmatic initiatives are insufficient to meet the need.

The District, like several other states, is expected to receive funds from opioid litigation settlements over the next 18 years. With nearly $50 million in settlement agreements, the District's Opioid Abatement Fund was created in 2022 and is administered by the Office of the Attorney General. The fund is intended to support programs and initiatives that address the opioid crisis in the District. It is a valuable resource that has the potential to make a significant impact on the lives of people at risk of or struggling with opioid addiction. In the District, the use of the opioid

settlement funds is governed by the Opioid Litigation Proceeds Amendment Act of 2022. Under this law, DBH is required to establish an Office of Opioid Abatement, which will work with the Mayor and the DC Council to establish an Opioid Abatement Advisory Commission. The Commission will make recommendations to the Mayor on how to use the funds to support evidence-based and evidence-informed opioid prevention, treatment, recovery, and harm reduction programs.

Most states have already established advisory commissions to begin planning for spending these funds on prevention, treatment, and recovery. The Committee appreciates that DBH has initiated preparations for the establishment of the Office of Opioid Abatement. However, the Committee is concerned about the FY 2024 proposed budget, which appears to wrongfully divert approximately $2 million that is already in the Opioid Abatement Fund to the General Fund. It is important that these funds are utilized for their intended purpose and not diverted to balance the budget or fund unrelated projects. Further, when the Committee asked DBH about its plans to establish the Office of Opioid Abatement, the agency's response implied that this Office would be separate from the State Opioid Response division. The Committee recommends that DBH instead create a unified division to consolidate the agency's work on opioid prevention, treatment, recovery, harm reduction, and research, regardless of funding source. The Committee believes that such an umbrella division will help DBH avoid duplicative initiatives and reduce the number of staff working in siloes. The Committee was not able to restore the swept funds, but it urges the Mayor to make it a priority to locate funding to return the improperly swept funds and to discontinue the practice of diverting the Opioid settlement funds for purposes other than their intended use.

In terms of the Advisory Commission, the Committee encourages DBH to move quickly to identify and nominate members and call the first meeting before the summer. There have been concerns that DBH does not engage stakeholders in the process of developing and implementing their strategic goals around opioids and substance abuse disorder, and this is an opportunity for DBH to improve in this regard. It is important that those with lived experience and those working on the front lines are included in the decision-making process, such as selecting providers, creating new programs, and determining the locations for targeted outreach.

To provide targeted outreach to areas with high drug use, the Committee is proposing a new Budget Support Act subtitle, the "Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2023." This subtitle would pilot the effectiveness of an influx of direct support, relationship development, and resource brokering for individuals in need of substance abuse and behavioral health services at the following three locations with concentrated outdoor drug use:

1. **The vicinity of the 600 block of T Street, N.W.:** Over the past year, the Office of Ward 1 Councilmember Brianne Nadeau has been coordinating with the Mayor's Office of Neighborhood Engagement, local Advisory Neighborhood Commissions, businesses, residents, Howard University, Cleveland Elementary Schools, and others to address concerns about the T Street Plaza site. The District has tried several deterrents, including fencing off areas and removing furniture, that temporarily address the issue but do not get to the root of the substance abuse and behavioral health issues faced by these individuals.

2. **The vicinity of the 1100-1300 blocks of Mount Olivet Road, N.E.:** The Office of Ward 5 Councilmember Zachary Parker has received several reports of drug use in alleys and abandoned buildings in the vicinity of the intersection of West Virginia Avenue, N.E. and Mount Olivet Road, N.E. Thus far, the District's response has been to increase police presence in the area, but this only provides a temporary solution. There are reports of overdosing in the area and repeated calls for emergency support. Neighbors also report this area is an open drug market for sales.

3. **The vicinity of the 3800-4000 blocks of Minnesota Avenue, N.E.:** The Office of Ward 7 Councilmember Vincent Gray has received numerous concerns from Ward 7 residents about the serious drug use in the 3800-4000 blocks of Minnesota Ave., N.E. Councilmember Gray's office has collaborated with the Department of Behavioral Health (DBH) and community organizations to develop solutions. It is especially concerning that young children and babies are frequently seen in the area with adults who are under the influence or actively using drugs. This underscores the urgent need for intervention and support in the area.

Each of these areas would greatly benefit from consistent and intensive outreach and support to connect individuals with the necessary services and resources and help them enter treatment and recovery. A targeted outreach team could improve access to treatment, provide harm reduction services, and address the root causes of drug use in the area. **The Committee is pleased to accept $200,000 in one-time local funds from the Committee on Public Works and Operations, and proposes an additional $400,000 one-time enhancement to fund the subtitle. In total, the Committee recommends an enhancement of $600,000 in one-time local funds for Program 6500 Adult/Transitional Youth Services, Activity 6513 Substance Use Disorder Treatment Svcs, CSG 50 to fund the Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2023.**

Saint Elizabeth's Hospital

DBH's FY 2024 proposed budget for Saint Elizabeth's is $102,966,000 representing a $1,347,000 decrease from FY 2023. DBH reports that this decrease is due to the removal of one-time funding for maintenance projects ($1,000,000), salary adjustments, supply costs reductions, and decreases in a range of fixed costs.

Several increases occurred at Saint Elizabeth's due to the impact of COLA, salary adjustments, and step increases. In addition, there were two one-time enhancements that aimed to support inflationary adjustments for patient medication ($704,816) and nutritional needs ($385,050). While the Committee acknowledges that calculating increases for food and prescription drugs can be a complex process that considers various factors such as supply and demand, production costs, government policies, changes in technology, and market competition, it encourages the DBH to provide more detailed and specific information on proposed funding enhancements in the future.

School-Based Behavioral Health Services

The goal of the School Based Behavioral Health (SBBH) program is to provide a diverse range of behavioral health services and resources to students attending public and public charter schools. To ensure the delivery of preventive and early intervention services that are not covered by Medicaid, the DC government decided to cover 50% of a clinician's salary. This funding model is consistent with the funding approach for community-based behavioral health services.

The program categorizes interventions into three tiers, as follows:

- Tier 1 involves mental health promotion and prevention activities for all students.
- Tier 2 comprises focused interventions for students who are at risk of developing behavioral health problems.
- Tier 3 includes intensive supports and treatment for individual students experiencing behavioral health issues.

Proposed FY 2024 SBBH funding includes grants to community-based organizations (CBOs) at the rate of $89,366 per clinician. This is a $19,491 decrease from FY 2023 funding that included a one-time per clinician increase of $28,037 for recruitment and retention bonuses, bringing the total per clinician FY 2023 funding to $108,857. The Mayor's FY 2024 proposed budget includes $8,546 per clinician for recruitment and retention bonuses. The grants provided by DBH do not represent the actual salaries of clinicians. Instead, they reflect DBH's contribution towards non-Medicaid billable services. Clinicians may receive additional compensation through billable services. Please see below a detailed breakdown, provided by DBH, of CBO grant funding per clinician.

Community Based Organization Grant Funding per Clinician			
Funding per Clinician	FY 23	Proposed FY 24	Comments
Salary	$ 63,153.00	$ 63,153.00	Funds prevention and early intervention
Professional development	1,000.00	1,000	Workforce development (licensure fees, exam test prep classes or CEUs)
Supervisory Support	16,667.00	16,667.00	Free supervision hours required for licensure
Core Funding	**$ 80, 820.00**	**$ 80,820.00**	
One-Time Work force Development	28,037.00 *(Local* 19,491.00 *ARPA* 8,546.00)	ARPA 8,546.00	Recruitment and retention bonuses
Total Funding	**$ 108,857.00**	**$ 89,366.00**	

In FY 2024, the Council made a $150,000 enhancement for DBH conduct a study on the actual costs associated with the complete implementation of the SBBH program. DBH has contracted with a consulting company and although study results were due to the Council by

December 31, 2022, the consultants are still collecting data due to initial poor response rate from providers. DBH anticipates that study results will be available in late spring 2023, and thus those findings were not incorporated into the proposed budget.

The Committee heard testimony at performance and budget oversight hearings from public witnesses advocating for additional funding to increase CBO clinician grants. The Committee agrees that adequate clinician compensation is essential to a strong SBBH program, but the Committee decided against recommending an across-the-board increase for FY 2024 because the Committee is confident that vacancy savings in FY 2024 will allow DBH to provide additional CBO grant payments for signing and retention bonuses, as they did in FY 2022 and FY 2023. The 2022-23 school year is projected to end with over 90 clinician vacancies and 73 partnered schools with a clinician vacancy. Due to workforce shortages in the behavioral health field, it is unlikely that all clinician positions will be filled.

The Committee encourages DBH is to explore whether the financial model for the SBBH program should be altered. The model was not designed to fully fund all services provided by CBOs. Initially, DBH anticipated that their grants would cover 50-60% of clinician costs after factoring in Medicaid billing. However, many CBOs face challenges in providing adequate billable services. The findings of the SBBH rate study should help DBH develop a long-term plan for funding the program, as it will not only analyze salary and benefits, but also expenses involved in providing non-billable services like school-wide and small group services.

Instead, the Committee proposes an alternative strategy for increasing access to behavioral health supports in schools. The Committee recommends the inclusion of a subtitle, the School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023, that aims to address the gap in access to behavioral health services by involving students in the effort. The pilot taps into evidence that suggests that adolescents often seek informal sources of support, including friends, for their behavioral health needs. During the FY 2022 performance oversight hearing, numerous students from the local non-profit, Young Women's Project, shared the results of a survey completed with their peers. The survey found that many of their peers did not know the name of their mental health clinician, and those who did know had little to no contact with them. The students spoke about their mental health struggles and the lack of support they received from their schools. At Bard DC Early College High School, 56% of respondents reported not receiving any mental health and wellness support from their school in the past three months, with only 2.4% responding "often." The pilot aims to increase access to school and community-based behavioral health services for high school students and caregivers, improve students' ability to cope with stress and trauma, educate them on building resilience, reduce stigma around seeking behavioral health services, and enhance student engagement and input into the SBBH program.

Through this pilot program, DBH will award grants to one or two community-based organizations to recruit, train, and supervise at least 100 peer educators, with a preference for programs that partner with SBBH cohort 1 high schools, or those located in Wards 5, 7, or 8. After undergoing comprehensive training on various behavioral health topics, peer educators will be responsible for presenting in classrooms, distributing educational materials, conducting one-on-one sessions with their peers, and sharing information to help students and caregivers connect with SBBH clinicians and other behavioral health staff.

The Committee recommends a one-time enhancement of $325,000 for Program 6600 Child/Adolescent/Family Services, Activity 6620 School Based Behavioral Health Services, CSG 50 to fund the School-Based Behavioral Health Student Peer Educator Pilot Program Act of 2023 included in Attachment B.

Community Response Team & Children and Adolescent Mobile Psychiatric Service (ChAMPS)

DBH's proposed FY 2024 budget for the Community Response Team (CRT) (6508) is $7,938,000 reflecting a $1,114,000 decrease from FY 2023. The agency reports that the decrease is due to an FTE reduction and a reduction in temporary staff contracts. The CRT provides round-the-clock crisis response services to District residents, including children and youth. In 2021, a partnership launched between DBH and the Office of Unified Communications (OUC), which allowed for rapid response teams in CRT to be dispatched to mental health-related 911 calls instead of automatically deploying police officers. The partnership has faced challenges but has been successful. As a result, residents have been calling on the CRT for assistance, but response times have lagged due to staffing challenges.

The CRT faces significant challenges in retaining and recruiting staff, given the stressful and demanding nature of their work. At the budget oversight hearing, DBH reported that 22 of the 66 CRT positions were vacant. The CRT works directly with MPD and prioritize hiring staff with lived experiences like those of the populations they serve. In FY 2024, CRT will need to recruit staff with experience providing crisis services to children and youth as the team will provide crisis services to children and youth Monday-Friday 8pm-8am and on the weekends. The reason for this change is a reduction in the contract with the Children and Adolescent Mobile Psychiatric Service (ChAMPS) contractor. In winter 2022-23, DBH reduced the contract for ChAMPS by ending weekend hours and evening hours after 8 pm.

The Committee is greatly concerned about DBH's capacity to address crises affecting children and youth. The proposed reduction of $500,000 to ChAMPS in FY 2024 could result in the organization downsizing their deployment teams. This could lead to longer wait times, or even worse, children and families being left without the support they require. This team has encountered challenges retaining and recruiting staff due to the rigorous and demanding nature of their work. However, their role is crucial in addressing the urgent needs of the District's children and families. **As such, the Committee recommends a one-time enhancement of $100,000 for Program 6600 Child/Adolescent/Family Services, Activity 6625 Crisis Services, CSG 41 for hiring/retention bonuses for the Child and Adolescent Mobile Psychiatric Service (ChAMPS).** This enhancement will provide funding for $5,000 hiring and retention bonuses in FY 2024 for the staff of the ChAMPs contractor.

Housing & Residential Treatment Facilities

DBH's FY 2024 proposed budget for Housing Support Services is $29,637,000. This reflects a $1,240,000 increase from FY 2023. This will fund independent and supervised housing in the community for 1,685 individuals with severe mental illness. According to budget oversight prehearing responses, FY 2024 proposed funding also includes an allocation of $11.5 million for

the Housing Voucher program, and $18.1 million to support Mental Health Community Residential Facilities (MHCRFs). The Housing Voucher program pays rental subsidies for individuals and heads of households who can live independently in apartments of their choice, with supports provided by service providers to ensure successful housing tenure.

The Committee recognizes that there are issues with MHCRF provider compensation. MHCRFs are facilities that provide congregate, 24-hour supervised living in a homelike setting for mentally ill individuals who require supervision and supports. MHCHRs have not received an inflationary adjustment to their payment amounts for several years. These contractors are not given the opportunity to bid for contracts with their own proposed pricing, and instead, they must choose between accepting the contract rates proposed by DBH or forfeiting payment entirely. This binary choice places an undue burden on the contractors, who may not be able to sustain their operations under these conditions. During the budget hearing, Mark LeVota, Executive Director of the District of Columbia Behavioral Health Association, testified that an estimated $3.3 million would be required to adjust operator payment rates to reflect inflation since the last update. Additionally, he suggested that a greater amount might be necessary to align with the new regulatory performance expectations. The lack of flexibility in payment amounts and bidding processes may also prevent some contractors from offering their services to DBH, thereby limiting the pool of qualified providers.

Individuals in MHCRF's receive assistance from MHCRF staff with their activities of daily living, medication management, socialization, and supports from service providers to attain and maintain their mental health recovery. Facilities also collect $1,354 of residents' monthly Supplemental Security Income (SSI) to pay for food, shelter and living expenses. The resident keeps the remaining $100 per month as their personal needs allowance (PNA). The PNA is the portion of a Social Security recipient's benefits that is allocated for personal expenses, such as clothing, hygiene products, and other daily necessities. The Committee is concerned that such a low PNA in a high-cost area such as the District can lead to financial hardship for individuals who rely on Social Security as their primary source of income and is taking steps under DHCF to increase the PNA to $130 for individuals living in Certified Residential Facilities or Assisted Living Facilities. Low PNA can significantly impact the financial stability and well-being of Social Security recipients, making it difficult for them to afford necessities and potentially leading to negative health outcomes.

The Mayor's FY 2024 proposed budget included a $1,700,000 allocation to support a new, person-centered, intensive housing case management program. At the budget oversight hearing, the Committee learned that DBH is working with the Deputy Mayor of Health and Human Services and the DC Housing Authority to craft a model and protocol for the population this program aims to service. DBH has not provided the Committee with a spend plan for the funding and it appears that the agency is in the early planning stages. The Committee endorses the augmentation of DBH's housing support services, particularly for individuals experiencing challenges living in the community. While the Committee anticipates the development of these plans, it is apprehensive that the agency does not have a clear, well-defined strategy for the program, given the difficulties in hiring personnel in this sector. The Committee believes that it is unlikely that the program will be fully operational until the second or third quarter of FY 2024. **Therefore, the Committee recommends a reduction of $873,690 in recurring funds for Program 6500**

Adult/Transitional Youth Services, Activity 6507 Housing Support Services, CSG 41 for a partial reduction of the Mayor's proposed enhancement for this contract, leaving $873,690 for this contract in FY 2024.

Mental and Behavioral Health Rate Increase

DBH's FY 2024 proposed budget includes a one-time increase of $24,485,870 to support the local portion of the Medicaid Match for mental and behavioral health services. Considering that DBH did not restore the one-time FY 2023 increase of $6,725,674 for mental health services, that yields an approximate increase of $17,760,000 from FY 2023 to FY 2024. These funds represent only the local dollars devoted to the increased rate for services. Through the Department of Health Care Finance (DHCF), these funds are matched by the federal government under the Medicaid Federal Matching Assistance Percentage (FMAP).

Generally, the FMAP for the District is statutorily set for most enrollees such that DC pays 30% of Medicaid expenditures from local funds, and the federal government matches with 70% of expenditures. During the COVID public health emergency (PHE), there was an enhancement of the FMAP to 76.2%. Over the rest of calendar year 2023, there is a gradual unwinding of the enhanced FMAP(76.2% through March 2023; 75% through June 2023; 2.5% through September 2023 and 71.5% through December 2023). For some enrollees—those enrolled under the Medicaid expansion made possible under the Patient Protection and Affordable Care Act (ACA)—the federal government matches at a rate of 90% and DC pays just 10% for those enrollees. This federal matching means that the $24,485,870 increase in local funds will overall increase the funding for the mental and behavioral provider rate increase by well over $75 million. But only for FY2024.

This large increase in funding for mental and behavioral health provider payments has not been sufficiently supported and justified by either DBH or DHCF. The rate study on which payment rate increases are to be based is not yet complete, and despite multiple requests to see the preliminary results on which the proposed budget was based, the Committee did not receive any additional information on the expected rates. When the Committee requested the current payment rates and the proposed FY 2024 payment rates for the services included under this budget line, all services had a FY 2024 payment rate of "TBD", or to be determined. Further, when asked how the budget was constructed, DHCF stated that "many assumptions are likely to change or be updated."

The proposed rate increase comes while these services are moving from being paid under a fee-for-service model to being carved into the Medicaid managed care organizations (MCOs). Medicaid will pay a capitated rate to the MCOs, and the MCOs will pay out to providers, based on negotiated rates, for any services provided to the MCO's members. A capitated rate is a method of payment used in the healthcare industry, where a healthcare provider is paid a fixed amount per patient, regardless of the services provided. This means that the provider assumes the financial risk of providing care to the patient, as they are paid a set amount per patient, regardless of the actual cost of care. Any update to the fee schedule resulting from the rate study will take time to implement in the MCOs. First, a new underlying fee-for-service fee schedule will be proposed based on the rate study. Then MCOs will have to incorporate those new rates. Finally, the MCOs and DHCF will have to negotiate new capitated rates so that Medicaid adequately pays the MCOs

for the mental and behavioral services. This will involve actuarial studies to determine the appropriate capitated payment rate.

Ultimately, the proposed budget increase has not been supported with data or explanation despite numerous requests from the Committee. The Committee supports increasing the rates for mental and behavioral health services that have not seen a rate increase for several years. However, before budgeting such a large amount of money in a tight fiscal year, the Mayor, DBH, and DHCF must provide full and complete information that went into calculating the amount of money necessary to support a rate increase. The Committee is concerned that the budget is based on preliminary results which have not been shared and cannot be verified. **Therefore, the Committee recommends a reduction of $3,100,000 in one time funds for Program 6500 Adult/Transitional Youth Services, Activity 6515 Behavioral Health Rehab. - Local Match, CSG 50 to reduce the Mayor's enhancement for the Behavioral Health Rehabilitation Local Match, resulting in a $21.4 million enhancement for FY 2024.** This $21.4 local Medicaid funding for behavioral health services, which will be matched with federal funds under the FMAP, will yield a total budget increase for mental and behavioral health services over $70 million.

Across the Agency Reductions

The Committee recommends the following reductions in recurring local funds:

- **$32,266** for Program 1800 Behavioral Health Authority, Activity 1889 Legislative and Public Affairs, CSG 40 to eliminate a contract for which a vendor has yet to be determined;
- **$74,944** for Program 6700 Policy, Planning, & Evaluation Admin, Activity 6703 Training Institute, CSG 40 to eliminate a contract for a training consultant for which a vendor has yet to be determined;
- **$26,148** for Program 6500 Adult/Transitional Youth Services, Activity 6513 Substance Use Disorder Treatment Svcs, CSG 40 to eliminate funding for a substance use disorder support contract for which a vendor has yet to be determined;
- **$199,596** for Program 3800 St. Elizabeth's Hospital, Activity 3880 Office Of Chief Clinical Officer-SEH, CSG 40 for a contract without a stated purpose or description, and without a listed vendor;
- **$100,000** for Program 6600 Child/Adolescent/Family Services, Activity 6640 Specialty Services, CSG 41 for a contract for which a vendor has yet to be determined; and
- **$233,824** for Program 6600 Child/Adolescent/Family Services, Activity 6650 Evidence Based Practices (Ebp), CSG 40 for Reduction to contract for evidence-based services and training, aligning to historic spending for this contract at approximately $800,000.

b. Fiscal Year 2024 - 2029 Capital Budget Recommendations

The Mayor's proposed FY 2024 – FY 2029 capital budget request for DBH is $12,100,000. This represents a decrease of $600,000 from the FY 2023 – FY 2028 Capital Plan. The FY 2024 – FY 2029 Capital Plan includes $9,500,000 for the construction of a second Stabilization and Sobering Center; and $2,600,000 for numerous Saint Elizabeth's Hospital projects. Both projects are discussed in further detailed below.

Stabilization and Sobering Center

DBH's FY 2024 proposed capital budget includes $9,500,000 to support the opening of a second Stabilization and Sobering Center (Sobering Center). The Sobering Center will be located at 1338 Park Road, NW. DBH anticipates that the entire allocation will be expended in FY 2024. The Sobering Center will offer behavioral health interventions, referrals for ongoing community care, and medication-assisted treatment to District residents experiencing substance abuse disorders, as well as other behavioral or psychiatric challenges. The Sobering Center will also provide counseling and linkages to long-term community services and supports, including for individuals with co-occurring disorders.

This project includes renovation of 6,900 square feet of the existing FEMS Engine Company 11 building. The facility will be equipped with dormitory space for clients, office space, showers, a kitchen, ambulatory access, parking, observation rooms, and a nurse's station. The Sobering Centers aim to offer an alternative to involving law enforcement or transferring individuals to an emergency department. This can potentially alleviate the burden on hospitals and reduce wait times.

The Committee welcomed the news that a second Sobering Center will be in Ward 1 near the Columbia Heights Plaza, which has experienced significant substance use issues, including multiple overdoses. Columbia Heights has seen a rise in opioid-related overdoses, including fatal overdoses, and the establishment of a Sobering Center will enhance DBH's capacity to transition individuals into treatment and connect them with community resources. The Sobering Center is expected to address concerns raised by community members and business owners regarding drug use and violence in the vicinity.

Although the Committee supports this project moving forward, we join with residents in of Wards 5,7, and 8 to express concern about the lack of focused attention on those areas when it comes to stabilization and outreach. According to a March 2023 report by the DC Office of the Chief Medical Examiner (OCME) on the presence of opioids in deaths observed by the OCM from 2017-2022, overdoses were most frequent in Wards 5, 7, and 8. Several factors contribute to the high rates of opioid use and opioid-related overdoses in these wards, such as poverty, inadequate access to healthcare, and the availability of illegal opioids. The Committee appreciates DBH's efforts to tackle the opioid crisis in these wards and urges DBH to prioritize one of these wards for the location of the next Sobering Center. The Committee also urges DBH to involve community stakeholders, particularly those with lived experience, in selecting a site for a potential third Sobering Center.

The Committee expresses deep concern regarding the shortage of residential treatment beds, particularly for individuals with substance use disorders (SUDs). As more individuals connect with services through the Sobering Centers, it is possible that demand for SUD residential treatment will increase, exacerbating the shortage of available beds. There are several risk and negative consequences to a lack of residential treatment beds such as limited access to treatment, increased overdose deaths, increased strain on emergency services, increased crime and public safety risks, and an increased cost to District's healthcare system. It is essential that DBH prioritize

the availability of treatment options to ensure that individuals have the access to the care they need to overcome addiction and improve their overall health and well-being.

Saint Elizabeth's Hospital

DBH's FY 2024 proposed capital budget includes $2,600,000 for Saint Elizabeth's Hospital facilities projects. DBH reported that many of the FY 2023 and FY 2024 capital budget projects were delayed due to the pandemic and now that circumstances have improved, the agency is able to move the projects forward. These projects include HVAC modernization, flooring upgrades, replacement of furniture, and other small capital repairs and improvements. The Committee proposes no changes to this funding.

3. COMMITTEE POLICY RECOMMENDATIONS

The Committee recommends the agency adopt the following policy changes:

1. Improve the School Based Behavioral Health Program.

The mental health of youth in the District, like youth across the nation, has been declining steadily for over a decade, and the COVID-19 pandemic has exacerbated this crisis. According to the American Psychological Association, more than half of teens reported feeling more stressed, sad, or hopeless, and more lonely as a result of the pandemic. The Office of the State Superintendent (OSSE) 2021 Youth Risk Behavior Survey (YRBS) revealed that a significant percentage of youth in the District reported feeling sad or hopeless for two consecutive weeks, with an increase from 2017. The data on suicide was alarming, with 25% of females and 10% of males in high school reporting that they thought seriously about suicide; and 21% of females and 10% of males reporting that they had a plan. The survey also found increases in disordered eating behaviors among students, and a concerning percentage (28%) of high school students reporting witnessing physical violence in their neighborhood. Additionally, almost a third of male and female students reported being in a physical fight in the past year.

According to YRBS data, student access to school-based supportive adults has declined, and DBH continues to face challenges filling clinician vacancies. As of the 2022-2023 school year, at least 91 clinician positions are expected to remain vacant. Advocates have testified at both performance and budget oversight hearings about the challenges of clinician hiring, including high rates of burnout and competition from other employers.

During the Committee hearing, parents and caregivers expressed their urgent need for behavioral health services for their children. Sharnetta Boone-Ruffin, a board member of Parents Amplifying Voices (PAVE) in Education Ward 8, emphasized the importance of having these services available in schools, stating that:

> By receiving mental health services in school, students will be able to get the necessary mental health help they so desperately need. Receiving services at school will also help the parents/guardians not feel overwhelmed with trying to find their child mental help. Having these available services in the schools gives the student time to embrace, reflect, and use what was learned during sessions.

The Committee has several recommendations for DBH to improve the SBBH program:

- Increase the FY 2024 grants for CBO clinicians based on the rate study recommendations, utilizing savings from clinician vacancies.
- Revise the CBO clinician contracts to include requirements such as:
    - Proactive engagement of students and caregivers, with technical support from DBH if needed.
    - Development of digital materials (e.g. social media, Google Presentations, websites) to provide contact information, office hours, and schedules of available activities.
    - A minimum number of Tier 1 and 2 activities per month.
- Explore options for increasing the number of mental health practitioners in schools, including non-clinical mental health staff for providing Tier 1 and 2 services.
- Develop a plan to better address the behavioral health needs of students of color and girls within the SBBH program.
- Coordinate with DCPS and charter school leaders to provide dedicated spaces for clinicians to meet with students and lead groups that are quiet, comfortable, well-lit, and personalized.
- Improve accessibility to information about services in schools for students and caregivers, including widely sharing the contact information of clinical staff and School Behavioral Health Coordinators.

2. Identify a location in Wards 5, 7 or 8 to establish a third Stabilization and Sobering Center, and ensure that all Centers are developed with community input, are culturally competent, and have resources for community engagement.

In spring 2023, DBH plans to establish the first Stabilization and Sobering Center ("Sobering Center") at 35 K Street, NE. The Sobering Center aims to provide person-centered care and a recovery-oriented alternative to law enforcement response or transfer to an emergency department for individuals under the influence of alcohol or drugs. The Sobering Center will operate 24/7 and serve individuals 18 years or older. It will offer onsite services to screen and assess medical and behavioral health status and address immediate personal needs.

During the performance and budget hearings, the Committee received testimony from witnesses expressing concerns that the Sobering Centers may not offer culturally sensitive services and may not meet individuals where they are, instead requiring individuals to come to them on their own terms. The Committee strongly encourages DBH to engage community stakeholders, particularly those with first-hand experience, in the design of Sobering Center services, and the selection of a third location. As mentioned above, the Committee also urges DBH to prioritize Ward 5,7, or 8 for the location of the next Sobering Center. Stakeholders have expressed concerns about the first Sobering Center being run by an out-of-state contractor. The committee suggests that DBH establish a stakeholder advisory group, including individuals who are already involved in this area of work, such as the DecrimPoverty DC Coalition. This group should review the previous Sobering Center RFP process and ensure that future selection processes for Sobering Centers are more transparent and equitable.

The Committee recommends that DBH prioritize cultural competency training for all staff members, including contractors. Substance use disorders in the District disproportionately affect Black and Brown residents, LGBTQ+ individuals, and people from lower socioeconomic backgrounds. These groups may face additional barriers to treatment, including cultural stigma, discrimination, or language barriers, which can impact their access to care and the effectiveness of treatment. Cultural competency training can help treatment center staff members understand and address these barriers by providing them with the tools to effectively communicate with and treat patients from diverse backgrounds. The Committee also recommends that, as DBH prepares to launch its first Sobering Center and plans for additional centers, it should implement a community engagement strategy to enhance decision-making, establish trust and credibility, and garner support for the Sobering Centers. During both budget and performance oversight hearings, the Committee heard testimony from numerous witnesses about growing interest in the establishment of harm reduction centers in the District. Harm reduction centers are facilities that provide services and resources to individuals who use drugs and operate under the principle that drug use is a complex health issue that requires a comprehensive and compassionate approach and seek to reduce the harms associated with drug use while respecting the dignity and autonomy of individuals who use drugs.

Tamika Spellman, Policy and Community Engagement Manager with HIPs shared her concerns regarding the Sobering Center model: "[E]veryone who uses substances is not experiencing chaotic using behaviors and 'sobering up' does not stop people from dying, reversing, or preventing an overdose. Providing drug checking services does, which the sobering center does not do, and will never do…Is the point of this place to save lives or make it look like we are?" The Committee strongly encourages DBH to consider various approaches, including the harm reduction center framework, when developing their plans for establishing additional Sobering Centers.

3. *Expedite the establishment the Office of Opioid Abatement and establish a unified DBH division to consolidate opioid prevention, treatment, recovery, harm reduction, and research programs and services, regardless of funding source.*

The District, like several other states, is expected to receive funds from opioid litigation settlements over the next 18 years. With nearly $50 million in settlement agreements, the District's Opioid Abatement Fund was created in 2022 and is administered by the Office of the Attorney General. The fund is intended to support programs and initiatives that address the opioid crisis in the District and it will be a valuable resource in making a significant impact on the lives of people at risk of or struggling with opioid addiction. DBH is required to establish an Office of Opioid Abatement, which will work with the Mayor and the DC Council to establish an Opioid Abatement Advisory Commission, and the Commission will make recommendations to the Mayor on how to use the funds to support evidence-based and evidence-informed opioid prevention, treatment, recovery, and harm reduction programs.

As mentioned above, the Committee recommends that DBH continues with its plan to quickly establish the Office of Opioid Abatement and collaborate with the Commission to oversee the grant process for the use of opioid abatement settlement funds. Although funding was not included in the FY 2023 budget, DBH plans to allocate a portion of the deposited settlement funds

to establish the office. The Committee encourages DBH to move quickly to identify and nominate members and call the first meeting before the summer. There have been concerns that DBH does not engage stakeholders in the process of developing and implementing their strategic goals around opioids and substance abuse disorder, and this is an opportunity for DBH to improve in this regard. It is important that those with lived experience and those working on the front lines are included in the decision-making process, such as selecting providers, creating new programs, and determining the locations for targeted outreach.

The Committee is pleased to learn that DBH plans to dedicate staff to set up the office while they hire staff. However, the Committee expresses concern that establishing an office with separate staff from existing programs could result in a disjointed DBH opioid response. Therefore, the Committee urges DBH to reorganize its opioid response divisions to ensure that staff work together in a way that minimizes duplication of work. This could be achieved by creating cross-functional teams or consolidating teams or staff.

4. *Increase the District's resources and efforts to support individuals struggling with gambling addiction by partnering with gambling addiction organizations to develop a comprehensive plan for addressing problem gambling in the District.*

In 2018, the Council allocated the first $200,000 in revenue from legalized sports betting in the District to fund programs through the Department of Behavioral Health (DBH) aimed at preventing, treating, and researching gambling addiction. However, the DBH's proposed FY 2024 budget did not include the $200,000 that was allocated for Gambling Addiction Treatment and Research in FY 2022 and FY 2023. According to the National Council on Problem Gambling (NCPG), this decision leaves the District as the only state that does not dedicate funds for problem gambling, while neighboring Maryland and Virginia each spend over $2 million on gambling addiction resources.

The NCPG estimates that between 12,000 and 15,000 District residents currently suffer from gambling addiction, which can affect anyone regardless of age, gender, race or socioeconomic status. Several factors increase a person's risk of developing gambling problems, such as a history of trauma or abuse, stressful life events, or a history of other mental health problems like depression, anxiety, or substance abuse. Problem gambling can devastate an individual's life, affecting their finances, relationships, and mental health. In 2022, the NCPG received 4,892 calls from numbers with a 202 area code to their hotline, representing a 35% increase over 2021.

In FY 2022, DBH released a solicitation for a contractor to develop and implement a comprehensive prevention, treatment, and recovery program for problem gambling. However, a contractor was not selected, and the funding went unused. The DBH has indicated that they can support treatment for gambling disorders through existing mental health services and resources, but the Committee recommends that the DBH identify providers with a strong track record of supporting individuals with gambling disorders.

The Committee is encouraged by the DBH's confidence that their existing provider network has the capacity to address the needs of individuals struggling with gambling disorders, but they

are concerned that there are significant barriers preventing those suffering from gambling addiction from accessing support and resources. For instance, the DBH website lacks information on gambling addiction, and internet searches do not provide any District resources.

The Committee urges DBH to partner with gambling addiction organizations like the NCPG to create a plan to educate the public, including children and youth, about problem gambling, provide support for problem gamblers, and support research on problem gambling.

5. Provide targeted support and programming for youth experiencing homelessness.

The Committee heard from witnesses during this year's performance and budget hearing about the challenges that youth experiencing homelessness face when accessing the District's behavioral health services and programming. These challenges include a lack of culturally competent staff and the issue of youth being assigned behavioral health services in wards that differ from their place of residence. According to the Youth Economic Justice and Housing Coalition (YEJHC), led by DC Action: "Youth experiencing or at risk of homelessness have higher rates of mental health issues including suicide, depression, anxiety, and conduct disorders than those in stable homes. Lack of access to behavioral health care further complicates most individuals' ability to seek treatment. Increasing access to mental health supports will save lives." The Committee was pleased to learn that in the past year, DBH and the YEJHC held quarterly meetings, and youth homelessness providers met with DBH staff to educate them on how District youth experiencing homelessness can access behavioral health services and programs. The Committee hopes that this partnership will continue and that their collaborative efforts will result in improvements to access and quality of services for youth experiencing homelessness.

To further improve access to services for youth experiencing homelessness, the Committee recommends that DBH continue to collaborate with homelessness providers and the YEJHC to identify gaps in service access and create a comprehensive plan for servicing this population. Specifically, the Committee recommends exploring the creation of a traveling behavioral health unit staffed by culturally competent clinicians trained in trauma-informed care that would rotate among the District's youth homelessness service programs. This approach would increase access to services for this vulnerable population, particularly those who may face barriers to accessing traditional brick-and-mortar clinics due to transportation or other issues.

6. *Provide improved support and resources to those suffering from hoarding disorder.*

The Committee recommends that DBH develop a comprehensive plan to improve services for individuals with hoarding disorders (HD). According to the International OCD Foundation, it is estimated that between 2% and 6% of the population may suffer from hoarding disorder. Individuals suffering with HD often suffer from stigma that can make it difficult to access the help they need. HD can lead to social isolation, financial problems, and even health problems.

HD disproportionately affects the elderly for several reasons. Firstly, as people age, they tend to accumulate more possessions over time, which can lead to difficulty in letting go of items due to sentimental attachment or perceived value. Also, the loss of loved ones or social connections, as well as physical limitations, can lead to social isolation, loneliness, and a lack of

purpose, causing some individuals to fill the void by collecting objects. Thirdly, age-related cognitive decline, such as memory impairment or decision-making difficulties, can also contribute to hoarding behaviors. Finally, traumatic experiences or significant life events, such as the loss of a spouse, can trigger hoarding behaviors as a coping mechanism, and these events may become more common as people age.

HD can lead to behaviors that put the individual suffering from HD and their family and neighbors at risk of fire-related injury and damage. Individuals suffering with HD often accumulate combustible materials such as paper, cardboard, and other debris that can quickly fuel a fire. Additionally, cluttered and obstructed pathways can impede escape routes and hinder firefighters' access to the building in the event of a fire. The Committee recommends developing resources around fire safety and prevention for people suffering from HD. The materials could be distributed to individuals with HD, their families, and their caregivers, as well as to FEMS first responders.

DBH's plan for addressing HD should also prioritize increasing awareness and education of HD, including the provision of education and training opportunities for mental health professionals and other service providers. This can be accomplished through public education campaigns, professional training workshops, and other outreach efforts. By prioritizing education and prevention efforts, DBH can improve services for individuals with HD, reduce the risk of fires, and promote a safer and healthier environment for all DC residents.

To ensure individuals with HD receive timely and appropriate care, it is also essential to improve coordination between the Department of Aging and Community Living (DACL) and DBH since HD disproportionally affects the elderly, as mentioned above. The Committee recommends developing clear protocols for identifying and referring individuals with HD between the two agencies. This may involve cross-training staff to promote collaboration and ensure that staff have a shared understanding of HD and the services available to support individuals with this condition.

D. DEPARTMENT OF HEALTH CARE FINANCE (HT0)

1. AGENCY MISSION & OVERVIEW

The mission of the Department of Health Care Finance (DHCF) is to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for residents of the District of Columbia. DHCF provides health care services to low-income children, adults, the elderly, and persons with disabilities. More than 315,000 District of Columbia residents (approximately 45% of all residents) receive health care services through DHCF's Medicaid and Alliance programs. DHCF strives to provide these services in the most appropriate and cost-effective settings possible.

DHCF operates through the following 9 divisions:

Health Care Delivery Management (HCDM) – ensures that quality services and practices pervade all activities that affect the delivery of health care to beneficiaries served by the District's Medicaid, Children's Health Insurance Program (CHIP), and Alliance programs. HCDM accomplishes this through informed benefit design; use of prospective, concurrent, and retrospective utilization management; ongoing program evaluation; and the application of continuous quality measurement and improvement practices in furnishing preventive, acute, and chronic/long-term care services to children and adults through DHCF's managed care contractors and institutional and ambulatory fee-for-service providers.

This division contains the following 5 activities:

- Managed Care Management
- Preventive and Acute Care (Children's Health Services)
- Division of Quality and Health Outcomes
- Division of Clinicians, Pharmacy and Acute Provider Services
- Health Care Delivery Management Support Services

Long-Term Care Administration (LTCA) – provides oversight and monitoring of programs targeted to the elderly, persons with physical disabilities, and persons with intellectual and developmental disabilities. Through program development and day-to-day operations, the LTCA also ensures access to needed cost-effective, high-quality extended and long-term care services for Medicaid beneficiaries residing in home and community-based or institutional settings. The office also provides contract management of the long-term care supports and services contract.

This division contains the following 4 activities:

- Long-Term Care Support Services
- Oversight
- Operations
- Intake and Assessment

Health Care Policy and Planning – maintains the Medicaid and CHIP state plans that govern eligibility, scope of benefits, and reimbursement policies for the District's Medicaid and CHIP programs; develops policy for the Health Care Alliance program and other publicly funded health care programs that are administered or monitored by DHCF based on sound analysis of local and national health care and reimbursement policies and strategies; and ensures coordination and consistency among health care and reimbursement policies developed by the various divisions within DHCF. The division also designs and conducts research and evaluations of health care programs.

This division contains the following 4 activities:

- Policy Unit Management (Regulation and Policy Management)
- Data Analysis (Division of Analytics and Policy Research)
- Member Management (Eligibility Policy)
- Health Care Policy and Planning Support (Health Care Policy and Research Support)

DCAS Project Management Administration – has responsibility to design, develop, implement, and manage the DC Access System (DCAS), which is an integrated eligibility system for all health and human services for the District. In addition, this administration is responsible for supporting the functionality and funding for all components of DCAS and their seamless interface with the Health Benefits Exchange and Department of Human Services program components.

This division contains the following 4 activities:

- Program Management
- Project Management
- Organizational Change
- Information Technology

Health Care Finance – provides provider payments for the following provider types: Medicaid providers, public providers, and Health Care Alliance providers.

This division contains the following 3 activities:

- Medicaid Provider Payment
- Medicaid Public Provider Payment
- Alliance Provider Payment

Health Care Operations – ensures the division of programs that pertain to the payment of claims and manages the fiscal agent contract, the administrative contracts, systems, and provider enrollment and requirements. The office provides contract management of the Pharmacy Benefits Manager, the Quality Improvement Organization contract, and the Medicaid Management Information System (MMIS) Fiscal Intermediary contract as well as additional administrative contracts.

This division contains the following 3 activities:

- Medicaid Information Systems (Claims Management)
- Division of Public and Private Provider Services
- Health Care Operations Support (Health Care Operations Support Services)

Health Care Reform and Innovation (HCRIA) – identifies, validates, and disseminates information about new health care models and payment approaches serving Medicaid beneficiaries with the goal of enhancing health care quality, improving care and outcomes, promoting health equity, and enhancing the value and efficiency of DHCF programs. The division creates and tests new delivery system and payment models among providers in the District and builds collaborative learning networks to facilitate innovation, implement effective practices, and facilitate technology improvements to support delivery system re-design and improvement.

This division contains the following 2 activities:

- Affordable Care Reform and Grants Development
- Health Care Reform and Innovative Support Services

Agency Management – provides for administrative support and the required tools to achieve operational and programmatic results. This division is standard for all agencies using performance-based budgeting.

Agency Financial Operations – provides comprehensive and efficient financial management services to, and on behalf of, District agencies so that the financial integrity of the District of Columbia is maintained. This division is standard for all agencies using performance-based budgeting.

2. COMMITTEE BUDGET RECOMMENDATIONS

MAYOR'S FISCAL YEAR 2022 – 2024 OPERATING BUDGET SUMMARY

Description	*FY 2022 Actual*	*FY 2023 Approved*	*FY 2024 Proposed*	*% Change from FY 2022*
Department of Health Care Finance				
Operating Budget	$4,114,139,588	$3,736,526,743	$4,294,961,514	14.9
FTEs	268.3	378.8	366.6	-3.2
Capital Budget	$72,105,406	$127,675,000	$126,560,810	-0.9
FTEs	0.0	0.0	0.0	N/A

COMMITTEE COMMENTS AND ANALYSIS

Medicaid Enrollment and Provider Payments

The Committee has worked closely with the agency to understand the implications of the end of the Medicaid continuous enrollment requirement under the federal COVID public health

emergency on projected Medicaid enrollment and the FY 2024 Medicaid budget. This section describes the process of unwinding from the PHE but does not propose any changes to the budget as proposed.

Key to understanding DHCF's FY 2024 proposed budget is understanding the change in the FY 2023 approved budget to actual spending. The FY 2023 budget was approved with the assumption that the federal COVID public health emergency (PHE) would conclude prior to the start of FY 2023. Therefore, DHCF believed that Medicaid-related expenses would return to pre-PHE status. During the PHE, there was a rule requiring continuous coverage under Medicaid so that there were very few ways that an individual could lose their Medicaid coverage (e.g., death, moving out of state, or enrollee requests coverage be terminated). Over the course of the PHE, Medicaid enrollment grew in the District by approximately 20%. The FY 2023 budget assumed that the enrollment numbers would decrease to approach pre-PHE numbers before the start of FY 2023, but due to continuation of the PHE and subsequent legislation that decoupled the end of the Medicaid continuous enrollment from the PHE, that process did not start until April 1, 2023. This resulted in increased actual expenditures and is projected to continue at a level higher than budgeted through the rest of FY 2023.

This increased enrollment was partially offset by an enhanced federal matching percentage. Generally, the District's Federal Matching Assistance Percentage (FMAP) is statutorily set at 70% such that local funds are used to pay for 30% of Medicaid spending and federal funds pay 70%. However, under the Families First Coronavirus Response Act (FFCRA) of March 2020, the FMAP was enhanced to 76.2% for the duration of the PHE. The FY 2023 budget anticipated returning to the 70% rate, but it has stayed at 76.2% and due to changes in the omnibus spending bill of 2022, will gradually wind down for the remainder of calendar year 2023 (76.2% through March 2023; 75% through June 2023; 72.5% through September 2023; and 71.5% through December 2023).

Thus, although the FY 2024 proposed budget appears to show an operating budget increase of 14.9%, or approximately $558 million, from the FY 2023 approved budget, this proposed budget is actually a decrease from the actual amount projected to be spent in FY 2023 of approximately $4,132,000,000 as of December 31, 2022. This updated projection is approximately $855 million over the FY 2023 approved budget amount.

DHCF has produced the State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions in line with requirements from the Centers for Medicare & Medicaid Services (CMS).[5] Per CMS guidance, DHCF will spread the total District Medicaid population recertifications across 12 months such that the portion of enrollees being recertified in a month never exceeds 1/9 of the total enrollees. DHCF has structured the plan such that there is a two-month ramp-up period with a lower percentage of enrollees being recertified and then conducting a larger share in months three through eight.

[5] DHCF. "State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions." The Department of Health Care Finance. *Available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/images/DCStateRenewalDistributionPlan%20%281%29.pdf (accessed Apr. 25, 2023).

As recertifications continue, Medicaid enrollees who are no longer eligible under the program requirements will have their coverage terminated and will have to find health insurance coverage elsewhere. While Medicaid enrollment numbers increased by approximately 20% during the PHE, DHCF estimates that the final enrollment after all recertifications have been completed will decrease by between 10-20%. As enrollment decreases over time, Medicaid expenditures should similarly fall over time.

By contrast, as enrollment falls, the enhanced federal contribution under the FMAP will also decrease over time. This decrease in federal funding will require an increase in local funding. So, as overall enrollment falls over time, the local share of expenditures will increase over time.

Alliance Provider Payments

Contrary to the delay of recertifications in the Medicaid program, recertifications for enrollees under the Alliance program resumed July 2022. This has led to a significant reduction in Alliance enrollment, which in turn has contributed to a significant decrease in expenditures for Alliance provider payments. The approved FY 2023 budgeted amount was approximately $30 million less than the actual amount spent in FY 2022. Even with the decrease in budget, FY 2023 expenditures are projected to be approximately $10 million less than the budgeted amount according to DHCF's pre-hearing responses. This contributed to the FY 2024 proposed budget which reflects a $10 million decrease compared to the FY 2023 approved budget amount.

a. Fiscal Year 2024 Operating Budget Recommendations

The Mayor's FY 2024 proposed operating budget for DHCF is $4,294,961,514, which represents an 14.9% increase in operating funds, compared with the approved FY 2023 budget. This is largely due to updated projections for Medicaid expenditures resulting from the delay in resuming recertifications. Other large budget factors include enhancements for information technology services for the DC Access System and accounting services to conduct a set of mandatory provider audits. The funding supports 366.6 Full-Time Equivalents (FTEs) at DHCF, a 3.2% decrease from the FY 2023 approved level.

DC Access System

The DC Access System (DCAS) is an information technology system intended to unify and streamline the application process for public benefits. It is a rules-based engine that standardizes eligibility decisions based on policies, federal and local laws, and compliance requirements. The goal is to provide a single access point for individuals to all public benefits available in the District.

DCAS first went online in October 2013. A second release went online in October 2016, and the final phase three release went online in 2021. Over the past decade of implementation, DCAS has received more than $600 million in budget allocation, according to testimony provided by Director Wayne Turnage at the budget oversight hearing.

The Committee has concerns about the DCAS program overall. These concerns were echoed by the Director Turnage. When asked in the budget oversight hearing whether DCAS was working as it was originally intended, he answered with a simple, "No."

The question for the Committee, then, is how to bolster the system so that it delivers the best service possible while preserving the public's resources and not sending budget dollars to a program that is not working as intended. According to DHCF's post-hearing responses, approximately 326,000 residents are processed through DCAS each year for benefits including the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), the Alliance, the Immigrant Children's Program, and Medicaid. With a budget of $80,310,000, that calculates to more than $245 per individual who is processed through DCAS. That money supports only the application process and eligibility review. None of that roughly $245 per individual applicant goes to the actual benefits provided to beneficiaries.

At the budget oversight hearing, DHCF pointed to two operational changes that it expects to improve efficiency. There is a $4.3 million enhancement in the Mayor's proposed budget for information technology management to onboard a technical operations and maintenance vendor who will be responsible for maintaining all IT aspects of DCAS. This will shift the operations and maintenance from in-house contractors to an external vendor.

DHCF claims that these new investments will improve services and make the program more efficient. However, the budget increase is attributed in each case to two quarters of overlap in which DHCF will be paying for both the current contractors to be performing the services and also the new vendors. While the Committee recognizes the importance of a smooth transition and appreciates DHCF's commitment to not having any breaks in service, this overlap is overly long and overly costly. The Committee believes that six months of complete overlap is excessive.

The Committee believes that one quarter, or three months, of overlap between the outgoing staff and incoming vendor is sufficient to ensure a smooth transition to the new service vendors. **The Committee therefore recommends a total reduction of $3,355,849 in recurring local funds from Program 300A, DCAS Program Management Administration, Activity 340A Information Technology Management: a $1,495,456 reduction from CSG 70 for IT equipment and a $1,860,393 reduction in from CSG 41 for IT contracts** to reflect the cost savings from reduced redundancy of service during the vendor transition. This change will leave DCAS with more than $51.7 million in the budget for information technology management and provides an increase in the budget over the FY 2022 amount actually spent and the FY 2023 approved budget.

Infertility Treatment Services

The Expanding Access to Fertility Treatment Amendment Act of 2023 will require individual and group health plans to cover diagnosis and treatment of infertility including in vitro fertilization (IVF) services and will require Medicaid and Alliance to cover diagnosis and medication treatment of infertility. Additionally, the Act requires DHCF and the Medicaid program to work with CMS to understand the options and opportunities to expand Medicaid and Alliance coverage to cover all infertility services including IVF and fertility preservation services.

Infertility is a prevalent issue affecting thousands of people nationally and in the District. According to the National Institutes of Health, about 9% of men and 11% of women of reproductive age in the U.S. experience fertility challenges.[6] Despite affecting approximately one out of every ten individuals, health insurance companies provide less coverage and financial support for infertility conditions than they do for other types of medical conditions. This is severely limiting because the cost of diagnosis and treatment is such that treatment becomes financially infeasible for many individuals seeking fertility services. The average cost of a single IVF cycle in the District ranges from $10,500 to $12,625 depending on the clinic.[7] Approximately 80% of people who underwent IVF fertility treatments in 2018 had hardly any or no insurance coverage at all.[8]

This Act will begin to turn the tide on costs prohibiting many individuals experiencing fertility challenges from accessing fertility treatments. In the private insurance market, coverage will expand to include the full suite of fertility treatments including IVF. In the Medicaid and Alliance programs, the District will match New York state with the most comprehensive coverage for diagnosis of infertility and treatment with medication approved for such purpose. Medicaid and Alliance will not be required to cover IVF and fertility preservation services under the Act, but the bill requires DHCF to explore potential pathways to expand Medicaid and Alliance coverage to include these additional fertility services to have parity across all insurance providers.

The Council hosted a public hearing on this legislation on October 24, 2022, and the two Committees to which it was referred plan to host markups soon. To implement this Act, the Committee recommends the following enhancements to Program 5000 - Health Care Finance under CSG 50:

- **$17,000** in recurring local funds for Activity 5003 – Alliance Provider Payments, for Alliance fertility diagnosis services
- **$69,000** in recurring local funds for Activity 5003 – Alliance Provider Payments, for Alliance ovulation enhancing drugs
- **$211,000** in one-time local funds for Activity 5003 – Alliance Provider Payments, for Alliance ovulation enhancing drugs
- **$97,000** in recurring local funding for Activity 5001 – Medicaid Provider Payment, for Medicaid ovulation enhancing drugs
- **$306,000** in one-time local funds for Activity 5001 – Medicaid Provider Payment, for Medicaid ovulation enhancing drugs
- **$940,000** in recurring federal Medicaid payments for Activity 5001 – Medicaid Provider Payment, for Medicaid ovulation enhancing drugs

[6] National Institutes of Health. "A to Z Fact Sheets: Infertility and Fertility." National Institute of Child and Human Development. *available at*:. https://www.nichd.nih.gov/health/topics/factsheets/infertility (accessed Apr. 24, 2023).
[7] IVF Options. "D.C. Fertility Clinics." *available at*: https://ivfoptions.com/d-c/d-c-d-c/ (accessed Apr. 24, 2023).
[8] FertilityIQ, "2021 FertilityIQ Workplace Index." *available at*: https://www.fertilityiq.com/topics/fertilityiq-data-and-notes/fertilityiq-workplace-index (accessed Apr. 24, 2023)

The Committee also transfers $50,000 to the Committee on Business and Economic Development for the Department of Insurance, Securities, and Banking to conduct an actuarial assessment in Program 2000 - Insurance, Activity 2080 - DC Market Operations Insurance, CSG 0041 - Contractual Services-Other.

Personal Needs Allowances

The PNA is the amount of monthly income a Medicaid-funded resident of a nursing home, intermediate care facility, assisted living facility, or certified residential facility can keep of their personal income. This is generally a portion of the social security benefit that the individual is permitted to keep with the remainder going toward funding the facilities services provided to the individual. These funds can be used for any personal expenses not covered by Medicaid such as haircuts, clothing, entertainment, dining out, gifts for friends or family, or personal snacks.

In her FY 2024 proposed budget, the Mayor drew attention to personal needs allowances (PNA) by devoting approximately $745,000 to increase the PNA for individuals with disabilities through the Department of Disability Services. Further, as of February 1, 2023, all PNAs for Medicaid enrollees were set at $100.

Prior to February 2023, residents of assisted living facilities and certified residential facilities had a PNA of $100, while residents of intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and nursing facilities had a PNA of $70. The Committee heard testimony from public witnesses and in meetings with advocates from the long-term-care community that the higher PNA reflected the disparate level of independence between the facilities. While nursing facilities and ICF/IIDs provide almost all of the needs for residents, residents of assisted living facilities or certified residential facilities are more independent and have more ability to engage in life outside of the facility. Along with that independence comes additional costs of activities, goods, and services.

The Committee supports the increase to $100 for the PNAs of nursing facility residents and ICF/IID residents. The Committee believes $100 is still insufficient for Medicaid beneficiaries in all of these settings and will continue working with DHCF to enhance the PNA across the board. However, given the realities of budget constraints for FY 2024, the Committee is focused on increasing the PNA for residents of assisted living facilities and certified residential facilities to reflect their greater independence and higher costs of living. **The Committee therefore recommends an enhancement of $269,280 in recurring funds to Program 5000 - Health Care Finance, Activity 5001 - Medicaid Provider Payment, CSG 50, for the purpose of increasing the PNA for residents of assisted living facilities and certified residential facilities from $100 to $130 per month.**

Diaper Bank

The Greater DC Diaper Bank provides a critical source for basic baby needs and personal hygiene products across the District. The Diaper Bank distributes approximately 11 million diapers each year along with period products, baby formula, and wipes. At the budget oversight hearing, Corinne Cannon, the executive director of the Diaper Bank, testified that 63% of participants say

they have chosen between diapers and other family necessities like utilities, food, transportation, or rent. Rationing diapers so that the baby is changed less often than she should be leads to infection, rash, discomfort, and other health issues. While $100,000 of the grant money is recurring, $400,000 of one-time funding was not restored in the Mayor's FY 2024 proposed budget. The Diaper Bank stated that with the full $500,000 grant, they could serve over 15,000 families in DC in FY 2024. **Therefore, the Committee recommends an enhancement of the $400,000 in recurring local funds for Program 8000 - Health Care Reform and Innovation, Activity 8002 Affordable Care Reform and Grants Dev., CSG 50, to provide $500,000 in recurring grant funding for the Diaper Bank.**

Produce Rx

The Committee is pleased to see that the Mayor's FY 2024 proposed budget maintains $500,000 for the Produce Prescription Program (Produce Rx). This grant program, currently awarded to DC Greens, and has expanded to serve 1,319 adults and 898 children in the District annually. Produce Rx enables medical professionals to prescribe fresh fruits and vegetables to low-income patients experiencing or at risk of diet-related chronic illness. Analysis of the program has demonstrated that many participants reported lower body mass index (BMI), and the majority of participants reported improved relationships with their health care provider. This program is one of a suite of locally funded healthy food access programs aimed at improving health outcomes through incentives to purchase nutritious food, such as Produce Plus, Healthy Corners, and Joyful Food Markets, all of which fall in the DC Health budget. **The Committee supports Produce Rx and encourages the agency also to explore options for funding programs like this through Medicaid (see Policy Recommendation 1 below).**

First-Time Mother Home Visiting

In prior years, home visiting programs for new mothers have received grants through DC Health. The Mayor did not propose to continue funding the portion of the home visiting grant under DC Health that is specific to a home visiting program for first-time mothers who are eligible for Medicaid. The Committee believes that the nurse home visiting program for first-time mothers is an important part of improving maternal health outcomes in the District. Further, the Committee understands that the current provider under the grant program is fully operational and would like additional time and resources to build evidence of effectiveness of the program in the District. The Committee is choosing to locate the enhanced grant funding in DHCF rather than DC Health because, as described in Policy Recommendation 1 below, the Committee believes that DHCF should work to incorporate the home visiting program for first-time mothers into a Medicaid State Plan Amendment so that it can receive Medicaid funding.

Therefore, the Committee accepts $225,000 in one-time local funds from the Committee on Public Works and Operations for Program 8000 - Health Care Reform and Innovation, Activity 8002 - Affordable Care Reform and Grants Dev., CSG 50 for a grant to support a home visiting program for first-time mothers eligible for Medicaid as described in the BSA subtitle, the First-Time Mothers Home Visiting Program Amendment Act of 2023.

DHCF Reporting Requirements

The Committee is funding a subtitle that would require the Director of DHCF to file reports to the Council regarding payment pathways for certain services under Medicaid. The required reports include one on payment pathways for medical respite care for individuals experiencing homelessness, a report on value-based purchasing under Medicaid MCOs, and quarterly reporting of certain MCO metrics including enrolled beneficiaries, number of beneficiaries without a primary care physician, and utilization metrics.

These new reporting requirements are similar to prior reporting requirements that were tied to funding for grant programs in previous fiscal years. The present subtitle would separate the reporting requirement from any grant programs. Medical respite care provides acute and post-acute care for individuals experiencing homelessness who are not able to recover from physical illness or injury living on the streets but who are not ill enough to warrant an inpatient stay in the hospital. Medical respite care provides short-term residential care so that individuals have the opportunity to rest and recover in a safe environment with supportive medical care and other services. Not only is medical respite care pivotal for the individual patients, but it can alleviate a burden on the health care system. The Committee has heard from several District hospitals who have provided care to individuals experiencing homelessness and encountered challenges when preparing the individual for discharge. When the individual no longer requires inpatient level of care but is unable to be discharged to a safe location for recovery, the hospital is left to provide additional services beyond the level of intensity the individual requires. This is an inefficient drain on our health care resources. This report will support efforts to provide medical respite care for individuals experiencing homelessness.

The MCO reports are important for understanding how the MCOs are providing value to the Medicaid program. First, the report on value-based payment models will shed light on the current efforts to align financial incentives and accountability with the total costs of health care. Additionally, the MCO information will provide data evidence showing whether MCO case management services are effective. MCOs are expected to connect all enrollees with primary care physicians, and this report will show whether that is in fact happening. Additionally, the emergency department utilization data for MCO enrollees will highlight whether the MCOs are effectively managing cases to avoid use of emergency services.

The Committee therefore recommends a one-time enhancement of $55,000 in one-time local funds for Program 3000 - Healthcare Policy and Planning, Activity 3010 - Health Care Policy and Planning Support, CSG 41, to fund the BSA subtitle to complete the reports.

b. Fiscal Year 2024 - 2029 Capital Budget Recommendations

The Mayor's FY 2024 – FY 2029 proposed capital budget for DHCF is $126,560,810. This represents a decrease of 0.9% from the FY 2023 – FY 2028 Capital Plan. The FY 2024 – FY 2029 Capital Plan includes moving the money allotted to the construction of Cedar Hill Medical Center up one year from FY 2025 to FY 2024. This project is discussed in further detail below.

Cedar Hill Medical Center GW Health (Saint Elizabeth's Medical Center)

DHCF works in tandem with the Department of General Services (DGS) to oversee the construction of a new full-service hospital and ambulatory care center at Saint Elizabeth's to improve health care and address inequalities in health access and outcomes. The facility will have 136 beds with the capacity to expand to an additional 48 beds and will be operated by Universal Health Services and George Washington Health.

The Mayor has proposed to move $10,000,000 of capital funding up from FY 2025 to FY 2024. The construction of Cedar Hill Medical Center has encountered cost increases due to inflation in the construction sector, but DHCF and DGS have managed to keep inflation lower than the national average. Additionally, supply chain challenges for large medical equipment have necessitated entering orders a year earlier than originally planned. The project has also obtained private funding to construct an additional floor on the Medical Center that will be an adaptable shell so that the floor can be developed in the future in accordance with the needs of the hospital. The Committee supports this move to ensure the Medical Center opens on time.

3. COMMITTEE POLICY RECOMMENDATIONS

The Committee recommends the agency adopt the following policy changes:

1. *Incorporate Medicaid State Plan Amendments and apply for waivers under section 1115 or 1915 of the Social Security Act to expand Medicaid coverage for additional support services.*

Evidence-Based Home Visiting: The Committee has supported home visiting services for expecting mothers through early childhood under grants from the Department of Health for years. These programs help families provide a nurturing, healthy environment for both the baby and mother. Over the last few years, at least 20 states have added evidence-based home visiting programs and services to their Medicaid coverage through State Plan Amendments. The Committee encourages DHCF to submit a State Plan Amendment to add evidence-based home visiting programs to Medicaid coverage in time for appropriate funding to be allocated for FY 2025. Along with a general effort to expand such coverage, DHCF should provide guidance to providers about qualifying as an evidence-based program. Further, DHCF should work with providers and programs to bolster their evidence by providing grants and technical assistance so that those programs delivering quality care can develop their evidence to qualify for Medicaid funding in the future.

At the budget oversight hearing, Medicaid Director Melisa Byrd indicated that home visiting programs should engage with Medicaid MCOs directly to obtain coverage under those plans. Although the Committee agrees that these programs should do outreach with the MCOs, the Committee believes that DHCF and the Medicaid program should implement formal policy through the State Plan Amendment to ensure coverage for these programs and services across all MCOs and fee-for-service Medicaid.

Violence Interruption Programs: Some violence interruption activities undertaken by the Mayor through the Deputy Mayor for Public Safety and Justice, Office of Neighborhood Safety

and Engagement, Office of the Attorney General, Office of Victim Services and Justice Grants, and other agencies likely qualify for Medicaid reimbursement. The Committee encourages DHCF to apply for any waivers necessary and to offer State Plan Amendments as appropriate to cover these programs through Medicaid. At the budget oversight hearing, DHCF stated they are in discussions with the Office of Neighborhood Safety and Engagement about what violence interruption services currently funded by the District could be covered under Medicaid. We urge DHCF to continue collaborating across the government to secure Medicaid funding for these activities.

Medically Tailored Meals: Under this program, medically tailored meals are delivered to individuals with severe illness as prescribed by a medical professional or healthcare plan. The meals are designed according to tailored recommendations by a registered dietitian nutritionist to address the individual's nutritional needs and improve health outcomes. Participation in a medically tailored meals program is associated with fewer hospital and nursing home admissions and with lower overall medical utilization and spending. The Committee urges DHCF and Medicaid to expand coverage for medically tailored meals so that individuals who need the nutrition support can receive the prepared meals to improve their health conditions.

Medical Respite Care for Individuals Experiencing Homelessness: Medical respite care provides acute and post-acute care for individuals experiencing homelessness who are not able to recover from illness or injury while unhoused, but who are not ill enough to warrant an inpatient stay in the hospital. Medical respite care provides short-term residential care so that individuals experiencing homelessness have the opportunity to rest and recover in a safe environment with supportive medical care and other services. Not only is medical respite care pivotal for the individual patients, but it can alleviate a burden on the health care system. The Committee has heard from several District hospitals who have provided care to individuals experiencing homelessness and, when the individual no longer requires inpatient level of care but has no safe location for recovery, the hospital is left to provide additional services beyond the level of intensity the individual requires. This is an inefficient drain on our health care resources. The Committee therefore urges DHCF to expand Medicaid funding to support medical respite care for individuals experiencing homelessness so that individuals have a safe location to which they can be discharged to receive care and supportive services while they recover.

2. *Explore opportunities to provide long-term care bed placements for Alliance members to be discharged after hospital stays.*

The need for long-term care bed placements for Alliance members echoes the need for medical respite care for individuals experiencing homelessness. Currently, Alliance does not reimburse providers for long-term care stays. When a hospital treats an Alliance member, they may reach a point where the individual no longer needs the hospital inpatient level of care and could safely be discharged to long-term care such as in a skilled nursing facility. However, because Alliance does not pay for these services, the hospital is not able to discharge the patient to such a facility. The result is that the hospital must continue to provide care in the inpatient setting which is beyond the level of intensity needed by the patient. The result is a waste of health care resources and a burden on the hospitals. Members of the DC Hospital Association have cited examples of patients with hospital stays longer than 300 days because of this discharging challenge. The Committee urges DHCF to work with hospitals and long-term care providers like skilled nursing

facilities to ensure there are places for Alliance members to be discharged to and that there is appropriate reimbursement for those services.

3. *Expand Medicaid eligibility to include a Medicaid Buy-In for Workers with Disabilities option.*

Individuals with disabilities who desire to enter the workforce are too often faced with a choice between enrolling in Medicaid and working. This is because in DC, residents with disabilities face a limit on the income they can earn to still qualify for Medicaid. Currently, Medicaid benefits are terminated when an individual earns approximately $14,580 annually for individuals enrolled in the program for Aged, Blind & Disabled, or about $29,000 annually for individuals enrolled in the home and community-based services waiver program. This level is severely insufficient to be able to afford the many services individuals with disabilities may require in a year. Forty-six states have recognized this issue and created a Medicaid Buy-In for Workers with Disabilities program so that individuals with disabilities can work, earn an income, and buy into the Medicaid program. The Committee urges DHCF to explore the pathway to implementing this program in the District.

4. *Continue working to increase wages for direct care providers.*

DHCF Director Turnage indicated during performance oversight that DHCF intends to reach an average pay of 117.6% of the living wage in FY 2024. At the budget oversight hearing, Director Turnage confirmed that DHCF is still on track to meet this average pay rate. Advocates have consistently argued that the rate of payment increases is insufficient to draw the necessary staffing levels to provide these important direct support services. While there may not be room in a tight budget to further accelerate the wage growth, the Committee affirms its support for continuing to search for opportunities to enhance the wages of direct care providers.

5. *Restart the Maternal Health Advisory Group.*

The Maternal Health Advisory Group was tasked with a set of primary objectives related to state plan amendments for Medicaid coverage from sixty days to 12 months postpartum, authorizing coverage of doula services, and implementing non-emergency transformation for Alliance and Immigrant Children's Program members. Once these objectives were achieved, the Group was concluded and disbanded. The Committee believes there is a need for ongoing work regarding maternal health to improve outcomes for new mothers and infants. At the budget oversight hearing, DHCF expressed an openness to restarting the Maternal Health Advisory group. The Committee urges DHCF to restart the Group and consider merging this Maternal Health Advisory Group with the Perinatal Mental Health Taskforce so that there is a unified group looking holistically at the mental and physical health of new and expecting mothers and their infants.

6. *Include a maternal health accountability metric for MCOs.*

The Committee recommends DHCF revise the MCO performance measures to include at least one maternal health metric. This would allow DHCF to withhold a portion of the MCO's reimbursement such that the MCO would only receive the withheld portion if it meets the threshold level on that metric. When Chairperson Henderson asked about this at the budget oversight hearing, Director Turnage said it would be a good idea to add a maternal health performance

measure for MCOs. In DHCF's post-hearing response #10, DHCF indicated that the full multi-year contract would allow DHCF to include a targeted maternal health initiative into a pay-for-performance program. DHCF further provided two performance metrics currently used to evaluate performance within maternal health including (1) the percentage of live births that received a prenatal care visit in the first trimester, and (2) the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. The Committee urges DHCF to add a measure that will appropriately hold MCOs accountable for their care coordination role in maternal health.

E. OFFICE OF THE DEPUTY MAYOR FOR HEALTH AND HUMAN SERVICES (HG0)

1. AGENCY OVERVIEW & MISSION

The mission of the Office of the Deputy Mayor for Health and Human Services (DMHHS) is to support the Mayor in coordinating a comprehensive system of benefits, goods, and services across multiple agencies to ensure that children, youth, and adults with and without disabilities can lead healthy, meaningful, and productive lives.

DMHHS provides leadership for policy and planning; government relations; and communication and community relations for the agencies under its jurisdiction, including:

1. Child and Family Services Agency (CFSA)
2. Department of Behavioral Health (DBH)
3. Department on Disability Services (DDS)
4. Department of Health (DC Health)
5. Department of Health Care Finance (DHCF)
6. Department of Human Services (DHS)
7. Department of Aging and Community Living (DACL)

DMHHS manages two special initiatives: Age-Friendly DC and the Interagency Council on Homelessness. DMHHS also oversees the administration's encampment cleaning and closure efforts.

The Office of the Deputy Mayor for Health and Human Services operates through the following 2 programs:

Human Support Services – supports the agency's mission to provide oversight and support for all citywide health and human services-related policies, activities, and initiatives under its jurisdiction, by:

- Developing and supporting policies and programs to improve the delivery of services by government agencies and contracted providers;
- Coordinating inter-agency activities and initiatives;
- Identifying opportunities for reducing redundancies, leveraging resources, creating economies of scale, and improving outcomes; and
- Ensuring compliance with local and federal mandates.

Agency Management – Provides for administrative support and the required tools to achieve operational and programmatic results. This program is standard for all agencies using performance-based budgeting.

2. COMMITTEE BUGET RECOMMENDATIONS

a. Fiscal Year 2024 Operating Budget Recommendations

The Mayor's proposed FY 2024 operating budget for DMHHS is $2,588,900, which represents a 9.5% decrease in operating funds, compared with the approved FY 2023 budget. This is largely due to a reduction of 1 vacant Full-Time Equivalent (FTE) position in the Agency Management Program and $124,652 in Subsidies in the Human Support Services program. The funding supports 13.8 FTEs, a 6.8% decrease from the FY 2023 approved level. Notably, the agency also employs 8 Interagency FTEs budgeted in other agencies, 2 from Department of Health Care Finance and 6 from the Department of Human Services.

Encampment Cleaning and Closure

DMHHS leads the Executive's efforts to clean and close encampments in the District, where unhoused individuals are living in tents or other non-permanent structures, and to work to connect those individuals with housing, behavioral health resources, and other supports. From August 2021 to July 2022, DMHHS led the Coordinated Assistance and Resources for Encampments (CARE) Pilot Program, which provided intensive case management, behavioral health/substance use support, and expediated affordable housing for individuals who were residing in three encampment sites (see more below). In FY 2022, the CARE Pilot cost $3.9 million, as seen in the Table below provided by DMHHS in their post-hearing written responses. In FY 2023, DHS services associated with encampment cleanings and closure rose to $4.2 million.

DHS	**FY21**	**FY22**
Encampment-Specific Outreach Staff and Equipment	208,375	1,252,500
Outreach Staff Equipment (one-time cost)	15,000	N/A
Client Related Costs	$14,000	$86,000
2 DHS FTEs (Housing Navigator and Encampment Liaison)	$35,333	$212,000
Outreach/Communications Campaign Supplies	$1,150	$3,500
DBH		
2 Multidisciplinary Teams (2 teams of 9 staff each)	N/A	$1,560,522
DPW		
Encampment-Specific Trash Route	$84,049	$336,199
Encampment-Specific Cleanup Team (7 staff)	$48,963	$293,780
Expanded Biohazard Contract	N/A	$180,000
Totals	$406,870	$3,924,501

Over performance and budget oversight, the Committee has heard from advocates and individuals experiencing homelessness who strongly oppose DMHHS' encampment cleaning and closure program. They raise several important points about the problems with this program. First, providing expedited affordable housing to individuals in encampments is unfair to individuals

living in shelters, cars, or on benches, who have been waiting for housing assistance for years. Second, and related, offering expedited housing to individuals in encampments drives more people to live in encampments and not seek out safer shelter elsewhere. Third, individuals who do receive expedited housing vouchers are still largely waiting in temporary shelters or hotels because the District has a significant shortage of caseworkers connecting people with vouchers to affordable housing.

To that point, in DMHHS' pre-hearing written responses, the agency reported that out of 135 residents forced to leave encampments in FY 2022, 85 were matched to a housing resource (PSH or RRH) and have been placed in temporary shelter/housing or permanently housed. In FY 2023, only 1 out of 10 individuals removed from encampments had been matched to housing. Many other individuals refuse services from the government, calling into question how effectively DMHHS is building relationships and trust with these individuals, and how the encampment clearing program is compromising the District's outreach.

Most recently, the closure of the large encampment at McPherson Square Park on February 15, 2023, sparked debate across the District. The National Park Service (NPS) property had become home to an encampment of approximately 74 residents. NPS and the District cited significant safety and public health concerns as the rationale for closing the park two months earlier than planned and during hypothermia season. Out of the 74 residents removed from the encampment, 47 refused services, 24 were matched with a housing resource (which, as described above, does not mean matching with housing), and three were not included in DMHHS' report.

The Committee does not make budget recommendations on the encampment cleaning and closure program since most of the budget lies within the Department of Human Services and Department of Public Works budgets. That said, the Committee urges DMHHS to focus its resources on clearing the backlog of individuals with vouchers waiting to be matched with permanent housing, improving its processes to build trust with individuals in encampments so that more will accept services and support, and improving its data collection and reporting on encampment closures, including better tracking how many individuals are successfully housed.

Vacancy Savings

DMHHS provides an important coordinating and oversight role over the agencies within its cluster. That said, it has a relatively large policy team, including three vacancies. The Committee talked to the agency and understands that offers have been made for two of these vacancies. **Therefore, the Committee recommends sweeping the remaining vacant FTE, a reduction in FY 2023 one-time local funds of $95,816 from CSG 11 and $15,522 from CSG 14 for Program 1000 Agency Management, Activity 1090 Performance Management Activity, to create FY 2023 vacancy savings, and a reduction in FY 2024 recurring local funds of $95,816 from CSG 11 and $15,522 from CSG 14 for Program 1000 Agency Management, Activity 1090 Performance Management Activity, to create vacancy savings.**

b. **Fiscal Year 2024 – 2029 Capital Budget Recommendations**

The Mayor's proposed budget for the Office of the Deputy Mayor for Health and Human Services does not include any capital funds.

2. COMMITTEE POLICY RECOMMENDATIONS

The Committee recommends the agency adopt the following policy changes:

1. *Publish the Coordinated Assistance and Resources for Encampments (CARE) Pilot Program Report and increase transparency on the goals, outcomes, and budget allocated to encampment cleanings and closures.*

From August 2021 through July 2022, the CARE Pilot, managed by DMHHS, provided intensive case management, behavioral health/substance use support, and expediated affordable housing for individuals who were residing in three encampment sites: NoMa (L/M St. Underpasses), the Park at New Jersey Ave and O Street NW, and 20th/21st and E St. NW. Although the Pilot ended in July 2022 and DMHHS testified that its CARE Pilot Program Report was finished and submitted to the Mayor in late FY 2022, the report has yet to be published. In its FY 2024 budget pre-hearing responses, DMHHS described that the report, and next steps on the District's encampment program, are now being held in abeyance as DHS works to reduce the number of existing cases in which residents who are matched to vouchers continue to await case management assignments and permanent housing placement.

The report being left unpublished is troubling for several reasons. First, it hinders the Council and public's ability to understand the outcomes of the program, including how many residents were housed and remain housed. It also means that the Executive will continue its encampment cleaning and closure efforts without the Council or the public understanding the outcomes of the most aggressive push to house residents affected by encampment closures, and how the Executive is incorporated lessons learned by the pilot into its continued encampment cleaning and closure program.

2. *Take a proactive role in ensuring that there is a detailed, feasible transition plan for the closure of United Medical Center and opening of the Cedar Hill Regional Medical Center, particularly related to patient care.*

At the United Medical Center FY 2024 budget oversight hearing, UMC testified that they are developing a transition plan for the closure of the hospital, which should be finalized by fall 2023. The Committee believes it is crucial that this plan is developed long before the planned opening of Cedar Hill Regional Medical Center in early 2025. Specifically, there needs to be a detailed plan for transferring UMC patients to the new hospital, and for safely discharging patients who do not meet the United Health Services' requirements for in-patient care, such as uninsured or underinsured patients who no longer need hospital care but have no funds for caregivers or long-term care. DMHHS should facilitate communication between the two hospital providers to ensure both parties share expectations and protocols, and should also be advising UMC on options for safely discharging patients who cannot be transferred to Cedar Hill.

F. NOT-FOR-PROFIT HOSPITAL CORPORATION & SUBSIDY (HX0)

1. AGENCY MISSION & OVERVIEW

The Not-For-Profit Hospital Corporation Subsidy provides a direct payment to the Not-For-Profit Hospital Corporation (NFPHC). The NFPHC is an independent District instrumentality, created by legislation adopted by the Council of the District of Columbia to hold the land, improvements, and equipment of the hospital known as United Medical Center.

NFPHC is governed by a Fiscal Management Board, which serves as a control board, consisting of 9 members, 7 of whom are voting members and 2 of whom are non-voting members. Voting members of the Fiscal Management Board include:

- The Chief Financial Officer of the District of Columbia, or his or her designee, who shall serve as chair of the Fiscal Management Board;
- The Deputy Mayor for Health and Human Services, or his or her designee;
- The Director of the Child and Family Services Agency, or his or her designee;
- One citizen member from Ward 8, appointed by the Mayor;
- A citizen member, appointed by the Mayor, who has experience serving as the City Administrator of the District of Columbia;
- An individual with expertise in hospital management or finance, appointed by the Mayor; and
- One representative from each of the two unions, selected by each representative union, maintaining the largest collective bargaining units at United Medical Center.

The Chief Executive Officer of the Corporation and the Chief Medical Officer of the Corporation serve as non-voting ex officio members.

The NFPHC operates through revenues generated primarily, though not exclusively, through its hospital patient operations.

Hospital Services – NFPHC operates an acute care program with 234 licensed acute care beds, which provides medical, surgical, and psychiatric care. Other hospital services include adult emergency care and outpatient and diagnostic services. Children's National Medical Center, through a lease arrangement and as a separately licensed organization, provides pediatric emergency care on the campus of NFPHC.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. Fiscal Year 2024 Operating Budget Recommendations

The Mayor's FY 2024 proposed subsidy for the Not-For-Profit Hospital Corporation is $15,000,000. In UMC's testimony submitted to the Committee, they mention that UMC has had staffing challenges pre-dating the pandemic due to the announcement of the hospital's planned closure. During the fourth quarter of FY 2022, there were improvements in nurse staffing in the ED, ICU, and Medical/Surgical/Telemetry units, but the hospital still faces staffing challenges. To address staff shortages, the contract labor budget was significantly increased from $3.5M to $7.8M, and the hospital continues to actively recruit for critical vacancies while using contract labor as necessary to support clinical operations.

The Committee approves the operating budget as proposed by the Mayor.

b. Fiscal Year 2024 - 2029 Capital Budget Recommendations

The Mayor's proposed budgets for the Not-for-Profit Hospital Corporation and the Not-for-Profit Hospital Corporation Subsidy do not include any capital funds. However, a capital budget of $3,049.433 has been set aside by DHCF for UMC improvements, which will primarily be used for eligible repair projects due to the aging physical plant. These projects are essential for maintaining a safe environment for patients and staff, as well as complying with regulatory standards throughout the year. A spending plan is currently being developed and will be distributed by DHCF to ensure effective management of these capital expenses.

3. COMMITTEE POLICY RECOMMENDATIONS

1. *Collaborate with the Deputy Mayor for Health and Human Services and community leaders to develop, publish and execute a comprehensive closure plan that emphasizes transparency and public engagement.*

The Committee recommends that the United Medical Center Board and leadership collaborate with the Deputy Mayor for Health and Human Services to develop and regularly update a comprehensive plan for the closure of the hospital by the end of the third quarter. This plan should include details on managing resources, transferring patients to alternative facilities, and transitioning staff to new positions. In addition, the Committee suggests that UMC hold public meetings to provide transparency and engage with the community to address any concerns or feedback.

2. *Work with Cedar Hill Regional Medical Center and Universal Health Services to ensure the safe transfer of patients, and in accordance with the Cedar Hill Agreements (L23-138), the voluntary training of staff who are interested in working at the new hospital.*

As required by the Council approved Cedar Hill Agreements, UMC should work with Cedar Hill and Universal Health Services on the specific voluntary training program for UMC employees interested in working at the new hospital. The Committee also urges UMC to work with Cedar Hill or other healthcare facilities on plans for the safe transfer of all patients in its care.

3. *Engage with community leaders and ANCs to address concerns regarding the Methadone clinic's relocation from Good Hope Road to United Medical Center, while continuing to partner with community leaders to address substance abuse in Wards 7 and 8.*

The Committee recommends that UMC take a leadership role in engaging with community leaders and ANCs to discuss the relocation of the Methadone clinic from Good Hope Road to United Medical Center, addressing any concerns or issues raised by the community and seeking input and feedback from stakeholders to ensure an effective and respectful relocation. Additionally, UMC should continue to collaborate with community leaders to address substance abuse in Wards 7 and 8, including supporting community-led initiatives to provide education and resources to individuals struggling with substance abuse disorders, as well as advocating for policy changes to address the underlying causes of substance abuse in the community. The Committee is encouraged by community advocates' conversations with UMC Board members regarding the relocation of the Ward 8 Methadone clinic and urges UMC to build upon these conversations to address critical community substance use issues.

G. HEALTH BENEFIT EXCHANGE AUTHORITY (HI0)

1. AGENCY MISSION & OVERVIEW

The mission of the D.C. Health Benefit Exchange Authority (HBX) is to implement a health insurance exchange program in the District of Columbia in accordance with the Patient Protection and Affordable Care Act, thereby ensuring access to quality and affordable health care to all District of Columbia residents.

In March of 2010, the federal Patient Protection and Affordable Care Act of 2010 (ACA) was signed into law with the central goal of ensuring that all Americans have access to quality, affordable health care. It enabled implementation of significant health insurance reforms including the establishment of Health Benefit Exchanges nationwide. The DC Health Benefit Exchange Authority (HBX) is a quasi-governmental agency of the District of Columbia charged with implementing and operating the District's Health Benefit Exchange. HBX operates DC Health Link, an online marketplace for District residents and small businesses to compare private health insurance plans, learn if they are eligible for tax credits or subsidies to purchase private insurance or qualify for Medicaid, and enroll in a health plan that best meets their needs. HBX enables individuals and small businesses and their employees to find affordable and easier-to-understand health insurance. HBX is now in its eleventh year of operation and concluded its tenth open enrollment period for people purchasing individual insurance on January 31, 2023.

The DC Health Benefit Exchange Authority operates through the following 5 programs:

Consumer Education and Outreach – educates and informs District residents, small business owners, and small business employees about health coverage options available through DC Health Link by organizing special events, participating in sponsored activities, conducting educational seminars, partnering with other District agencies and organizations as well as conducting intensive outreach through all of these methods.

This program contains the following 3 activities:

- Consumer Education and Outreach Support Services
- Marketing and Communication
- Navigators, Counselors, and In-Person Assisters (IPA)

Marketplace Innovation Policy and Operations – performs functions required of all state-based marketplaces, including plan management eligibility determinations, and certification of qualified health and dental plans, as well as to ensure the efficient operation of an online insurance marketplace where individuals, families, small businesses, and their employees can shop and enroll in health insurance.

This program contains the following 6 activities:

- Contact Center
- Plan Management

- Eligibility and Enrollment
- Member Services
- Data Analytics and Reporting
- SHOP Operations

IT Related Operations – provides critical development, maintenance, and support for DC Health Link. The work includes providing operations and maintenance of HBX systems, managing the team of consultants that develop functionality for DC Health Link, and managing the EDI Operations team that oversees information transmitted between carriers and DC Health Link.

Agency Management – provides for administrative support and the required tools to achieve operational and programmatic results. This program is standard for all agencies using performance-based budgeting.

Agency Financial Operations – provides comprehensive and efficient financial management services to, and on behalf of, District agencies so that the financial integrity of the District of Columbia is maintained. This program is standard for all agencies using performance-based budgeting.

MAYOR'S FISCAL YEAR 2022 – 2024 OPERATING BUDGET SUMMARY

Description	*FY 2022 Actual*	*FY 2023 Approved*	*FY 2024 Proposed*	*% Change from FY 2022*
DC Health Benefit Exchange Authority				
Operating Budget	$39,657,848	$35,684,055	$37,552,148	5.2
FTEs	103.7	117	123	5.1
Capital Budget	$0	$0	$0	N/A
FTEs	0.0	0.0	0.0	N/A

COMMITTEE COMMENTS & ANALYSIS

HealthCare4ChildCare

The Committee commends Director Mila Kofman and her staff at HBX for their collaboration with the Office of the State Superintendent of Education to facilitate affordable health insurance coverage for early childhood development facilities. The Committee heard from multiple public witnesses regarding the significant shift in enrollment for the employees at these facilities. As of April 2023, 136 facilities out of the total 394 licensed facilities, or approximately 35% of eligible facilities have enrolled through the program, covering 33% of eligible DC residents who work at OSSE-licensed facilities. At CommuniKids Preschool, which has 5 facilities in the District, 82 of 92 employees were able to enroll in health insurance coverage through HealthCare4ChildCare. Prior to the program, only 17 out of 132 employees systemwide, including those in Virginia, were able to afford coverage. This program has had a major effect on a facility that employees a staff of 99% immigrants and 95% women. The initial investment in the program was $18 million, of which $1,135,000 had been spent to support premiums under the program through March 31, 2023.

Equity-Based Benefit Design

HBX also deserves credit for the significant efforts it has made to improve plan coverage design to address key areas of health disparities. Beginning January 1, 2023, plans enhanced coverage for Type 2 diabetes care to include insulin, lab work, eye and foot exams, prescriptions, and supplies without co-payments, co-insurance, or deductibles. Beginning January 1, 2024, plans will cover pediatric mental and behavioral health at reduced cost sharing. Under this coverage, cost-sharing will be just $5 for office visits, certain lab work, and medication. This reflects a decrease of copay requirements from $45 down to just $5. Each of these programs is an important step to improve health equity, and the Committee supports HBX in these efforts.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. Fiscal Year 2024 Operating Budget Recommendations

The Mayor's FY 2024 proposed operating budget for HBX is $37,552,148, which represents a 5.2% increase in operating funds compared with the approved FY 2023 budget. HBX is entirely self-funded through an assessment fee on health insurers in the District. The $1,882,312 increase in the FY 2024 budget is largely to support an increase of 6.0 FTEs across multiple programs and to fund additional IT operations.

The Committee approves the operating budget as proposed by the Mayor.

b. Fiscal Year 2024 - 2029 Capital Budget Recommendations

The Mayor's proposed budget for HBX does not include any capital funds.

3. COMMITTEE POLICY RECOMMENDATIONS

1. *Continue to monitor the stability of District health insurance rates and explore opportunities to make health care more accessible.*

The Committee is proud of DC's second place ranking in the United States for lowest uninsured rate with more than 96% of DC residents covered under a health insurance plan. HBX testified at the budget oversight hearing that a small number of plans on the Exchange actually have lower premiums in 2023 than they did in 2022. The Committee encourages HBX to continue to advocate for the lowest possible premiums for DC residents. This advocacy will be especially important as the District emerges from the COVID public health emergency. There was significant federal aid providing during the public health emergency that lowered premiums on the Exchange, and HBX should do everything it can to ensure premiums stay as low as possible going forward by implementing and building on the aid continued under the Inflation Reduction Act of 2022.

After years of continuous enrollment under Medicaid due to the COVID public health emergency, in which individuals generally could not be disenrolled from Medicaid, the recertification process for enrollees has resumed starting April 1, 2023. Over the next 12-14

months, the Department of Health Care Finance (DHCF) estimates that between 10-20% of current Medicaid enrollees will no longer be eligible for coverage. Many of those individuals will need to obtain health insurance through DC Health Link. The Committee is glad to hear that HBX is following all recommendations from the federal Centers for Medicare & Medicaid Services (CMS) regarding special enrollment period. The Committee urges HBX to work closely with DHCF to ensure that when individuals are notified that they are no longer eligible for Medicaid, they are simultaneously connected with DC Health Link to obtain health insurance.

2. *Continue developing strategies to address health equity and racism in health care.*

The challenges of health disparities and racism in health care are well-known. The Committee urges HBX to continue to work to address these challenges head-on. As described in the above narrative, HBX has worked with insurance providers to enhance coverage for Type 2 diabetes care without co-payments or co-insurance. This is an important step to address a condition that disproportionately affects Black and Latine residents. HBX should seek additional opportunities to work with health insurance providers to enhance coverage, expand provider networks, and reduce cost-sharing for key conditions that affect communities of color.

3. *Work with DC Health Link insurance carriers to ensure there are sufficient pediatric mental and behavioral health providers to serve members looking to take advantage of the reduced cost-sharing for such services.*

Reducing cost-sharing requirements for pediatric mental and behavioral health services, while vitally important, is only one step in improving access to these services. Coverage with a low cost-sharing requirement does not improve access to those services if there are not sufficient providers within the network to meet the demand for services. The Committee has heard across agencies of staffing shortages for mental and behavioral health providers. It is imperative that insurance providers work with the mental and behavioral health provider community to bring more providers into the covered network so that the coverage with lower cost-sharing can be translated to truly improved access to these important services.

4. *Continue working with the Office of the State Superintendent of Education (OSSE) to bolster the HealthCare4ChildCare program to ensure the program is enduring and sustainably funded.*

As described above in the narrative, the Committee heard great praise for HealthCare4ChildCare at the performance and budget oversight hearings. However, there is concern amongst some eligible facilities that the funding may not be sufficient to ensure the program endures in the medium- to long-term. The Committee knows that funding is available to sustain the program, and the Committee recommends that HBX work with OSSE on a comprehensive engagement strategy with childcare providers to let them know about the program and its benefits.

III. BUDGET SUPPORT ACT RECOMMENDATIONS

On Wednesday, March 22, 2023, Chairman Mendelson introduced, on behalf of the Mayor, the "Fiscal Year 2024 Budget Support Act of 2023" (Bill 25-202). The bill contains two subtitles for which the Committee has provided comments. The Committee also recommends the addition of four new subtitles.

A. RECOMMENDATIONS ON MAYOR'S PROPOSED SUBTITLES

The Committee on Health provides comments on the following subtitles of the "Fiscal Year 2024 Budget Support Act of 2023":

1. Title V, Subtitle A. Public Health Laboratory
2. Title V, Subtitle B. Medicaid Hospital Provider Reimbursement

The legislative language is included in Attachment B.

1. Title V, Subtitle A. Public Health Laboratory

a. Purpose, Effect, and Impact on Existing Law

As proposed by the Mayor, this subtitle would establish the Public Health Laboratory (PHL) within the Department of Health (DC Health). The subtitle defines the scope of the PHL in the District and authorizes the Mayor to establish fees for the provision of services by the PHL and to promulgate regulations for the PHL.

The subtitle also transfers all public health laboratory services within the Department of Forensic Sciences (DFS) to DC Health by October 1, 2023. DFS currently operates the Forensic Sciences and Public Health Laboratory, so this subtitle in effect removes the public health laboratory component from the DFS Laboratory and transfers it to be under the management of DC Health. The subtitle repeals several provisions in the D.C. Code that were recently amended by the Restoring Trust and Credibility to Forensic Sciences Amendment Act of 2022, enacted on January 19, 2023, which restructures the Forensic Sciences and Public Health Laboratory as an independent agency within the executive branch. The subtitle repeals provisions in that Act that refer to the public health laboratory.

The subtitle makes several conforming amendments to the Department of Forensic Sciences Establishment Act of 2011 which, taken together, remove all aspects of public health laboratory services from DFS.

The Committee Print makes several changes to the subtitle as introduced, including enhancing the defined scope of the PHL; requiring DC Health to submit to the Council an organizational assessment of the PHL by December 31, 2023; and establishing a non-lapsing Public Health Laboratory Fund for any revenue collected by the PHL.

b. Committee Reasoning

The Committee is generally supportive of the transfer of the Public Health Laboratory (PHL) from the Department of Forensic Sciences (DFS) to DC Health. The PHL provides testing of biological and chemical samples that relate to public health and safety, such as infectious diseases, hazardous chemicals, or biological contamination, up to and including biological or chemical terrorist attacks. The transfer to DC Health would align the District with 45 other states whose public health laboratories are located within their public health agencies. DC Health has testified that this transfer will allow DC Health to better respond to public health emergencies and creates efficiencies in funding, since most federal funding for the PHL must come through DC Health to be transferred through MOUs to DFS. Under this new model, DC Health saves the administrative costs of transferring the funds to DFS. The Committee also believes there is potential for DC Health to use the PHL to enhance other public health services within the agency.

Currently, the PHL is part of the combined Forensic Sciences and Public Health Laboratory at DFS, located in a state-of-the-art facility that opened in 2012.[9] After this transition, the PHL would remain in the facility, but be under the oversight and management of DC Health. The stated purpose of co-locating these laboratories in 2012 was to "improve efficiency, delivery, and customer service" and to increase efficiencies around operations, facilities, equipment, security, and other shared costs. In its pre-hearing written responses, DC Health stated that it will be conducting an organizational assessment for the PHL and exploring how to use the PHL to support other agency activities. The Committee believes this organizational assessment will be key for understanding the PHL's proper scope, workforce, revenue, and future coordination with the DFS Laboratory and thus the Committee Print adds a requirement for DC Health to publish the assessment in time for the development of the FY 2025 budget.

The Committee Print amends the subtitle as introduced by enhancing the defined scope of the PHL to align it with the U.S. Center for Disease and Control's recommendations for the functions of a state public health laboratory.[10] The Committee print also creates a Public Health Laboratory Fund, a non-lapsing fund for DC Health to deposit revenue collected for public health laboratory services, such as proving expert witness testimony.

The Committee recommends inclusion of this subtitle, including the changes incorporated in the Committee Print, in the Budget Support Act.

c. Section-by-Section Analysis

Sec. 5001. Short Title.

Sec. 5002. Establishes the Public Health Laboratory (PHL) within the Department of Health; defines the services to be provided by the PHL; requires Department of Health to submit to Council by December 21, 2023 an organizational assessment of the PHL.

[9] https://www.tradelineinc.com/reports/2013-10/dc-facility-consolidates-public-health-medical-examiner-and-forensic-sciences

[10] https://www.cdc.gov/training/publichealth101/laboratories.html

Sec. 5003. Gives the Mayor the authority to establish fees for the provision of services by the PHL.

Sec. 5004. Gives the Mayor the authority to issue rules to implement this subtitle.

Sec. 5005. Creates a non-lapsing Public Health Laboratory Fund within DC Health for revenue collected pursuant to Section 5003.

Sec. 5006. Transfers public health laboratory services, including all authority, responsibility, duties, assets, and functions, from the Department of Forensic Sciences to DC Health by October 1, 2023. States that rules and regulations related to public health laboratory services at DFS shall continue in force until new rules are issued.

Sec. 5007. Amends the Department of Forensic Sciences Establishment Act of 2011, the Confirmation Act of 1978, the District of Columbia Government Comprehensive Merit Personnel Act of 1978, the Address Confidentiality Act of 2018, the Sexual Assault Victim's Rights Act of 2014, the Retired Police Officer Redeployment Amendment Act of 1992, the Firearms Control Regulations Act of 1975, and Section 23-1910(b)(3) of the District of Columbia Official Code with conforming amendments to remove public health laboratory services from the Forensic Sciences and Public Health Laboratory.

Sec. 5008. States that the provisions in Section 5007 that amend provisions affected by the Restoring Trust and Credibility to Forensic Sciences Amendment Act of 2022, enacted on January 19, 2023, shall take effect on the applicability date of that Act.

d. Fiscal Impact

The changes made by the Committee do not affect the fiscal impact of this subtitle, which was incorporated into the FY 2024 budget and financial plan.

2. Title V, Subtitle B. Medicaid Hospital Provider Reimbursement

a. Purpose, Effect, and Impact on Existing Law

As proposed by the Mayor, this subtitle would cap the capitated Medicaid payments to Medicaid managed care organizations (MCOs) such that MCO payments to hospitals for outpatient services are capped at 110% of the fee-for-service fee schedule rates, and for inpatient services are capped at the rate in effect on March 31, 2023.

Under existing law, there are minimum payments to Medicaid managed care organizations (MCOs) set at 100% of the fee-for-service (FFS) rates, which are themselves prescribed by law based on the underlying hospital costs. This subtitle provides maximum levels of payments from MCOs to hospitals by limiting the amount that can be paid in capitated rates from Medicaid to the MCOs. The cap on payments for inpatient services is intended to freeze in place the status quo and assure that hospitals do not shift the costs from outpatient care to inpatient care and begin charging a higher rate for inpatient care.

As proposed by the Mayor, the cap on maximum payments would apply to all hospitals except (1) hospitals owned by the federal government, (2) specialty hospitals as designated by the Medicaid State Plan, (3) hospitals reimbursed under specialty hospital reimbursement methodology under the Medicaid State Plan, or (4) hospitals serving an economically underserved area as defined by the Medicaid State Plan or by DHCF in the managed care directed payment proposal.

b. Committee Reasoning

The Committee is generally supportive of the subtitle's goal to bring down Medicaid costs by capping the payment rates MCOs can pay to hospitals. As the Committee heard in testimony from Director Turnage, the FFS payment rates are generally set at 98-100% of the costs accrued for a given service within the FFS population. However, because of the different risk profiles and utilization rates between the FFS and MCO patient populations, the FFS group generally have costs higher for a given procedure than do the MCO patients. The result is that paying at 100% of FFS costs is paying greater than 100% of the actual costs experienced for MCO patients. Since hospitals are already receiving Medicaid reimbursement in excess of their costs, it stands to reason that the amount above such rates should be limited.

The Committee recommends inclusion of this subtitle in the Budget Support Act without change.

c. Section-by-Section Analysis

Sec. 3011. Short Title.

Sec. 3012. Definitions

Sec. 3013. Sets minimum and maximum hospital provider payments by Medicaid MCOs in the inpatient and outpatient setting for covered hospitals.

Sec. 3014. Requires DHCF to publish annual reports for all-payer hospital costs.

d. Fiscal Impact

The fiscal impact of this subtitle was incorporated into the FY 2024 budget and financial plan.

B. RECOMMENDATIONS FOR NEW SUBTITLES

The Committee on Health recommends the following new subtitles to be added to the "Fiscal Year 2024 Budget Support Act of 2023":

1. School-Based Behavioral Health Student Peer Educator Pilot

2. First-Time Mothers Home Visiting Program
3. Substance Abuse and Behavioral Health Targeted Outreach Pilot
4. DHCF Reporting Requirements

The legislative language is included in Attachment B.

1. Title V, Subtitle X. School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023

a. Purpose, Effect, and Impact on Existing Law

This subtitle would amend the Early Childhood and School-Based Behavioral Health Infrastructure Act of 2012, effective June 7, 2012 (D.C. Law 19-141, D.C. Official Code § 2-1517.31 *et seq.*) by creating a peer educator program for at least 100 District public and public charter high school students.

b. Committee Reasoning

The mental health of youth in the District, like youth across the nation, has been declining steadily for over a decade, and the COVID-19 pandemic has exacerbated this crisis. According to the American Psychological Association, more than half of teens reported feeling more stressed, sad, or hopeless, and lonelier because of the pandemic. The Office of the State Superintendent (OSSE) 2021 Youth Risk Behavior Survey (YRBS) revealed that a significant percentage of youth in the District reported feeling sad or hopeless for two consecutive weeks, with an increase from 2017. The data on suicide was alarming, with 25% of females and 10% of males in high school reporting that they thought seriously about suicide; and 21% of females and 10% of males reporting that they had a plan. The survey also found increases in disordered eating behaviors among students, and a concerning percentage (28%) of high school students reporting witnessing physical violence in their neighborhood. Additionally, almost a third of all students reported being in a physical fight in the past year.

Leah Mallard, student at Bard High School Early College DC testified at the FY 2022 performance oversight hearing:

> Mental health isn't emphasized enough at Bard. Most students are involved with a lot of different things, and they have to handle their home lives too. So, when they start feeling stressed at school, it ends up looking like fighting in the hallways or not paying attention in class because we weren't taught any alternative solutions to de-stress and how stress impacts our bodies.

According to YRBS data, student access to supportive adults in schools has declined, and DBH continues to face challenges filling clinician vacancies. As of the 2022-2023 school year, at least 91 clinician positions are expected to remain vacant. Advocates have testified at both performance and budget oversight hearings about the challenges of clinician hiring, including high rates of burnout and competition from other employers.

The School-Based Behavioral Health Student Peer Educator Pilot aims to increase access to school and community-based behavioral health services for high school students and caregivers, improve students' ability to cope with stress and trauma, educate them on building resilience, reduce stigma around seeking behavioral health services, and enhance student engagement and input into the SBBH program.

For years, District students have been advocating for increased access to behavioral health programs and shared their frustrations with not receiving the behavioral health support they need. During the FY 2022 performance oversight hearing, numerous students from the local non-profit, Young Women's Project, shared the results of a survey of their peers. The survey found that many of their peers did not know the name of their mental health clinician, and those who did know had little to no contact with them. The students spoke about their mental health struggles and the lack of support they received from their schools. At Bard DC Early College High School, 56% of respondents reported not receiving any mental health and wellness support from their school in the past three months, with only 2.4% responding "often."

Aniyah Thomas, student at HD Woodson Senior High School spoke at the FY 2022 performance oversight hearing:

> Students at HD Woodson, myself included don't concern themselves with mental health staff or support counselors. Either we don't trust them, we don't know about them, or we don't feel as though confiding in them will be effective. There is a lack of connection between the mental health staff and students…. A month ago, I learned that my school had a therapist. I was shocked that I didn't know about him earlier, especially since I am the Vice President, meaning that I interact with staff daily. This just goes to show how inaccessible our mental health staff are.

The pilot program aims to address the gap in access to behavioral health services by involving students in the effort. Recognizing the significance of social influence and peer attachments during the teen years, the pilot taps into evidence that suggests that adolescents often seek informal sources of support, including friends, for their behavioral health needs.

Through this pilot program, DBH will provide grants to one or two community-based organizations to recruit, train, and supervise at least 100 peer educators, with a preference for organizations that partner with high schools in cohort 1 of the School-Based Behavioral Health expansion plan or high schools in Wards 5, 7, and 8. Schools that were selected for cohort 1 of the SBBH expansion were identified as having the most pressing needs. After undergoing comprehensive training on various behavioral health topics, peer educators will be responsible for presenting in classrooms, distributing educational materials, conducting one-on-one sessions with their peers, and sharing information to help students and caregivers connect with SBBH clinicians and other behavioral health staff.

c. Section-by-Section Analysis

Sec. 5XX1. States the Short Title

Sec. 5XX2. Amends the Early Childhood and School-Based Behavioral Health Infrastructure Act of 2012, effective June 7, 2012 (D.C. Law 19-141, D.C. Official Code § 2-1517.31 *et seq.*) by establishing grants awarded by DBH to non-governmental entities to train and supervise at least 100 high school students as student behavioral health peer educators ("peer educators"). One grantee would be designated as the coordinating organization. All grantees would be required to provide a defined set of activities and interventions. DBH would be required to provide grantees and peer educators with the contact information for public and public charter school clinical staff and school behavioral health coordinators.

d. Fiscal Impact

The Office of Revenue Analysis estimates that the fiscal impact of this program is the funding granted for the School-Based Behavioral Health Student Peer Educator Pilot, which has been funded by the Committee at $325,000.

2. Title V, Subtitle X. First-Time Mothers Home Visiting Program

a. Purpose, Effect, and Impact on Existing Law

Since the Leverage for Our Future Amendment Act of 2019 and the FY 2020 budget, the Council has funded a grant program for a home visiting provider to provide evidence-based home visiting services to first-time mothers who are eligible for Medicaid. This subtitle increases the grant amount for FY 2024 to $225,000 for this program and relocates the grant program to DHCF.

b. Committee Reasoning

The Committee believes that the nurse home visiting program for first-time mothers is an important part of improving maternal health outcomes in the District. Further, the Committee understands that the current provider under the grant program is fully operational and would like additional time and resources to build evidence of effectiveness of the program in the District. The Committee is choosing to locate the enhanced grant funding in DHCF rather than DC Health because, the Committee believes that DHCF should work to incorporate the home visiting program for first-time mothers into a Medicaid State Plan Amendment so that it can receive Medicaid funding. Although this likely would not take effect until at least FY 2025, the Committee believes it is beneficial to start funding some evidence-based home visiting programs through DHCF grants. Relocating the grant to DHCF will begin the relationship between DHCF and the provider of first-time mother home visiting services that will be ongoing once Medicaid coverage is secured for such services. The Committee would like to continue funding this first-time mother's home visiting program an additional year to review results and determine the success of this type of home visiting program in the District.

c. Section-by-Section Analysis

Sec. 5xxx. States the short title.

Sec. 5xxx. Limits the Department of Health Care Finance from providing an amount that exceeds $225,000 to the home visiting provider who was awarded the competitive grant pursuant to paragraph (1) of this subsection.

d. Fiscal Impact

The Office of Revenue Analysis estimates that the fiscal impact of this program is the funding granted for the First-Time Mother's Home Visiting Program which has been funded by the Committee at $225,000.

3. Title V, Subtitle X. Substance Abuse and Behavioral Health Targeted Outreach Pilot

a. Purpose, Effect, and Impact on Existing Law

The purpose of this subtitle is to require DBH to provide grant funding to a 501(c)(3) by October 31, 2023 to provide direct support, relationship development, and resource brokering to individuals in need of substance abuse and behavioral health services at three sites with high drug activity and substance abuse: (1) the vicinity of the 600 block of T Street, N.W., (2) the vicinity of the 1100-1300 blocks of Mount Olivet Road, N.E., and (3) the vicinity of the 3800-4000 blocks of Minnesota Ave. N.E.

b. Committee Reasoning

The opioid epidemic has had a devastating impact on communities across the country, and the District has been no exception. According to the CDC, the District ranks first in all drug overdoses and second in opioid overdose deaths per capita. From 2021 to 2022, there were over 10,000 non-fatal drug overdoses, and in 2022, there were 448 opioid-related fatal overdoses, with an average of 37 deaths per month. The Office of the Chief Medical Examiner reported that in 2022, 96% of overdoses involved Fentanyl, representing a significant increase since 2017.

Opioid-related deaths can be prevented, and opioid dependency is a treatable medical condition. Moreover, opioid use is linked to an increased risk of HIV infection, and implementing strategies to prevent opioid use can also help to curb the spread of HIV. Across the District, there are public spaces where individuals who are using opioids and other narcotics gather and use drugs together. These concentrated drug use locations are dangerous for those using drugs, and cause frustration for neighbors, schools, and local businesses who do not feel safe walking past. This subtitle would pilot the effectiveness of an influx of direct support, relationship development, and resource brokering for individuals in need of substance abuse and behavioral health services at the following three locations with concentrated outdoor drug use:

1. **The vicinity of the 600 block of T Street, N.W.:** Over the past year, the Office of Ward 1 Councilmember Brianne Nadeau has been coordinating with the Mayor's Office of Neighborhood Engagement, local Advisory Neighborhood Commissions, businesses, residents, Howard University, Cleveland Elementary Schools, and others to address concerns about the T Street Plaza site. The District has tried several deterrents, including fencing off areas and removing furniture, that temporarily address the issue but do not get to the root of the substance abuse and behavioral health issues faced by these individuals.

2. **The vicinity of the 1100-1300 blocks of Mount Olivet Road, N.E.:** The Office of Ward 5 Councilmember Zachary Parker has received several reports of drug use in alleys and abandoned buildings in the vicinity of the intersection of West Virginia Avenue, N.E. and Mount Olivet Road, N.E. Thus far, the District's response has been to increase police presence in the area, but this only provides a temporary solution. There are reports of overdosing in the area and repeated calls for emergency support. Neighbors also report this area is an open drug market for sales.

3. **The vicinity of the 3800-4000 blocks of Minnesota Avenue, N.E.:** The Office of Ward 7 Councilmember Vincent Gray has received numerous concerns from Ward 7 residents about the serious drug use in the 3800-4000 blocks of Minnesota Ave., N.E. Councilmember Gray's office has collaborated with the Department of Behavioral Health (DBH) and community organizations to develop solutions. It is especially concerning that young children and babies are frequently seen in the area with adults who are under the influence or actively using drugs. This underscores the urgent need for intervention and support in the area.

Each of these areas would greatly benefit from consistent and intensive outreach and support to connect individuals with the necessary services and resources, and help them enter treatment and recovery. A targeted outreach team could improve access to treatment, provide harm reduction services, and address the root causes of drug use in the area.

A similar program has been tested and been successful in Columbia Heights, where dedicated funding for focused and regular outreach helped to mitigate conflict and provide services to those who needed it. The Committee seeks a similar impact at these three locations by providing funding to an existing harm reduction or substance abuse outreach organization that has the expertise and capacity to do outreach on an ongoing basis.

c. Section-by-Section Analysis

Sec. 5xx1. Short Title.

Sec. 5xx2. Requires the Department of Behavioral Health to award a grant in the amount of $600,000 to a 501(c)(3) organization to provide direct support, relationship development, and resource brokering to individuals in need of substance abuse and behavioral health services in the vicinity of the 600 block of T Street, N.W., the vicinity of the 1100-1300 blocks of Mount Olivet Road, N.E, and the vicinity of the 3800-4000 blocks of Minnesota Avenue, N.E.

d. Fiscal Impact

The Office of Revenue Analysis estimates that the Financial Impact of this subtitle is $600,000 in one-time funding, which is equal to the cost of the grant.

4. Title V, Subtitle X. Department of Health Care Finance Reporting Requirements

a. Purpose, Effect, and Impact on Existing Law

This subtitle would require the Director of DHCF to file reports to the Council regarding payment pathways for certain services under Medicaid. The required reports include one on payment pathways for medical respite care for individuals experiencing homelessness, a report on value-based purchasing under Medicaid MCOs, and quarterly reporting of certain MCO metrics including enrolled beneficiaries, number of beneficiaries without a primary care physician, and utilization metrics.

b. Committee Reasoning

This subtitle will require DHCF to produce a report on Medicaid payment possibilities for medical respite care for individuals experiencing homelessness.

These new reporting requirements are similar to prior reporting requirements that were tied to funding for grant programs in previous fiscal years. The present subtitle would separate the reporting requirement from any grant programs. Medical respite care provides acute and post-acute care for individuals experiencing homelessness who are not able to recover from physical illness or injury living on the streets but who are not ill enough to warrant an inpatient stay in the hospital. Medical respite care provides short-term residential care so that individuals have the opportunity to rest and recover in a safe environment with supportive medical care and other services. Not only is medical respite care pivotal for the individual patients, but it can alleviate a burden on the health care system. The Committee has heard from several District hospitals who have provided care to homeless individuals and encountered challenges when preparing the individual for discharge. When the individual no longer requires inpatient level of care but is unable to be discharged to a safe location for recovery, the hospital is left to provide additional services beyond the level of intensity the individual requires. This is an inefficient drain on our health care resources. This report will support efforts to provide medical respite care for individuals experiencing homelessness.

The MCO reports are important for understanding how the MCOs are providing value to the Medicaid program. First, the report on value-based payment models will shed light on the current efforts to align financial incentives and accountability with the total costs of health care. Additionally, the MCO information will provide data evidence showing whether MCO case management services are effective. MCOs are expected to connect all enrollees with primary care physicians, and this report will show whether that is in fact happening. Additionally, the emergency department utilization data for MCO enrollees will highlight whether the MCOs are effectively managing cases to avoid use of emergency services.

c. Section-by-Section Analysis

Sec. XXXX. Short Title.

Sec. XXXX. Requires the Director of DHCF to submit reports regarding medical respite care for individuals experiencing homelessness and MCO value-based payment methods and requires MCOs report information to DHCF regarding enrollee utilization.

d. Fiscal Impact

The Office of Revenue Analysis estimates that the fiscal impact of this subtitle is $55,000 in local one-time funding, which has been funded by the Committee, to support an independent contractor completing the report.

IV. COMMITTEE ACTION AND VOTE

On Wednesday, April 26, 2023, at 11:30 a.m., the Committee on Health met virtually to consider and vote on the Mayor's proposed FY 2024 budget for the agencies under its jurisdiction, the provisions of the FY 2024 Budget Support Act of 2023 referred to the Committee for comment, the Committee's budget report, and the ledger of Committee actions. Chairperson Christina Henderson determined the existence of a quorum with the presence of Councilmembers Charles Allen, Vincent C. Gray, and Brianne K. Nadeau. Chairperson Henderson provided an overview of the draft report, the ledger of committee actions, and the changes recommended to the Mayor's proposed budget, and then invited other members to provide comments on the Committee's report and recommendations.

Councilmember Gray stated that he was happy to see the capital investment for the Cedar Hill Regional Medical Center. He was also happy to see that the Committee recommended fully funding Bill 24-903, High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022, which he introduced last year. He remarked that funding the scholarship is vital to remove barriers for people to become healthcare workers, and is that it will greatly benefit low income residents who want to work to support their families with a meaningful career. Finally, he thanked the Committee for including the Ward 7 location (3800-4000 Minnesota Avenue, N.E.) into the BSA Subtitle "Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2023."

Councilmember Allen commended Chairperson Henderson and her staff for putting together these recommendations. He remarked that the Mayor's FY 2024 proposed budget included devastating cuts to things Councilmembers care about, and the financial projections meant the Council had to say no to good ideas this year. He was happy to see the Committee's recommendation to restore the cut FTEs for the Health Regulations and Licensing Administration, which would have affected staffing within the Health Professional Licensing division. He remarked that his office received constant complaints about licensing—it recently took one resident 7 months to receive a physical therapy license. He commented that there is a massive need for trained health professionals in the District, and that he would like to work together to make our system capable of smooth licensure. He also said that he fully supports the investment in the Expanding Access to Fertility Treatment Amendment Act of 2023, which would expand access to fertility treatment. He commented that healthcare companies do not provide sufficient support, and that the average treatment costs $10,000-12,000. He looks forward to the Committee markup of that bill. Councilmember Allen noted his support of the BSA Subtitle Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2023, but noted that Ward 6 is not included in the pilot, and he looks forward to working together to expand this program to more locations across the District. He also noted his support for the BSA subtitle School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023. He noted that while DBH finalizes the rate study, he is happy to see the Committee working to meet the moment, as students continue to suffer from mental health challenges after the pandemic. He also stated that he was happy to see the funding to partially fund the Street Vendor Advancement Amendment Act of 2023. He thanked the Committee for accepting transfers from the Committee on Transportation and the Environment, which he chairs, including $170,000 to fund the Dementia Training for

Direct Care Workers Act of 2019, which he is happy to see implemented. Regarding the Public Health Laboratory transfer from DFS, he reiterated his concern and opposition for breaking up DFS laboratory, stating that the timing does not seem right, circumstances are suspect, and that the laboratory is in a different location from DC Health.

Councilmember Nadeau thanked Chairperson Henderson and her staff for accepting transfers from the Committee on Public Works and Operations, which she chairs, including $225,00 for a First-Time Mothers Home Visiting grant at DHCF for Medicaid-eligible first-time mothers. She noted that this will strengthen parenting, families, and reduce abuse and neglect in the District. She also thanked the Committee for accepting the transfer of $200,000 for the BSA Subtitle Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2023, which includes a location in Ward 1 (T Street Plaza), which she notes has significant public drug use. She noted that while she has worked with neighborhood leaders, the problem has persisted, and she looks forward to seeing people getting the care they need. She thanked the Committee for restoring the grant to Joseph's House, which provides care for critically ill patients who have experienced chronic homelessness, located in Ward 1. She also thanked the Committee for partially funding the Street Vendor Advancement Amendment Act of 2023, which she has championed. She noted it has been a long road to get this legislation passed and is happy to see it funded. She thanked Chairperson Henderson for her partnership on the legislation, including creating provisions to create a Microenterprise Home Kitchen Permit, which strengthened the bill. She ended by stating that the Committee report truly prioritized the health of District residents and she was happy to be voting for it.

Chairperson Henderson then moved for approval of the Committee's Fiscal Year 2024 Local Budget Act recommendations, the Committee's Fiscal Year 2024 Budget Support Act of 2023 recommendations, the Committee's budget report, and the ledger of committee actions, with leave for staff to make technical and conforming changes to reflect the Committee's actions. The Members voted 4-0 to approve the recommendations, voting as follows:

Members in favor: Henderson, Allen, Gray, Nadeau
Members opposed: 0
Members voting present: 0
Members absent: Parker

Chairperson Henderson then thanked the members of the Committee for all of their work and support during the budget process. She thanked her staff, including Chief of Staff Michael Shaffer, Deputy Chief of Staff Heather Edelman, Committee Director Ona Balkus, Legislative Director Gabrielle Rogoff, Communications Director Chantal Fuller, Constituent Services Director Ana S. Berríos-Vázquez, Senior Policy Advisor Marcia Huff, Policy Counsel Boyd Jackson, Legislative Assistants Ashley Strange and Nico Pcholkin, and Staff Assistant Taylor Coleman. She also thanked Errol Spence-Sutherland, Anne Phelps, and Jen Budoff of the Council Budget Office and Assistant General Counsel David Guo for their invaluable assistance.

Chairperson Henderson adjourned the meeting at 12:19 p.m.

Councilmember Parker had an unavoidable conflict and was not able to attend the Committee markup. He requested that the Committee include the following written statement in the report for the record:

"Thank you to Chairperson Henderson, Committee Director Ona Balkus, and the committee staff for working hard on this report. I am excited to see that the committee is advancing specific adjustments to the Mayor's proposed budget that will mean material change in DC residents' lives. The committee proposes:

- $200,000 to launch a Substance Abuse and Behavioral Health Targeted Outreach pilot to address the opioid crisis including a specific location on Mount Olivet Road in Trinidad in Ward 5;
- $325,000 for a peer educator pilot program for school-based behavioral health (SBBH). Students have stated they were not aware their school has SBBH, the services the program provides, or of who their clinicians are;
- Encourages Department of Health Care Finance to apply for Medicaid reimbursement and funding for violence interruption programs housed in the Office of Neighborhood and Safety and Engagement and Office of Neighborhood Safety and Engagement which could save the city money;
- $100,000 in funding for hiring and retention bonuses for Children and Adolescent Mobile Psychiatric Service (CHAMPS) contractor staff;
- Restores $250,000 for people with HIV/AIDS or cancer to have stable housing and appropriate medical care through Joseph's House, a place that provides nursing care and housing support;

I have some additional questions about the committee report and look forward to finding solutions for dedicating $2 million to fund a burn center at Medstar Hospital Center. Additionally, the report does not mention exempting Children's National Hospital from the proposed Medicaid reimbursement cap at an approximate cost of $5 million. My office has heard that this could disproportionately harm the hospital. Lastly, generally I support the transition of the Health Lab to DC Health and will coordinate on the transition."

V. ATTACHMENTS

A. Chart of the Committee's Recommended Changes to the Budgets of the Agencies under its Jurisdiction
B. Bill 25-202, Fiscal Year 2024 Budget Support Act of 2023 Recommended Subtitles
C. Witness List and Testimony Submitted for the March 30, 2023, Fiscal Year 2024 Budget Oversight Hearing on the DC Health Benefit Exchange Authority
D. Witness List and Testimony Submitted for the March 30, 2023, Fiscal Year 2024 Budget Oversight Hearing on the Not-for-Profit Hospital Corporation (United Medical Center)
E. Witness List and Testimony Submitted for the March 30, 2023 (public witnesses) and April 6, 2023 (government witness), Fiscal Year 2024 Budget Oversight Hearing for the Department of Behavioral Health
F. Witness List and Testimony Submitted for the April 5, 2023, Fiscal Year 2024 Budget Oversight Hearing on the Office of the Deputy Mayor for Health and Human Services and the Department of Health Care Finance
G. Witness List and Testimony Submitted for the April 10, 2023 (public witnesses) and April 12, 2023 (government witness), Fiscal Year 2024 Budget Oversight Hearing for the Department of Health

ATTACHMENT
A

Agency	Scenario	Committee	Agency Code	Fund Type	Fund Detail	Program	Activity	Service	CSG	Project	Proposed Change in FTEs	Resources/ Budget	Adjustment	Recurring or One-Time Change	FY23	FY24	FY25	FY26	FY27	Comments	Legislation
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8505 - HEALTH CARE ACCESS BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Reduction	Recurring		($2,211,148)	($2,248,738)	($2,286,966)	($2,325,844)	Reduction to local grant funding for Howard Center of Excellence.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6500 - ADULT/TRANSITIONAL YOUTH SERVICES	6515 - BEHAVIORAL HEALTH REHAB. - LOCAL MATCH		0050 - SUBSIDIES AND TRANSFERS			Budget	Reduction	One Time		($3,100,000)				Reduction to one-time Mayoral enhancement for the Behavioral Health Rehabilitation Local Match.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8600 - PUBLIC HEALTH LABORATORY			0011 - REGULAR PAY - CONT FULL TIME			Budget	Reduction	Recurring		($392,246)	($398,914)	($405,696)	($412,593)	Reduction to Public Health Laboratory to increase vacancy savings.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	300A - DCAS PROGRAM MANAGEMENT ADMINISTRATION	340A - INFORMATION TECHNOLOGY MANAGEMENT		0070 - EQUIPMENT & EQUIPMENT RENTAL			Budget	Reduction	Recurring		($1,495,456)	($1,520,879)	($1,546,734)	($1,573,028)	Reduction to DCAS project IT Management equipment budget.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	300A - DCAS PROGRAM MANAGEMENT ADMINISTRATION	340A - INFORMATION TECHNOLOGY MANAGEMENT		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Reduction	Recurring		($1,860,393)	($1,892,020)	($1,924,184)	($1,956,895)	Reduction to DCAS project IT Management contracts budget.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	1800 - BEHAVIORAL HEALTH AUTHORITY	1889 - LEGISLATIVE AND PUBLIC AFFAIRS		0040 - OTHER SERVICES AND CHARGES			Budget	Reduction	Recurring		($32,266)	($32,815)	($33,372)	($33,940)	Reduction to eliminate legislative and public affairs contract for which a vendor has yet to be determined.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6700 - POLICY, PLANNING, & EVALUATION ADMIN	6703 - TRAINING INSTITUTE		0040 - OTHER SERVICES AND CHARGES			Budget	Reduction	Recurring		($74,944)	($76,218)	($77,514)	($78,831)	Reduction to eliminate contract for a training consultant for which a vendor has yet to be determined.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6500 - ADULT/TRANSITIONAL YOUTH SERVICES	6513 - SUBSTANCE USE DISORDER TREATMENT SVCS		0040 - OTHER SERVICES AND CHARGES			Budget	Reduction	Recurring		($26,148)	($26,593)	($27,045)	($27,504)	Reduction to eliminate funding for substance use disorder support contracts for which a vendor has yet to be determined.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	3800 - ST. ELIZABETHS HOSPITAL	3880 - OFFICE OF CHIEF CLINICAL OFFICER-SEH		0040 - OTHER SERVICES AND CHARGES			Budget	Reduction	Recurring		($199,596)	($202,989)	($206,440)	($209,949)	Reduction to eliminate funding for contracts for the Office of Chief Clinical Officer with no stated purpose or description and no vendor determined.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6650 - EVIDENCE BASED PRACTICES (EBP)		0040 - OTHER SERVICES AND CHARGES			Budget	Reduction	Recurring		($233,824)	($237,799)	($241,842)	($245,953)	Reduction to contract for evidence based services training for which a vendor has yet to be determined.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6640 - SPECIALTY SERVICES		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Reduction	Recurring		($100,000)	($101,700)	($103,429)	($105,187)	Reduction of contract for which a vendor has yet to be determined.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6500 - ADULT/TRANSITIONAL YOUTH SERVICES	6507 - HOUSING SUPPORT SERVICES		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Reduction	Recurring		($873,690)	($888,543)	($903,648)	($919,010)	Partial reduction of mayor's enhancement for case management contract for which a vendor has yet to be determined.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Reduction	One Time		($250,000)				Partial reduction to one-time mayoral enhancement to support dental insurance coverage for seniors.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	3000 - HIV/AIDS HEPATITIS STD AND TB ADMIN	3040 - PREVENTION AND INTERVENTION SERVICES		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time		$250,000				Enhancement to restore grant for Joseph's House, which was reduced in the FY24 proposed budget.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Enhance	Recurring		$1,300,000	$1,675,000	$1,675,000	$0	Enhancement to fund the fiscal impact of B24-943 - High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022 (Scholarships and Repayment portion).	B24-943
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0011 - REGULAR PAY - CONT FULL TIME		1.00	Budget	Enhance	Recurring		$97,947	$99,612	$101,306	$103,028	Enhancement to fund the fiscal impact of B24-943 - High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022 (Salary for Program Specialist).	B24-943
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	Recurring		$21,842	$22,355	$22,881	$23,418	Enhancement to fund the fiscal impact of B24-943 - High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022 (Fringe for Program Specialist).	B24-943
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8506 - FAMILY HEALTH BUREAU		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$2,000,000	$1,862,977	$1,867,862	$2,103,744	Partial restoration of Children's National School Nurse Services grant.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4515 - FOOD DRUG RADIATION AND COMM. HYGIENE		0012 - REGULAR PAY - OTHER		1.00	Budget	Enhance	Recurring		$58,591	$60,463	$120,925	$124,669	Enhancement to fund Health portion of the fiscal impact for B25-0068 - Street Vendor Advancement Amendment Act of 2023 (Inspector Salary).	B25-68
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4515 - FOOD DRUG RADIATION AND COMM. HYGIENE		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	Recurring		$12,480	$13,201	$26,348	$27,799	Enhancement to fund Health portion of the fiscal impact for B25-0068 - Street Vendor Advancement Amendment Act of 2023 (Inspector Fringe).	B25-68
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4515 - FOOD DRUG RADIATION AND COMM. HYGIENE		0012 - REGULAR PAY - OTHER		1.00	Budget	Enhance	Recurring		$80,784	$83,289	$85,794	$88,300	Enhancement to fund Health portion of the fiscal impact for B25-0068 - Street Vendor Advancement Amendment Act of 2023 (Program Staff Salary).	B25-68
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4515 - FOOD DRUG RADIATION AND COMM. HYGIENE		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	Recurring		$17,207	$18,184	$19,087	$20,077	Enhancement to fund Health portion of the fiscal impact for B25-0068 - Street Vendor Advancement Amendment Act of 2023 (Program Staff Fringe).	B25-68
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	5000 - HEALTH CARE FINANCE	5003 - ALLIANCE PROVIDER PAYMENTS	F600 - MCO ALLIANCE	0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$280,000	$73,000	$78,000	$84,000	Enhancement to fund the implementation of B25-034 Expanding Access to Fertility Treatment Amendment Act of 2023 pending approval by Council (Ovulation Enhancing Drugs - Alliance).	B25-34
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	5000 - HEALTH CARE FINANCE	5003 - ALLIANCE PROVIDER PAYMENTS	F600 - MCO ALLIANCE	0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$17,000	$18,000	$20,000	$21,000	Enhancement to fund the implementation of B25-034 Expanding Access to Fertility Treatment Amendment Act of 2023 pending approval by Council (Fertility Diagnosis - Alliance).	B25-34
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	5000 - HEALTH CARE FINANCE	5001 - MEDICAID PROVIDER PAYMENT	F020 - PRESCRIBED DRUGS	0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$403,000	$103,000	$110,000	$118,000	Enhancement to fund the implementation of B25-034 Expanding Access to Fertility Treatment Amendment Act of 2023 pending approval by Council (Ovulation Enhancing Drugs - Medicaid Local).	B25-34
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0250 - FEDERAL MEDICAID PAYMENTS	8250 - FEDERAL MEDICIAD PAYMENTS	5000 - HEALTH CARE FINANCE	5001 - MEDICAID PROVIDER PAYMENT	F020 - PRESCRIBED DRUGS	0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$940,000	$240,000	$244,000	$248,000	Enhancement to fund the implementation of B25-034 Expanding Access to Fertility Treatment Amendment Act of 2023 pending approval by Council (Ovulation Enhancing Drugs - Medicaid Federal).	B25-034
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8000 - HEALTH CARE REFORM AND INNOVATION	8002 - AFFORDABLE CARE REFORM AND GRANTS DEV.		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$400,000	$406,800	$413,716	$420,749	Enhancement to Diaper Bank Grant Program bringing the total allocation for the program to $500,000 recurring annually.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	3000 - HEALTHCARE POLICY AND PLANNING	3010 - HEALTH CARE POLICY AND PLANNING SUPPORT	P200 - HEALTH CARE POLICY & RESEARCH SUPPORT	0041 - CONTRACTUAL SERVICES - OTHER			Budget	Enhance	One Time		$55,000				Enhancement to implement BSA Subtitle requiring reporting on medical respite care for individuals experiencing homelessness.	BSA Title V, Department of Health Care Finance Reporting Requirements
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	5000 - HEALTH CARE FINANCE	5001 - MEDICAID PROVIDER PAYMENT	F087 - IPD WAIVER	0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	Recurring		$269,280	$273,858	$278,513	$283,248	Increase to personal need allowances for residents in longterm care community settings.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6620 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time		$325,000				Enhancement to fund BSA Subtitle establishing a Youth Mental Health Educators Pilot Program.	BSA Title V, School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6500 - ADULT/TRANSITIONAL YOUTH SERVICES	6513 - SUBSTANCE USE DISORDER TREATMENT SVCS		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time		$600,000				Enhancement to fund BSA Subtitle Substance Abuse Targeted Outreach Pilot at T Street Plaza, Ward 5, and Ward 7 Location	BSA Title V, Substance Abuse and Behavioral Health Targeted Outreach Pilot
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4515 - FOOD DRUG RADIATION AND COMM. HYGIENE		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Enhance	Recurring		$2,000,000	$1,862,977	$1,867,862	$2,113,689	Enhancement to restore proposed reduction to contract with Humane Rescue Alliance for rescue animal services.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	RM0	0100 - LOCAL FUND	0100 - LOCAL - APPROPRIATED FUNDS	6600 - CHILD/ADOLESCENT/FAMILY SERVICES	6625 - CRISIS SERVICES		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Enhance	One Time		$100,000				Enhancement to support signing/retention bonuses for the Child and Adolescent Mobile Psychiatric Service (ChAMPS).	
Department of Health Care Finance	Committee Recommendation	Committee on Health	HT0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8000 - HEALTH CARE REFORM AND INNOVATION	8002 - AFFORDABLE CARE REFORM & GRANTS DEVLP.	R420 - AFFORDABLE CARE REFORM & GRANTS DEVLP.	0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time		$225,000				Enhancement to fund BSA Subtitle: First time home visiting grants to DHCF.	BSA Title V, First-Time Mothers Home Visiting Program
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8513 - NUTRITION AND PHYSICAL FITNESS		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time		$150,000				Enhancement to restore Healthy Food Access Grants to FY 2023 levels--Healthy Corners.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8513 - NUTRITION AND PHYSICAL FITNESS		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time		$25,000				Enhancement to restore Healthy Food Access Grants to FY 2023 levels--Nutritional Home Delivery of Meals.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	8500 - COMMUNITY HEALTH ADMINISTRATION	8513 - NUTRITION AND PHYSICAL FITNESS		0050 - SUBSIDIES AND TRANSFERS			Budget	Enhance	One Time		$200,000				Enhancement to restore Healthy Food Access Grants to FY 2023 levels--Produce Plus.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4530 - HEALTH CARE FACILITIES REGULATION		0041 - CONTRACTUAL SERVICES - OTHER			Budget	Enhance	One Time		$170,000				Enhancement to support implementation of legislatively required dementia training for direct care workers.	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	HG0	0100 - LOCAL FUND	0100 - LOCAL FUNDS				0011 - REGULAR PAY - CONT FULL TIME			Budget	Reduction	One Time	($95,816)					Eliminate vacant position 10012724: Policy Analyst and recognize FY23 vacancy savings.	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	HG0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	1000 - AGENCY MANAGEMENT	1090 - PERFORMANCE MANAGEMENT ACTIVITY		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	One Time	($15,522)					Eliminate vacant position 10012724: Policy Analyst and recognize FY23 vacancy savings.	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	HG0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	1000 - AGENCY MANAGEMENT	1090 - PERFORMANCE MANAGEMENT ACTIVITY		0011 - REGULAR PAY - CONT FULL TIME		(1.00)	Budget	Reduction	Recurring		($95,816)	($97,445)	($99,101)	($100,786)	Eliminate vacant position 10012724: Policy Analyst.	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	HG0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	1000 - AGENCY MANAGEMENT	1090 - PERFORMANCE MANAGEMENT ACTIVITY		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Reduction	Recurring		($15,522)	($15,887)	($16,260)	($16,642)	Eliminate vacant position 10012724: Policy Analyst.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0012 - REGULAR PAY - OTHER		2.25	Budget	Enhance	Recurring		$203,869	$207,335	$210,859	$214,444	Enhancement for salaries to restore 2.25 FTEs within HRLA to help with processing licensing applications: position numbers 106919 Complaint Coordinator; 42425 Health Services Program Coordinator; 92179 Investigator.	

Agency	Scenario	Committee	Agency Code	Fund Type	Fund Detail	Program	Activity	Service	CSG	Project	Proposed Change in FTEs	Resources/ Budget	Adjustment	Recurring or One-Time Change	FY23	FY24	FY25	FY26	FY27	Comments	Legislation
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4200 - HEALTH PROFESSIONAL LICENSE ADMIN		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	Recurring			$45,464	$46,532	$47,626	$48,745	Enhancement for fringe to restore 2.25 FTEs within HRLA to help with processing licensing applications: position numbers 106919 Complaint Coordinator; 42425 Health Services Program Coordinator; 92179 Investigator.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4515 - FOOD DRUG RADIATION AND COMM. HYGIENE		0012 - REGULAR PAY - OTHER		1.00	Budget	Enhance	Recurring			$67,995	$69,151	$70,326	$71,522	Enhancement for salary to restore position number 0039467 Sanitarian for HRLA Food Inspections Division.	
Department of Health	Committee Recommendation	Committee on Health	HC0	0100 - LOCAL FUND	0100 - LOCAL FUNDS	4500 - HEALTH REGULATION AND LICENSING ADMIN.	4515 - FOOD DRUG RADIATION AND COMM. HYGIENE		0014 - FRINGE BENEFITS - CURR PERSONNEL			Budget	Enhance	Recurring			$15,222	$15,580	$15,946	$16,321	Enhancement for fringe to restore position number 0039467 Sanitarian for HRLA Food Inspections Division.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Fund Balance Sweep	One Time	$289,451					Reduction to estimated fund balance of Smoking Cessation fund.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Shift Local Funds to Next FY	Recurring	($289,451)	$289,451				Shift fund balance sweep of Smoking Cessation fund to FY24.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer out	One Time		($50,000)				Transfer to Committee on Business and Economic Development for implementation of B25-034 Expanding Access to Fertility Treatment Amendment Act of 2022 pending approval by Council: DSB Counsel and Actuary Study.	B25-34
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer out	One Time		($433,410)				Transfer to Committee on Recreation, Libraries, and Youth Affairs to restore the proposed sweep of SPR DCPL Revenue Generating Fund.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer out	Recurring		($629,442)	($641,150)	($653,075)	($665,222)	Transfer to Committee on Recreation, Libraries, and Youth Affairs to restore Mayor's cut to custodial maintenance DCPL.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer out	One Time		($500,000)				Transfer to Committee on Housing to enhance the FY24 amount for the Emergency Rental Assistance Program.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer out	One Time		($350,000)				Transfer to Committee on the Judiciary and Public Safety to restore reductions for poverty lawyer loan repayment at the Office of Victim Services and Justice Grants.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer out	One Time		($100,000)				Transfer to Committee on Recreation, Libraries, and Youth Affairs to provide a one-time grant to the organization Horton's Kids, which serves Ward 8 students, including mental health supports, high impact tutoring, and violence intervention.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer out	Recurring		($822,367)	($204,352)	($208,152)	($212,024)	Transfer to Committee of the Whole to partially restore reductions to the Healthy Schools Fund ($622K One-Time, $200K Recurring).	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer out	One Time		($50,000)				Transfer to Committee on Public Works and Operations to fund self-release boots at the Department of Public Works.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer in	One Time		$225,000				Transfer-in from Committee on Public Works and Operations to fund BSA Subtitle: First time home visiting grants to DHCF.	BSA Title V, First-Time Mothers Home Visiting Program
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer in	One Time		$200,000				Transfer-in from Committee on Public Works and Operations to fund BSA Subtitle Substance Abuse Targeted Outreach Pilot at T Street Plaza and Ward 5 Location.	BSA Title V, Substance Abuse and Behavioral Health Targeted Outreach Pilot
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer in	One Time		$150,000				Transfer-in from Committee on Transportation and the Environment to restore Healthy Food Access Grants to FY2023 levels--Healthy Corners.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer in	One Time		$25,000				Transfer-in from Committee on Transportation and the Environment to restore Healthy Food Access Grants to FY2023 levels--Nutritional Home Delivery of Meals.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer in	One Time		$200,000				Transfer-in from Committee on Transportation and the Environment to restore Healthy Food Access Grants to FY2023 levels--Produce Plus.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Transfer in	One Time		$170,000				Transfer-in from Committee on Transportation and the Environment to DC Health for implementation of legislatively required dementia training for direct care workers.	
	Committee Recommendation	Committee on Health		0250 - FEDERAL MEDICAID PAYMENTS	8250 - FEDERAL MEDICIAD PAYMENTS							Resources	Change in Certified Revenues	Recurring		$940,000	$240,000	$244,000	$248,000	To recognize additional Medicaid revenue from the passage of B25-034 Expanding Access to Fertility Treatment Amendment Act of 2023 ($704k One-Time, $236k Recurring).	B25-34
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Shift Local Funds to Next FY	One Time	($111,338)	$111,338				Shift FY23 vacancy savings from DMHHS to FY24.	
	Committee Recommendation	Committee on Health		0100 - LOCAL FUND	0100 - LOCAL FUNDS							Resources	Shift Local Funds to Next FY	One Time		($5,938)	$5,938			Shift local forward.	

ATTACHMENT
B

TITLE V. HUMAN SUPPORT SERVICES

SUBTITLE A. PUBLIC HEALTH LABORATORY

Sec. 5001. Short title.

This subtitle may be cited as the "Public Health Laboratory Act of 2023".

Sec. 5002. Establishment of Public Health Laboratory within the Department of Health.

(a) There is ~~hereby~~ established within the Department of Health ("Department"), the Public Health Laboratory ("PHL").

(b) The ~~Public Health Laboratory~~ PHL shall provide public health laboratory services for the District ~~of Columbia~~, including ~~services in the following functional areas~~:

(1) Disease prevention, control, and surveillance~~:~~;

(2) Clinical diagnostic testing;

(3) Integrated data management;

(4) Reference and specialized testing;

(5) ~~Environmental testing~~ Environmental health and protection;

(6) Food safety and surveillance;

(7) Laboratory improvement and regulation;

(8) Policy development;

(9) Public health preparedness and response;

(10) Public health-related research;

~~(5) Monitoring and detection of health threats:~~

(11) Training and education;

(12) Partnerships and communication with academia, government, and private industries; and

(13) Other services to monitor and detect health threats.

(~~b~~c) The Department may provide public health laboratory services to the federal government, state and local jurisdictions, academic institutions, nonprofit organizations, and hospitals and other health-related entities.

(d) By December 31, 2023, the Department shall submit to the Council an organizational assessment of the PHL, which shall include:

(1) An organizational plan, including an organization chart and a listing of all current full-time equivalent positions;

(2) A strategic human capital plan, which shall identify the skills and personnel necessary to fulfill the functions of the PHL, current available human resources, and recruiting priorities and efforts;

(3) A detailed assessment of the services currently provided by the PHL and other potential services it could provide, including best practices from other state public health laboratories;

(4) A detailed description of how the PHL is currently funded, with a breakdown of local and federal funding sources, and identification of other potential non-local revenue, such as fees and grants, based on examples from other state public health laboratories;

(5) A detailed description of how the PHL will interact with the laboratories co-located with it, including protocols for how the laboratories are assigning shared equipment, facility space and fixed costs, security, and other shared costs;

(6) A detailed description of how the Department will identify, investigate, and develop corrective actions for any allegations of negligence, misconduct, or misidentification or other testing error related to the PHL; and

(7) A detailed plan of how the PHL will be integrated into the Department's core mission and services.

Sec. ~~3003~~5003. Fees.

The Mayor may establish fees, to be deposited into the Public Health Laboratory Fund established pursuant to section ~~3004~~5005, for the provision of services by the Public Health Laboratory and may impose charges for reasonable costs related to expert witness testimony provided by employees of the Public Health Laboratory, including the cost of ~~any~~ preparation, travel, and related administrative functions.

Sec. ~~3004~~5004. Rules.

The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq.*), may issue rules to implement this subtitle.

Sec. 5005. Public Health Laboratory Fund.

(a) There is established as a special fund the Public Health Laboratory Fund ("Fund"), which shall be administered by the Department of Health in accordance with subsection (c) of this section.

(b) Revenue collected pursuant to section 5003 shall be deposited in the Fund.

(c) Money in the Fund shall only be used to fund the expenses of the Public Health Laboratory, including for services, materials, non-grant funded research, equipment, laboratory staff, and trainings.

(d)(1) The money deposited into the Fund shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time.

(2) Subject to authorization in an approved budget and financial plan, any funds appropriated in the Fund shall be continually available without regard to fiscal year limitation.

Sec. ~~3005~~5006. Transfer of public health laboratory services and functions from the Department of Forensic Sciences.

(a) The Mayor shall provide for the orderly transfer to the Department of Health of all of the authority, responsibilities, duties, assets, and functions of the Department of Forensic Sciences pertaining to public health laboratory services and functions by October 1, 2023.

~~Sec. 3006. Continuity of rules and regulations.~~

(b) Rules and regulations relating to a function which is transferred by this subtitle to the Department of Health, and any Mayor's order or administrative order not in conflict with this subtitle and relating to a function transferred by this subtitle, shall continue in force until such time as new rules, regulations, or orders governing the subject thereof are issued.

Sec. ~~3007~~5007. Conforming amendments.

(a) The Department of Forensic Sciences Establishment Act of 2011, effective August 17, 2011 (D.C. Law 19-18; D.C. Official Code § 5-1501.01 *et seq.*), is amended as follows:

(1) Section 2 (D.C. Official Code § 5-1501.01) is amended as follows:

(A) Paragraph (3) is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(B) Paragraph (4A) is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(C) Paragraph (6) is repealed.

(2) Section 3 (D.C. Official Code § 5-1501.02) is amended as follows:

(A) The section heading is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(B) Subsection (a-1) is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(C) The lead-in language of ~~section 3(b) (D.C. Official Code § 5-1501.02(b))~~ subsection (b) is amended by striking the phrase "forensic science services and public health laboratory services" and inserting the phrase "forensic science services" in its place.

(3) Section 5(a)(4) (D.C. Official Code § 5-1501.04(a)(4)) is amended by striking the phrase "forensic science services and public health laboratory services" and inserting the phrase "forensic science services" in its place.

(4) The section heading of section 5a is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(5) Section 7 ~~(c-1), (c-2), and (c-3)~~ (D.C. Official Code § 5-1501.06~~(c-1), (c-2), and (c-3)~~) is amended by repealing subsections (c-1), (c-2), and (c-3)~~are repealed~~.

(6) Section 7a (D.C. Official Code § 5-1501.06a) is amended as follows:

(A) Subsection (a) is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(B) Subsection (b) is amended to read as follows:

"(b) Fees collected for forensic science services provided by the Department shall be deposited into the Fund.".

(7) Section 9 (D.C. Official Code § 5-1501.08) is amended as follows:

(A) Subsection (a-1) is repealed.

(B) Subsection (b) is amended by striking the phrase "subsections (a) and (a-1)" and inserting the phrase "subsection (a)" in its place.

(8) The lead-in language of section 11(a) (D.C. Official Code § 5-1501.10(a)) is amended by striking the phrase "forensic science services ~~and~~ or public health laboratory services" and inserting the phrase "forensic science services" in its place.

(9) Section 12(a-1) (D.C. Official Code § 5-1501.~~10~~11(a-1)) is amended as follows:

~~(A) Paragraph (1) is amended by striking the phrase "forensic science discipline or public health laboratory" and inserting the phrase "forensic science discipline" in its place.~~

(~~B~~A) Paragraph (3) is amended by striking the semicolon and inserting the phrase "; and" in its place.

(~~C~~B) Paragraph (4) is amended by striking the semicolon and inserting a period in its place.

(~~D~~C) Paragraphs (5) and (6) are repealed.

(10) Section 13 (D.C. Official Code § 5-1501.12) is amended as follows:

(A) Paragraph (1) is amended by striking the phrase "forensic science services or public health laboratory services" and inserting the phrase "forensic science services" in its place.

~~(B) Paragraph (4A) is amended by striking the phrase "forensic science services and public health laboratory services" and inserting the phrase "forensic science services" in its place.~~

(~~C~~B) Paragraph (5) is amended by striking the phrase "the Department, forensic sciences services, or public health laboratory services" and inserting the phrase "the Department or forensic science services" in its place.

(11) Section 13a(a) ~~(not yet codified)~~ is amended as follows:

(A) Paragraph (1) is amended by striking the phrase "forensic science services or public health laboratory services" and inserting the phrase "forensic science services" in its place.

(B) Paragraph (2) is amended by striking the phrase "forensic science services or public health laboratory services" and inserting the phrase "forensic science services" in its place.

(12) Section 14(a)(11) (D.C. Official Code § 5-1501.~~14~~13(a)(11)) is amended by striking the phrase "forensic science services or public health laboratory services" and inserting the phrase "forensic science services" in its place.

(13) Section 15 (D.C. Official Code § 5-1501.14) is amended as follows:

(A) Paragraph (1)(A) is amended by striking the phrase "forensic science services or public health laboratory services" and inserting the phrase "forensic science services" in its place.

(B) Paragraph (2) is amended by striking the phrase "the Department, forensic sciences services, or public health laboratory services" and inserting the phrase "the Department or forensic science services" in its place.

(14) Section 16(a)(1)(A) (D.C. Official Code § 5-1501.15(a)(1)(A)) is amended by striking the phrase "forensic science services ~~and~~ or public health laboratory services" and inserting the phrase "forensic science services" in its place.

(b) Section 2(f)(48) of the Confirmation Act of 1978, effective May 3, 1979 (D.C. Law 2-142; D.C. Official Code § 1-523.01(f)(48)) is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(c) The District of Columbia Government Comprehensive Merit Personnel Act of 1978, effective March 3, 1979 (D.C. Law 2-139; D.C. Official Code § 1-601.01 *et seq.*), is amended as follows:

(1) Section 406(b)(31) (D.C. Official Code § 1-604.06(b)(31)) is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" both ~~places~~ times it appears and inserting the phrase "Forensic Sciences Laboratory" in its place.

(2) Section 908(20) (D.C. Official Code § 1-609.08(20)) is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(d) Section 101(10) of the Address Confidentiality Act of 2018, effective July 3, 2018 (D.C. Law 22-118; D.C. Official Code § 4-555.01(10)), is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(e) Section 201(6A) of the Sexual Assault Victim's Rights Act of 2014, effective November 20, 2014 (D.C. Law 20-139; D.C. Official Code § 4-561.01(6A)), is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(f) Section 2(f) of the Retired Police Officer Redeployment Amendment Act of 1992, effective September 29, 1992 (D.C. Law 9-163; D.C. Official Code § 5-761(f)), is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(g) Section 1013(a)(1)(J) of the Firearms Control Regulations Act of 1975, effective April 27, 2021 (D.C. Law 23-274; D.C. Official Code § 7-2510.13(a)(1)(J)), is amended by striking the phrase "Forensic Sciences and Public Health Laboratory" and inserting the phrase "Forensic Sciences Laboratory" in its place.

(h) Section 23-1910(b)(3) of the District of Columbia Official Code is amended by ~~by~~ striking the phrase "Forensic Sciences and Public Health Laboratory" both times it appears and inserting the phrase "Forensic Sciences Laboratory" in its place.

Sec. ~~3008~~5008. Applicability.

Section ~~3007~~5007(a)(1)(A) and (B), (a)(2)(A) and (B), (a)(4), (a)(6)(A), (a)(9), (a)(11), (b), (c), (d), (e), (f), (g), and (h) shall apply on the date of applicability of the Restoring Trust and Credibility to Forensic Sciences Amendment Act of 2022, enacted ~~without the Mayor's signature~~ on January 19, 2023 (D.C. Act 24-780; 70 DCR 937).

SUBTITLE B. MEDICAID HOSPITAL PROVIDER REIMBURSEMENT

Sec. 3011. Short title.

This subtitle may be cited as the "Medicaid Hospital Provider Reimbursement Act of 2023".

Sec. 3012. Definitions

For the purposes of this subtitle, the term:

(1) "Department" means the Department of Health Care Finance.

(2) "Hospital" shall have the same meaning as provided in section 2(a)(1) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501(a)(1)), except as provided in subparagraph (B) of this paragraph.

(B) The term "hospital" shall not include:

(i) Any hospital operated by the federal government;

(ii) Any specialty hospital, as defined by the State Plan;

(iii) Any hospital that is reimbursed under a specialty hospital reimbursement methodology under the State Plan; or

(iv) Any hospital that serves an economically underserved area, as defined in the State Plan or as defined by the Department in the managed care directed payment proposal.

(3) "Medicaid" means the medical assistance programs authorized by Title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 *et seq*.) ("Social Security Act"), and by section 1 of An Act To enable the District of Columbia to receive Federal financial assistance under title XIX of the Social Security Act for a medical assistance

program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code §§ 1-307.02)), and administered by the Department.

(4) "State Plan" means the District's Medicaid State Plan.

Sec. 3013. Medicaid hospital provider reimbursement.

(a) Effective October 1, 2023, the Department shall fund capitation rates for each managed care organization at a level that ensures:

(1) Minimum outpatient hospital reimbursement at a level that is in accordance with the Medicaid Hospital Outpatient Supplemental Payment Act of 2017, effective December 13, 2017 (D.C. Law 22-33; D.C. Official Code § 44-664.03);

(2) Minimum inpatient hospital reimbursement at a level that is in accordance with the Medicaid Hospital Inpatient Rate Supplement Act of 2017, effective December 13, 2017 (D.C. Law 22-33; D.C. Official Code § 44-664.13 *et seq.*);

(3) Maximum outpatient hospital reimbursement of 110% of the fee-for-service rate methodology set forth in the State Plan; and

(4) Maximum inpatient hospital reimbursement equal to the negotiated managed care hospital rates that were in effect on March 31, 2023 for the managed care organization for inpatient hospital services.

(b) If necessary to ensure federal concurrence with the provisions of this section, the Department shall, by September 30, 2023, submit a managed care directed payment proposal to the Center for Medicare and Medicaid Services.

Sec. 3014. Annual hospital costs reporting.

By December 31, 2023, and by December 31 of each year thereafter, the Department shall publish on its website a report on District all-payer hospital costs.

SUBTITLE XXX. SCHOOL-BASED BEHAVIORAL HEALTH STUDENT PEER EDUCATOR PILOT

Sec. 1XX1. Short title.

This subtitle may be cited as the "School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023".

Sec. 1XX2. The Early Childhood and School-based Behavioral Health Infrastructure Act of 2012, effective June 7, 2012 (D.C. Law 19-141, D.C. Official Code § 2-1517.31 *et seq.*), is amended as follows:

(a) Section 202 (D.C. Official Code § 2-1517.31) is amended as follows:

(1) A new paragraph (1A) is added to read as follows:

"(1A) "DC Prevention Center" means a District of Columbia neighborhood-based center that promote healthy, drug-free living.

(2) New paragraphs (3) and (4) are added to read as follows:

"(3) "Resilience building" means the process by which individuals become better at reframing thought patterns and tapping into a strengths-based approach to working through obstacles.

"(4) "School behavioral health coordinator" means a public or public charter school employee who coordinates behavioral health services and referrals.

(b) A new section 204 is added to read as follows:

"Sec. 204. School-based behavioral health student peer educator pilot.

"(a) In Fiscal Year 2024, the Department of Behavioral Health ("DBH") shall award up to 2 grants totaling $325,000 to non-governmental entities to train and supervise at least 100 high school student behavioral health peer educators ("peer educators") by December 31, 2023. Peer

educators shall work in public and public charter schools as behavioral health peer educators and perform the functions identified in subsections (d) and (e) of this section.

"(b) To qualify for a grant, an applicant shall:

"(1) Submit an application that specifies at least 3 public and public charter school high schools, with a preference for schools identified in Cohort 1 of the DBH School Based Behavioral Health Program expansion or located in Wards 5, 7, or 8, the applicant intends to partner with, the maximum number of peer educators the applicant plans to recruit, train, and supervise, the types of interventions it will train peer educators to perform, and target numbers for each intervention type;

"(2) Be located in the District;

"(3) Have experience providing workshops and programming to youth ages 14 to 21 on behavioral health, resiliency, and workforce readiness; and

"(4) Agree to:

"(A) Create a plan to reach at least 25% of the students, calculated by the in-seat attendance rate, at each school they partner with;

"(B) Recruit, train, and supervise at least 50 peer educators to work during the 2023-2024 school year;

"(C) Compensate peer educators with a monthly stipend of no less than $200;

"(D) On a monthly basis, provide peer educators at least:

"(i) 8 hours of behavioral health training;

"(ii) 2 hours of training in workforce readiness, self-advocacy and personal agency, career exploration, life skills, and financial literacy; and

"(iii) 4 hours of supervision; provided that at least 4 hours of training or supervision each month shall be in person;

"(E) Provide quarterly reports to DBH that shall include:

"(i) A list of public and public charter students working as peer educators;

"(ii) A list of activities and interventions performed by peer educators;

"(iii) The total number of training hours conducted with peer educators and the topics covered, including the number of peer educators who participated in each training session;

"(iv) A list of the training topics that were covered during the reporting period; and

"(v) Progress made on objectives and benchmarks identified in the grant agreement.

"(c)(1) If there is more than one grantee, DBH shall provide an additional $25,000 from the funds identified in subsection (a) of this section to one of the grantees to serve as the coordinating organization for the pilot program. If only one grantee is selected, that grantee shall perform the duties of the coordinating organization.

(2) The coordinating grantee organization shall:

"(A) Develop and collect behavioral health training curricula for peer educator training;

"(B) Collect and share on a public dashboard or database data on peer educators' activities;

"(C) Compile and maintain a public dashboard or database of information on the public and public schools in the pilot program, which shall include:

"(i) The contact information and school location of clinicians and peer educators;

"(ii) Information on school services and programs; and

"(iii) A method for students and caregivers to make appointments with behavioral health staff and submit referrals for services.

"(d) Peer educators shall perform at least 3 of the following activities:

"(1) Conducting behavioral health classroom presentations and trainings;

"(2) Working with public and public charter school clinicians and staff to co-lead support groups;

"(3) Distributing paper and electronic materials on behavioral health and resilience-building topics;

"(4) Distributing paper and electronic materials to public and public charter students on school and community behavioral health services, programs, and resources; and

"(5) Conducting individual education sessions with public and public charter students on behavioral health and resilience-building topics;

"(e) Peer educators may additionally perform the following activities:

"(1) Creating and leading school and community events and programs;

"(2) Creating a website that includes public and public charter school behavioral health services and resources and behavioral health educational information;

"(3) Surveying public and public charter students regarding their ability to access school and community-based behavioral health resources;

"(4) Partnering with a DC Prevention Center to increase youth access to drug prevention resources;

"(5) Partnering with governmental and non-governmental youth and adult peer support specialists; and

"(6) Any other activities or interventions that increase public and public charter school student access to school and community based behavioral health services and resources, and behavioral health information.

"(f) DBH shall provide to the grantees and peer educators the contact information, including phone number, email address and office location, of public and public charter school clinicians and school behavioral health coordinators and connect grantees and peer educators with the clinicians and school behavioral health coordinators and with the operators of the DC Prevention Centers.".

SUBTITLE X. FIRST-TIME MOTHERS HOME VISITING PROGRAM

Sec. 5xxx. Short Title.

This subtitle may be cited as the "First-Time Mothers Home Visiting Program Amendment Act of 2023".

Sec. 5xxx. Section 105a(a) of the Birth-to-Three for All DC Amendment Act of 2018, effective September 11, 2019 (D.C. Law 23-16; D.C. Official Code § 4-651.05a(a)), is amended by adding a new paragraph (5) to read as follows:

"(5) In Fiscal Year 2024, DHCF shall provide an amount not to exceed $225,000 to the home visiting provider who was awarded the competitive grant pursuant to paragraph (1) of this subsection, to be expended for the purposes set forth in that paragraph.".

SUBTITLE X. SUBSTANCE ABUSE AND BEHAVIORAL HEALTH SERVICES TARGETED OUTREACH PILOT

Sec. xxx1. Short title.

This subtitle may be cited as the "Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2023".

Sec. xxx2. Substance abuse and behavioral health services targeted outreach pilot.

By October 31, 2023, the Department Behavioral Health shall award a grant in the amount of $600,000 to a 501(c)(3) not-for-profit organization with experience in substance abuse harm reduction services to provide direct support, relationship development, and resource brokering to individuals in need of substance abuse and behavioral health services at the following locations:

(a) The vicinity of the 600 block of T Street, N.W.;

(b) The vicinity of the 1100-1300 blocks of Mount Olivet Road, N.E.; and

(c) The vicinity of the 3800-4000 blocks of Minnesota Avenue, N.E.

SUBTITLE X. DEPARTMENT OF HEALTH CARE FINANCE REPORTING REQUIREMENTS

Sec. XXXX. Short title.

This subtitle may be cited as the "Department of Health Care Finance Reporting Amendment Act of 2023."

Sec. XXXX. The Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.01 *et seq*.), is amended by adding a new section 11c to read as follows:

"Sec. 11c. Department of Health Care Finance reporting requirements.

"(a) By January 1, 2024, the Director shall submit the following reports to the Council:

"(1) A report on medical respite care for homeless individuals, including:

"(A) Recommendations for the establishment of medical respite care services for homeless individuals, through either an amendment to the District of Columbia Medicaid State Plan or a waiver pursuant to section 1115 of the Social Security Act, approved July 25, 1962 (76 Stat.192; 42 U.S.C. § 1315);

"(B) The types of services that may be offered to homeless individuals through a medical respite care program; and

"(C) An identification of any potential restrictions on the provision of services identified pursuant to subparagraph (B) of this paragraph, including the use of prior authorization.

"(2) A report on the status of value-based payment methods within the District's public and locally funded health benefit programs operated by managed care organizations ("MCOs"), which shall include:

"(A) Specific efforts undertaken by each of the District's public and locally funded health benefit programs operated by MCOs to incorporate value-based payment initiatives with their network providers, along with qualitative and quantitative outcomes associated with those efforts;

"(B) A description of how each public and locally funded health benefit program operated by MCOs aligns financial incentives and accountability with the total costs of care and overall health outcomes;

"(C) A description of how each public and locally funded health benefit program operated by MCOs aligns payments directly with quality and efficiency of care; and

"(D) An analysis of the percentage of total medical expenditures by public and locally funded health benefit programs operated by MCOs that are linked to alternative payment methods.

"(b)(1) Beginning January 1, 2024, and every 3 months thereafter, each of the District's public and locally funded health benefit programs operated by MCOs shall report to the Department the following data on a de-identified basis:

"(A) The total number of beneficiaries in its plan, including those enrolled in a value-based payment model;

"(B) The number of its beneficiaries who do not have an assigned primary care physician;

"(C) The number of its beneficiaries who have not had a primary care visit in the previous 12 months; and

"(D) The number of its beneficiaries who have had more than five emergency room visits in the previous ninety-days."

(2) Within 30 days of receiving the information required under paragraph (b)(1), the Director shall report such information to the Council and post it publicly on the Department's website.

ATTACHMENT
C

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
PUBLIC HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH
ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Health Benefit Exchange Authority

And

Not-for-Profit Hospital Corporation (UMC)

ON

Thursday, March 30, 2023, 9:00 a.m.
Virtual Meeting via Zoom Video Conference Broadcast
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

Health Benefit Exchange Authority

1. Kimberly Perry, Executive Director, DC Action
2. Rebecca Barson, Public Witness
3. Nicole Quiroga, President and CEO, Greater Washington Hispanic Chamber of Commerce
4. Che Ruddell-Tabisola, Director, Government Affairs and Member Advocacy Restaurant Association Metropolitan Washington
5. Lisa Nipp, Public Witness

6. Angela Franco, President & CEO, DC Chamber of Commerce
7. Jaye Yarbrough, Data and Training Manager, Whitman Walker Health
8. Floyd May, Interim Executive Director, Leadership Council for Healthy Communities
9. Gabriela Morgan, Chief People Officer (CPO), CommuniKids Preschool
10. Marlene Cherry, Director, Montessori School of Chevy Chase
11. Yasmina Castellanos, Manager, Community of Hope
12. Alexandra Jellerette, President, Zane Networks, LLC
13. Danjale Williams, Teacher/Office Admin, Children Of The Future CDC

Government Witness

1. Mila Kofman, Executive Director, DC Health Benefit Exchange Authority

Not-for-Profit Hospital Corporation (UMC)

Government Witnesses

1. Dr. Jacqueline Payne-Borden, Chief Nursing Officer, United Medical Center
2. Lilian Chukwuma, Chief Financial Officer, United Medical Center

RAMW
RESTAURANT ASSOCIATION METROPOLITAN WASHINGTON

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Suite 450
Washington, DC 20037
T: 202-331-5990
info@ramw.org

Testimony of
Che Ruddell-Tabisola, Director, Government Affairs and Member Advocacy
Restaurant Association Metropolitan Washington

Before the
The Council of the District of Columbia
Committee on Health
Christina Henderson, Chairperson

At the
DC Health Benefit Exchange Authority
FY 24 Budget Oversight Hearing

March 30, 2023

Chairperson Henderson, members of the Committee, and Committee staff, thank you for the opportunity to testify. I am Che Ruddell-Tabisola, Director of Government Affairs and Member Advocacy at the Restaurant Association Metropolitan Washington (RAMW). I am here today to present testimony on behalf of the DC Health Benefit Exchange Authority (DCHBX).

The Restaurant Association Metropolitan Washington actively supports and promotes the Washington, DC area foodservice industry on behalf of our 1,400 plus members, which includes restaurant owners and operators, food distributors, and service providers. Our membership soundly represents the diversity and range of businesses within the foodservice industry in the District.

In DC, 96% of full-service restaurants are independently operated, meaning a majority of local restaurants are small businesses; including RAMW. We are a DC Health Link SHOP marketplace customer and have served as a small business partner of HBX since 2014. In DC, small business restaurants contribute significantly to the economy and employ thousands of Washingtonians. Access to affordable health benefit options help to attract and retain staff, which is a key component of operations.

DCHBX continues to be an invaluable resource for small businesses and residents in the District by fostering competition and transparency in the local health insurance market and by providing a platform to purchase affordable, quality health insurance.

Through our partnership with DCHBX, we are able to support outreach, education, and enrollment efforts to the foodservice community. We are able to commit dedicated staff to outreach and programming efforts that offer access to brokers, who provide restaurant employers with the necessary support in evaluating their ability to offer health insurance, starting the enrollment process, making changes to benefits, and keeping their employees well-informed of the available coverage options. We provide information about individual enrollment options to restaurant workers attending our training classes. When employer-sponsored insurance is not offered, we work with DCHBX on initiatives such as the DC Health Link @ Work initiative, which gives small businesses the choice of having a DCHBX representative meet employees onsite to inform workers of coverage options and offer enrollment assistance.

As a collective voice with DC HBX, other business partners, and community organizations, we advocate against regulations that jeopardize critical Affordable Care Act (ACA) protections that would have adverse effects on our local marketplace's ability to provide quality and affordable health insurance.

Additionally, we help to keep this important benefit option and resource in the forefront of operators and decision-makers through amplifying messaging around the Open Enrollment Period; participating in events such as the popular POWERUP DC Small Business Summit; integrating DCHBX in our events, training classes, and member-focused meetings; and through the continuous presence of DCHBX in RAMW’s member communications and digital assets.

Small businesses have a great need for options to help them operate and grow their businesses. The efforts by DCHBX will continue to be an invaluable asset and resource in providing access to quality, affordable health insurance options.

As you review budget submission for FY 24, we respectfully request that you support the DCHBX budget submission so it can continue the work it does to ensure quality, affordable health insurance for all District

residents and businesses. Adequate funding to support its outreach, education, and enrollment activities is paramount to its ongoing success.

RAMW pledges its continued support of the DC Health Benefit Exchange Authority and urges the Council to do the same. It's what's best for our city.

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

Mary's Center
Quality healthcare. Stronger communities.

Testimony for Health Benefit Exchange Authority
Public Oversight Hearing
Committee on Health
March 30, 2023

Veronica Hernandez
Entitlement Manager
Mary's Center for Maternal and Child Care, Inc
2333 Ontario Rd NW

Good morning, Chairperson Henderson, and Members of the Committee,

Thank you for the opportunity to testify today. My name is Veronica Hernandez, and I am the Entitlement Manager at Mary's Center. Mary's Center employs two (2) In-Person Assisters who implement our Health Benefits Exchange program. Mary's Center and the Health Benefits Exchange Authority have had our partnership for nearly 10 years. At Mary's Center, we witness firsthand the impacts our In-Person Assisters have in supporting DC residents accessing health insurance providers through the DC Health Link- the Affordable Care Act online health insurance marketplace in DC.

Within the calendar year of January 1 – December 31, 2022, our two (2) In-Person Assisters supported 2,477 DC residents and their families obtain health insurance.

We conduct in-person and virtual outreach events in English, Spanish, and Amharic to educate our community of health insurance benefits and enrollment processes. We are present in the community during evening hours, throughout weekends, and host indoor and outdoor community events.

Our dedication and tenacity to maximize opportunities for uninsured DC residents to enroll in health insurance speaks volumes to Mary's Center's Health Benefits Exchange program's perseverance to ensure the highest percentage of residents obtain health insurance coverage. The DC residents we serve express their

Mary's Center
Quality healthcare. Stronger communities.

gratitude for providing culturally specific services in their native languages, specifically with increasing health insurance literacy and enrolling in qualified health plans.

We have appreciated the partnership and leadership of the DC Health Exchange, working with us to ensure the staff are trained and supported in their roles, and to help identify and arrange events that can best meet those who still lack insurance.

Thank you for this opportunity to testify and I will be happy to answer any questions you may have.

Testimony of Alexandra Jellerette
Founder, Zane Networks
1205 Good Hope Road SE, Suite 204
Washington, DC 20020
Before the
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
Budget Oversight Hearing
DC Health Benefit Exchange Authority

Thursday, March 30, 2023 – 9:00 am
Live via Zoom Video Conference Broadcast

Good morning Chairwoman Henderson and members of the Committee on Health. My name is Alexandra Jellerette. I am the co-founder of Zane Networks. I am pleased to offer testimony before you today regarding DC Health Link and the positive impact it has had on our small business, as well as our employees.

Zane Networks is a District Certified Business Enterprise (CBE) designated company. Zane Networks specializes in health technology. We provide strategic services in health quality improvement, Medicaid consulting, virtual health, web and application development, audio and video technical support, and staffing. Our company is headquartered on Good Hope Road in Southeast DC and our employees work out of the office, remotely and in some hospital and healthcare settings. In addition to our work in other states, we have a few District contracts where we assist healthcare and human services organizations to utilize health technologies such electronic health records, telehealth and the health information exchange.

We have been DC Health Link customers since 2018. We offer our employees coverage at all metal level plans through United Healthcare. This way they can choose the plan that best fits their needs. Because we work in the health technology sector, providing our employees with access to quality, affordable health insurance coverage is important to us as a company. Beyond that, providing these benefits to our employees helps us as a small business. We can compete with larger firms for high-quality employees because we offer great benefits through DC Health Link. We're also able to show our team how important they are to us by offering quality health insurance coverage. Because this is a budget oversight hearing, I'd like to add that offering our team quality health benefits helps our small business's budget. Overing quality health insurance coverage greatly helps employee retention, which means less money spent on

recruitment and training. On top of that, if a team member does get sick, they can receive treatment from a doctor and return to work more quickly.

Before we became DC Health Link customers, we provided our employees a credit so they could purchase health insurance. However, this didn't always mean that our employees got covered. Having to purchase insurance on your own could be a daunting, often frustrating experience before the Affordable Care Act. As a company, we are proud to offer benefits through DC Health Link and feel so much better knowing that our team is covered. DC Health Link's portal is easy to use, and our team has had great experiences accessing their benefits.

Also, as a small business owner, it gave me peace of mind to know that our employees had the coverage they needed during the pandemic. The past three years have been stressful for everyone. Having quality health insurance coverage meant that our team had one less stressor to worry about, and that makes us feel great.

Thank you very much for the opportunity to share my experience. I would be happy to answer any questions you may have.

Testimony of Danjale Williams
Children of the Future CDC
2003 Bunker Hill Road, NE
Washington, DC 20018
Before the
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
Budget Oversight Hearing
DC Health Benefit Exchange Authority

Thursday, March 30, 2023 – 9:00 am
Live via Video Conference Broadcast

Good morning, Chairwoman Henderson and members of the Committee on Health. My name is Danjale Williams, and I am the administrator of, and a teacher at, the Children of the Future Child Development Center. Thank you for the chance to testify before you today and share the positive experience we have had with DC Health Link and what a godsend the HealthCare4ChildCare program has been for us.

Children of the Future is a small child development center in Ward 5. We currently have three full-time teachers, including me, and the capacity for 20 students from 6 months old to 5 years old. Because we are a smaller facility, we rely on the strength and dedication of our teachers. For our child development center to succeed, we need to support our teachers in any way that we can. In a center our size, having healthy teachers is critical. We are around kids all the time and kids are sick quite often. So, when a teacher is out because of sickness for an extended period of time, it is a big challenge to overcome because we are a small staff.

As I said earlier, the HealthCare4ChildCare program has been a godsend for the Children of the Future Child Development Center. In general, teachers aren't paid as well as other professions. Our teachers wouldn't have health insurance coverage without the HealthCare4ChildCare program. We now have peace of mind knowing that health insurance coverage if we need it. Personally, I'm much more confident in my ability as a teacher because I don't have to worry about getting sick without access to care. On top of all these benefits, HealthCare4ChildCare is responsible for a huge morale boost at Children of the Future Child Development Center. As a team, we are much happier now that we have health insurance coverage. Having peace of mind removes worry so that we can focus on our most precious resource—children.

Thank you very much for the opportunity to share my experience. I would be happy to answer any questions you may have.

Testimony of Gabriela Morgan
4719 Wisconsin Ave, NW
Washington, DC 20016
Before the
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
Budget Oversight Hearing
DC Health Benefit Exchange Authority

Thursday, March 30, 2023 – 9:00 am
Live via Video Conference Broadcast

Good morning, Chairwoman Henderson and members of the Committee on Health. My name is Gabriela Morgan, and I am the Chief People Officer for CommuniKids Preschool. Thank you for the chance to testify before you today and share our extremely positive experience with DC Health Link and the HealthCare4ChildCare program.

Communikids is a bilingual early childcare education center that offers preschool classes as well as after-school programs. We tell the parents of our students that we want to give their children the super power of being bilingual by the time they reach kindergarten. There are currently four Communikids locations throughout the District. CommuniKids language immersion school got its start back in 2003, and we are staffed by a dedicated group of child educators. Our preschool classes incorporate a play-based approach that stimulates cognitive, linguistic, motor/physical, and social-emotional development. We currently have 97 teachers in total at our four DC locations.

I can't say enough about how much Communikids and its teachers have benefitted from the HealthCare4ChildCare program. Thanks to HealthCare4ChildCare, 82 of our teachers have health coverage for the first time. Our employees pay no monthly health premiums, nor does Communikids as a small business. We want to give our teachers the peace of mind that comes with health insurance coverage so that they can fully focus on our students. HealthCare4ChildCare makes this possible.

Because this is a budget hearing, it's worth mentioning that HealthCare4ChildCare is already having a positive impact on our budget. As the Chief People Officer, I can tell you that the number one benefit teachers are looking for in a solid, competitive compensation package is health insurance coverage. HealthCare4ChildCare is a wonderful tool to retain teachers and hire new teachers. This program has helped bring the turnover rate for full-time employees down to

zero. Plus, word of mouth about health insurance with no premiums is bringing potential new teachers to us.

I want to add that DC Health Link provides solid customer service, and the representatives working with me have always been very helpful. Thank you very much for the opportunity to share my experience. I would be happy to answer any questions you may have.

Testimony of Nicole Quiroga
President and CEO
of the
GREATER WASHINGTON HISPANIC CHAMBER OF COMMERCE

Before the

COUNCIL OF THE DISTRICT OF COLUMBIA
Committee on Health
FY 2024 Budget Oversight Hearing
Thursday, March 30, 2023
9:00 am
Location: JAWB Room C
Virtual Meeting Platform

Good morning members of the Committee on Health and Chair of the Committee, Councilmember Christina Henderson. My name is Nicole Quiroga*, President and CEO of the Greater Washington Hispanic Chamber of Commerce*. I am here today to testify on behalf of DC Health Benefit Exchange Authority, which manages and operates the District's online health insurance marketplace, DC Health Link.

Since 2013, GWHCC has partnered with DC Health Link to engage, educate and facilitate health insurance enrollment for DC individuals, families, small businesses and their employees. To ensure the accomplishment of its mission, the Chamber has collaborated with community-based organizations, local businesses as well as federal and local government entities to provide access to high quality, affordable health insurance to members of the Hispanic community and other minorities in the District of Columbia.

In the area of education and enrollment, GWHCC partnered with DC Health Link to host the popular Virtual One Touch Enrollment (VOTE) events. Over this past year, GWHCC touched more than **400** individuals and families resulting in **200** new enrollments and **180** renewals.

GWHCC also hosted **52** outreach & educational online sessions where GWHCC touched more than **3000** small business owners to inform them about the benefits of health insurance through DC Health Link.

Through online networking events, GWHCC was able to touch, promote and disseminate information during several specialty events including the women's group event, webinars and the Annual GWHCC Business Expo.

GWHCC, in association with DCHL's small business partners, plays a significant role in hosting DC Health Link's annual Small Business Summit. "POWERUP DC" event each year.

As a result of various marketing, outreach and specialty events, GWHCC was able to enroll 120 new business on the exchange and are successfully tracking and seeking to close the goal for another 150 businesses.

GWHCC will continue to work side by side with DC Health Link and its leaders to ensure District of Columbia individuals, families, small business owners and their employees have access to high quality, affordable health insurance. We will continue to focus our efforts in developing creative marketing strategies for outreach, include bilingual staff of all identifiable languages in

the DC demographic, and use bilingual promotional flyers and brochures to educate and facilitate an easy, efficient and convenient enrollment process supporting the implementation and sustainability of the Affordable Care Act in the District.

We are very proud of our award-winning DC Health Link marketplace and respectfully request the Council to continue to support the mission and goals of the DC Health Benefit Exchange Authority as it continues to provide DC residents accessibility, dignity, and the basic human rights of health insurance coverage.

Thank you for the opportunity to testify.

Nicole Quiroga
President and CEO
Greater Washington Hispanic Chamber of Commerce

Testimony of Floyd May

Executive Director
Leadership Council for Healthy Communities (LCHC)

Before the

Council of the District of Columbia Committee on Health
Christina Henderson, Chairperson

Budget Hearing

DC Health Benefit Exchange Authority

Thursday, March 30, 2023

9:00 a.m.

Good morning, Chairwoman Henderson and members of the DC Council Committee on Health, I am Floyd May, Executive Director of the Leadership Council for Healthy Communities (LCHC) at 10 G Street NE, Washington, DC 20002. I am pleased to provide testimony at the FY 2023 Budget Hearing on behalf of the DC Health Benefit Exchange Authority. LCHC is an organization of clergy leaders, medical professionals, public and community leaders working together to help African

Americans and other communities of color promote healthy behaviors and eliminate health disparities. LCHC has had the privilege of serving as an Assister organization of the Health Benefit Exchange since its first open enrollment. We have built relationships with clergy organizations, neighborhood businesses, and houses of worship that allow continuous access to residents who need health insurance coverage. We are all keenly aware of the great work the Exchange is doing and how helpful they are in assisting DC residents with accessing affordable, quality health insurance through DC Health Link. It is abundantly clear how important and worthwhile our work is in getting persons enrolled. One example in particular comes to mind when a 32 year old woman, who had less than a month to give birth, reached out for enrollment assistance.

With the help of the LCHC Assister and DC health Link Call Center, the resident was able to obtain health insurance coverage. The Consumer, recalling the enrollment process, said, " I was 8 months pregnant when I moved to Washington DC from North Carolina on a job transfer. Unfortunately, my employer does not cover health insurance. I had to look for

information on how to enroll for health insurance benefits. On google search, I found contacts through DC Health Link's website. The LCHC Assister and the DC health link Call Center, understanding my situation, expedited my enrollment into a qualified health plan. Surprisingly, the same day I gave birth, I became eligible for my health plan. Thanks to Almighty God and the team who assisted me. "I would highly suggest DC Health Link".

During the COVID-19 pandemic the Exchange, in collaboration with LCHC and other Assister organizations, successfully pivoted its efforts to reach residents throughout the COVID-19 pandemic with enrolling in health insurance after losing their jobs and losing health insurance coverage through their employers. Hundreds of calls were made to provide information and assist people with enrolling in health insurance plans.

The Exchange's effort to reach the uninsured is unending. With the passing of President Biden's American Rescue Plan Act, the Exchange embarked upon a campaign, Health Care 4 Child Care, to reach uninsured and underinsured childcare workers to also assist them with getting affordable, quality health insurance. We continue to make every effort to meet people

where they are. To that end, LCHC Assisters have participated in numerous outreach efforts including DC Metropolitan Police Department's "Beat the Streets" events, Martin Luther King Day health fair, AMC movie theaters, HealthCare4Child Care enrollment at the DC Amory as well as other health fairs and COVID 19 vaccination pop-up clinics For those consumers and so many others, I hope there is a steadfast commitment to DCHBX to continue with the involvement of LCHC and other Assister organizations.

This work is done to help improve individual and community health. To quote Dr. Martin Luther King, Jr., we deeply believe that "*of all the forms of inequity, injustice in health care is the most shocking and inhumane."* The work is a solemn task and sacred duty. I commend the leadership and staff of the DC Health Benefit Exchange Authority, and I pray they will continue the work to lend to the success in their service to DC residents.

Respectfully submitted,

Floy May
Interim Executive Director

Testimony of Lisa Nipp
322 12th Street SE
Washington, DC 2003
Before the
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
Budget Oversight Hearing
DC Health Benefit Exchange Authority

March 30, 2023 – 9:00 am
Live via Video Conference Broadcast

Good morning, Chairwoman Henderson and members of the Committee on Health. My name is Lisa Nipp and I am a Ward 6 resident. I thank you for allowing me to speak before you today regarding DC Health Link and the positive impact it has had on my life as a small business owner in DC. I have health insurance coverage through DC Health Link's individual marketplace.

As this is a budget oversight hearing, I want to share how DC Health Link and the Affordable Healthcare Act have allowed my family to purchase health insurance multiple times for almost a decade as my family's employment status changed. I have worked as a self-employed corporate photographer for over 20 years, and I am now a single mother after the death of my husband last year. Without DC Health Link, I would be unable to afford coverage for me and my son.

My family has been DC Health Link customers on and off since 2015. At the time we became DC Health Link customers, my late husband worked as a baseball analyst for MASN as an independent contractor and this work did not include employer-sponsored health insurance. When we reached out to DC Health Link, we were immediately offered help finding a plan. Despite not qualifying for any subsidies because of our income, we were able to afford coverage with lower deductibles at better price points as the years went on. We were very pleased with both the quality of our medical and dental plans and the customer service provided by DC Health Link.

In 2017, MASN offered my husband the opportunity to purchase insurance through their employer plan. So, we left DC Health Link because it was cheaper to take the coverage MASN offered. My husband contracted a rare form of cancer in January 2020 and passed away one year later. Over those 12 months that he was ill, this private plan paid out almost 5 million dollars in healthcare expenses. Our total out-of-pocket was less than $1000.

During the Covid 19 Pandemic, my husband's television show was canceled and he was laid off again. My photography business shut down completely. Neither of us worked during most of 2020. MASN kindly continued to allow my husband to remain on their insurance plan, but my son and I were removed from this plan in September 2020. After all I had been through dealing with insurance billing during my husband's sickness, I was terrified of being without insurance myself in case something else happened. I reached out in tears to DC Health Link, and within 24 hours they connected me with a person who helped enroll my son and me in a Medicaid plan.

With the passage of the American Rescue Plan Act, I received a notice from DC Health Link about premium reductions. This notification came around the same time that my income recovered enough that I was no longer eligible for Medicaid, but I did not think I could afford to buy a plan on the exchange. I worked with a DC Health Link representative and found that I qualified for a Silver level plan at an affordable $111/month. It was SUCH a relief to know that I had this coverage AND that I could return to the doctors and other healthcare providers I had used for years.

After the Inflation Reduction Act extended lower premiums from the American Rescue Plan last year, we were able to stay with a Silver plan My income has recovered significantly, and with help from the federal monthly tax credit, I have a plan that saves me $6,400 annually.

As a single parent to a teenage soccer player who spends his weekends at Urgent Care, our healthcare plan is always at the forefront of my mind. I have seen firsthand that good insurance prevents financial ruin during times of life-changing illness. The Silver Plan I have through DC Health Link allows me to sleep at night without worry because I know that I have coverage that will provide for the care I need, a deductible that I can afford, and the support of the customer service representatives at DC Health Link.

Thank you for the opportunity to share my healthcare journey. I am happy to answer any questions you have.

Testimony of Marlene Cherry
Montessori School of Chevy Chase
5312 Connecticut Ave, NW
Washington, DC 20015
Before the
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
Budget Oversight Hearing
DC Health Benefit Exchange Authority

Thursday, March 30, 2023 – 9:00 am
Live via Video Conference Broadcast

Good morning, Chairwoman Henderson and members of the Committee on Health. My name is Marlene Cherry, and I am the owner and director of the Montessori School of Chevy Chase. Thank you for the chance to testify before you today and share the positive experience we have had with the HealthCare4ChildCare program and DC Health Link.

The Montessori School of Chevy Chase is a 12-month accredited school located in Ward 3. We are a culturally diverse community of lifelong learners with toddler, primary English, and French immersion programs. Through a strong academic curriculum based on the Montessori philosophy, we want to foster self-esteem, independence, empathy, and social consciousness in our students. It is our priority to provide an environment in which our students are safe, happy, self-motivated, and excited about learning. To do this, we need exceptional teachers. We currently have 14 full-time teachers, including myself, and 40 students with the capacity for more.

The HealthCare4ChildCare program has been a blessing for the Montessori School of Chevy Chase. When I first started the Montessori School of Chevy Chase, I couldn't afford health insurance coverage. I firmly believe that everyone should have health insurance and it was disappointing that we couldn't provide coverage to all of our teachers. They deserve coverage. Thanks to HealthCare4ChildCare, all of our teachers now have access to quality health insurance coverage. Since this is a budget oversight hearing, it's great to be able to report that this program also saves our school money.

It is great to be able to give our teachers peace of mind knowing they have health insurance coverage if they need it. I can tell you that the benefits from HealthCare4ChildCare have already boosted morale. One of our teachers is so much happier since she got access to health insurance coverage that she has really stepped up lately. It could be a coincidence, but I'd like

to think her positive energy comes from the peace of mind coverage gives her. I believe that HealthCare4ChildCare will be a great tool to recruit new teachers, like her, as more students enroll.

Thank you very much for the opportunity to share my experience. I would be happy to answer any questions you may have.

Testimony for Committee on Health Budget Hearing – DC Health Benefit Exchange Authority
March 30, 2023
Rebecca Barson, MPH

Good morning, Chairperson Henderson and members of the Committee on Health, and thank you for allowing me to speak before you today. My name is Rebecca Barson, and I am a Ward 3 resident. I am also the owner of RDB Strategies, a small health policy and advocacy consulting firm, a proud DC Health Link customer, and a member of the DC Health Benefit Exchange Standing Consumer Advisory Board. As you consider the DC Health Benefit Exchange Authority's budget in today's hearing, I want to share with you the positive impact that DC Health Link has had on my life and career.

Just over seven years ago, in early 2016, DC Health Link allowed me to fulfill a lifelong dream of self-employment by allowing me to purchase high-quality health insurance that I could afford as a small business owner, something that had been unattainable before the existence of the Affordable Care Act and the health insurance marketplaces it established. And one of the reasons that I needed to ensure that I had such coverage is because I am part of the nearly half the population that has a chronic condition – particularly, I am one of the 47 million Americans who have migraine disease. In my case, it is chronic, meaning I have more than 15 migraine days a month, and it significantly affects my quality of life. Excellent insurance coverage is essential.

And I have found that through DC Health Link. The website is incredibly informative, and the enrollment process is intuitive. While I didn't need online or in-person assistance, I appreciate that these options are available and abundant.

I have had coverage for the past seven years with CareFirst Blue Cross Blue Shield, and I am grateful for their broad network of providers because I have had to see a lot of providers to get the care right for my condition. With my PPO plan, when I exhausted the options in the DC area, I have been now able to get care at Jefferson Headache Center in Philadelphia, considered the best headache care facility on the East Coast, on an in-network basis.

In addition, there have been a lot of new drugs and treatments for migraine in the last several years, and, I have consistently had access to all of these as they have come on the market. I am in several Facebook groups for those with migraine, and people often complain about how their insurance won't cover their treatments, and I feel so lucky that I haven't had that experience. I also have coverage for complementary services like acupuncture and chiropractic, as well as coverage for mental health services, which is so important when dealing with a chronic illness.

While I continue to search for the best treatments that will help me feel my best, it is such a relief that my insurance coverage isn't a barrier to these efforts. The coverage I have through DC Health Link really is as good – or possibly better – than what I would have through an employer. I also appreciate DC Health Link's efforts to get rates as affordable as possible for their customers so I can continue to afford this excellent coverage.

Thank you, Chairperson Henderson, for the opportunity to share my experience with DC Health Link today. I am happy to answer any questions.

DC HEALTH LINK

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DC Health Benefit Exchange Authority

Mila Kofman, J.D., Executive Director

HBX Proposed Budget FY24
Budget Oversight Hearing
DC Council Committee on Health
Chairperson Councilmember Henderson
March 30, 2023

DC HEALTH LINK
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DC Health Link: Affordable Care Act State-Based Online Health Insurance Marketplace

- **Private-public partnership** (private Executive Board)
- Last state to start IT build, 1 of 4 state marketplaces opened for business on time (& stayed open) Oct 1, 2013
- **Small group & individual market through DC Health Link**:
  - 100,000 covered lives with private health insurance: 80,000+ people in SHOP (5,300 District small businesses; 11,000 Congress -- Members and designated staff in district offices and on the Hill); 15,000 - 20,000 residents (individual market paid covered lives)
- **Responsible for over $670 million** in annual premiums
- **Cut uninsured rate in half** since DC Health Link opened for business. Near universal coverage with more than 96% of DC residents covered
  - ✓ DC ranks **#2** in U.S. for lowest uninsured

DC HEALTH LINK
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2023 HEALTH INSURANCE OPTIONS THROUGH DC HEALTH LINK

Plans:

- **211** Small Group Plans
  - 5 plans with lower premiums than in 2022
- **27** Individual Plans (includes 2 catastrophic)

HBX: Advocate for lowest possible premiums for all customers

Insurers:

- 3 UnitedHealthcare Companies (group only);
- 2 Aetna Companies (group only);
- CareFirst BlueCross BlueShield; and
- Kaiser Permanente.

DC HEALTH LINK
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DC Health Link State-Based Marketplace Advantage

- ✓ **Standard Plans: No deductibles** for primary care, specialists, mental and behavioral health, urgent care and generic Rx.
- ✓ **Equity-Based Benefit Design:** Starting January 1, 2023 standard plans cover:
  - ✓ **Type 2 diabetes care** including insulin, lab work, eye and foot exams, and Rx and supplies without co-payments, co-insurance, and deductibles.
  - ✓ **Starting January 1, 2024 standard plans cover pediatric mental and behavioral health services** at reduced cost sharing.
    - ✓ $5 for office visits, certain lab work and medication (e.g. reduced $45 copay to $5 copay)
- ✓ **More residents qualify for lower monthly premiums** because of Inflation Reduction Act.
  - ➢ Of the 20,000 residents with individual coverage, 16% qualify for lower premiums (APTC)
  - ➢ **Premiums as low as $11/month**

DC HEALTH LINK
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DC Health Link State-Based Marketplace Advantage

- ✓ **HealthCare4ChildCare** through DC Health Link helps OSSE-licensed early child development facilities provide affordable health insurance for their employees. Free premiums and lower premiums started Jan.1, 2023 & are guaranteed for 2023.

DC HEALTH LINK
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HBX PROPOSED BUDGET FY24

- PROCESS: Staff, Board Finance Committee, Standing Advisory Board (diverse stakeholders) & HBX Executive Board (November 2022)
- Efficiency: Leverage DC gov't agencies; phase-out consultants and transition to FTEs, and reduce operational costs through partnership with the Massachusetts Health Connector
  - **$1,646,544** savings with MA partnership (lower contract costs and reimbursement)
- FY24 PROPOSED BUDGET **$37,552,148:**
  - Funding from $36,123,148 in health carrier assessments, $1,329,000 from MA, and $100,000 from investment income
- **Funded through an assessment on health carriers (projected assessment: 0.82%)**

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ANNUAL ASSESSMENT ON HEALTH CARRIERS

Projected assessment for FY24 and historical actual assessment rates

To fund (FY)	Assessment Rate
FY24	**0.820%**
FY23	0.800%
FY22	0.825%
FY19, FY20, FY21	0.900%
FY15, FY16, FY17, FY18	1.000%

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BUDGET COMPARISON: FY23 & FY24

	FY23 APPROVED BUDGET	FY24 PROPOSED BUDGET	$ CHANGE	% CHANGE
MARKETPLACE INNOVATION POLICY AND OPERATIONS (Marketplace Operations)	$13,325,626	$13,768,917	$443,292	3.33%
CONSUMER EDUCATION AND OUTREACH	$3,231,706	$3,363,705	$131,999	4.08%
IT (DCHealthLink.com)	$12,346,018	$13,225,400	$879,381	7.12%
AGENCY MANAGEMENT PROGRAM	$5,974,210	$6,365,078	$390,868	6.54%
AGENCY FINANCIAL OPERATIONS	$806,495	$829,048	$22,552	2.80%
TOTAL BUDGET	**$35,684,055**	**$37,552,148***	**$1,868,092**	**5.24%**

***FY24 BUDGET FOR ASSESSMENT: $36,123,148**

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BUDGET RECONCILIATION TO ASSESSMENT BUDGET

FY24 Proposed Budget	**$37,552,148**
Less:	
6.0 FTEs Budgeted for MA Health Connector	(800,000)
Admin Fees Budgeted for MA Health Connector	(237,000)
Contact Center Costs Budgeted for MA Health Connector	(180,000)
Mailing and Postage Fees Budgeted for MA Health Connector	(40,000)
Cloud Security for MA Health Connector	(72,000)
FY24 Investment and Interest Earnings	(100,000)
Net FY24 Budget for Assessment Calculation	**$36,123,148**

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FY24 REDUCTION IN HBX OPERATING COSTS THROUGH MA HEALTH CONNECTOR PARTNERSHIP

Category	FY24 Budget
Personnel – 6.0 FTEs	800,000
Admin Fees	237,000
Premium Aggregation*	317,544
Contact Center Fees	180,000
Mailing and Postage	40,000
Cloud Security	72,000
Total	**$1,646,544**

* SAVINGS ALREADY REFLECTED IN FY24 PROPOSED BUDGET

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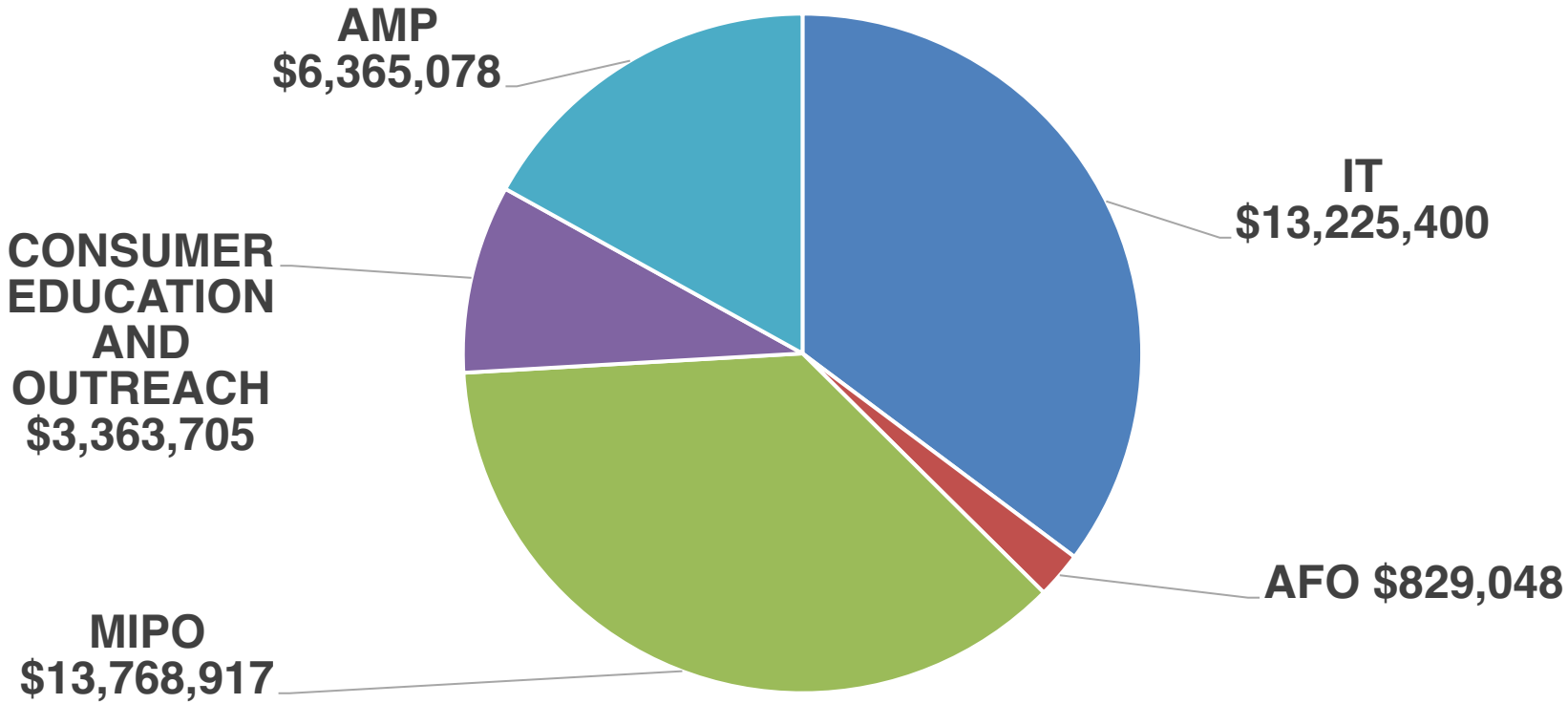
PROPOSED FY24 BUDGET BY PROGRAM



FY24 BUDGET FOR ASSESSMENT: $36,123,148

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MARKETPLACE INNOVATION, POLICY AND OPERATIONS (MIPO)

PROPOSED FY24 BUDGET: $13,768,917
(FY23: BUDGET $13,325,626)

- PERSONNEL SERVICES BUDGET FOR 57.0 FTEs: $7,476,954
- NON-PERSONNEL SERVICES (NPS) BUDGET: $6,291,963

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MIPO: CONTACT CENTER

PROPOSED NPS FY24 BUDGET: $3,906,947
(FY23 BUDGET: $4,220,103)

- CONTACT CENTER SERVICE CONTRACT: $3,504,726 (REDUCED PRICE ACHIEVED THROUGH RFP & NEGOTIATIONS WITH VENDOR)
- SALESFORCE LICENSES : $173,021
- MICROSOFT OFFICE 365 LICENSES: $18,000
- PHONE SYSTEM (TELEPHONY): $84,000
- ADMIN (COURIER SERVICE, EQUIPMENT, COMPUTER REFRESH, SUPPLIES): $64,800
- LANGUAGE LINE: $62,400

MIPO: ELIGIBILITY AND ENROLLMENT (INDIVIDUAL MARKETPLACE)

PROPOSED NPS FY24 BUDGET: $463,000
(FY23 BUDGET: $467,000)

- MOA WITH OFFICE OF ADMINISTRATIVE HEARINGS FOR ELIGIBILITY APPEALS: $6,000
- NOTICE PRINTING/MAILING: $180,000
- AMHARIC/SPANISH TRANSLATION OF NOTICES: $27,000
- CONSULTING SERVICES: $250,000

MIPO: PLAN MANAGEMENT

PROPOSED NPS FY24 BUDGET: $831,600
(FY23 BUDGET: $835,000)

- ACTUARIAL SERVICES: $175,000
- PLAN MATCH (ANONYMOUS SHOPPING), DOCTOR DIRECTORY, HEALTH PLAN MATCH, PRESCRIPTION DRUG FORMULARY LOOKUP TOOL, DENTAL PLAN MATCH: $656,600 (negotiated lower price)

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MIPO: SMALL BUSINESS MARKETPLACE (S.H.O.P.)

PROPOSED NPS FY24 BUDGET: $899,822
(FY23 BUDGET: $899,822)

- PREMIUM AGGREGATION: $504,822*
- CONSULTING SERVICES: $250,000
- MAILING AND POSTAGE: $120,000**
- TRANSLATION: $25,000

**REFLECTS SAVINGS OF $317,544 FROM MA HEALTH CONNECTOR PARTNERSHIP*
***INCLUDES $40,000 TO BE REIMBURSED BY THE MA HEALTH CONNECTOR*

DC HEALTH LINK
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MIPO: PERFORMANCE MANAGEMENT

PROPOSED NPS FY24 BUDGET: $190,594
(FY23 BUDGET: $177,000)

- COMPUTER REFRESH, SUPPLIES, TRAINING, NAHU (broker training), POSTAGE AND SHREDDING; SURVEY TOOL: $155,594
- EMMA EMAIL TOOL: $35,000

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CONSUMER EDUCATION AND OUTREACH

PROPOSED FY24 BUDGET: $3,363,705
(FY23 BUDGET $3,231,706)

- PERSONNEL SERVICES FOR 7 FTEs: $1,098,856
- NON-PERSONNEL SERVICES: $2,264,849
  - ENROLLMENT OUTREACH (DCCC, GWHCC, RAMW) AND NAVIGATORS/ASSISTERS: $1,050,000 (increased over FY23)
  - MARKETING OUTREACH: $1,092,050
  - HEALTH INSURANCE LITERACY CAMPAIGN: $90,000
  - DATA RESOURCES: $25,000
  - ADMIN: $7,799

IT (DCHealthLink.com)

PROPOSED FY24 BUDGET: $13,225,400
(FY23 BUDGET: $12,346,018)

- PERSONNEL SERVICES FOR 35 FTEs: $5,733,863
- NON-PERSONNEL SERVICES BUDGET: $7,491,537 (FY23 BUDGET $7,099,898)
  - IT CONSULTANTS: $5,126,060
  - SOFTWARE: $1,620,079
  - EXTRA CARE (additional resources post deployments for quicker ticket resolution): $510,000
  - MICROSOFT OFFICE 365 LICENSES: $35,000
  - OCTO: $107,000
  - ADMIN: $93,398 (computer refresh, copier, supplies, training)

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AGENCY MANAGEMENT PROGRAM (AMP)

PROPOSED FY24 BUDGET: $6,365,078
(FY23 BUDGET $5,974,210)

- PERSONNEL SERVICES FOR 21.0 FTEs: $4,097,327
- NON-PERSONNEL SERVICES BUDGET: $2,267,752
  - FIXED COST (INCLUDES RENT & TELEPHONE): $1,653,499
  - MOA WITH DCHR FOR HR SUPPORT SERVICES: $100,250
  - MOA WITH DCHR FOR CAPITAL CITY FELLOWS: $83,522
  - MOA WITH DISB FOR ASSESSMENT SERVICES: $50,000
  - MOA WITH CONTRACT APPEALS BOARD: $5,000
  - MOA WITH DSLBD: $700
  - LEGAL EXPENSES (CONSULTANTS, WESTLAW, ETC): $44,650
  - EMPLOYEE TRAINING (INCLUDING SOCIAL JUSTICE INITIATIVE TRAINING): $150,000
  - MEMBERSHIPS & SUBSCRIPTIONS: $30,000
  - CONSULTING SERVICES: $20,000
  - ADMIN (COMPUTER REFRESH, EQUIPMENT, TRAVEL, OFFICE SUPPLIES): $130,130

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AGENCY FINANCIAL OPERATIONS (AFO)

PROPOSED FY24 BUDGET: $829,048
(FY23 BUDGET: $806,495)

- PERSONNEL SERVICES FOR 3 FTEs: $663,515
- NON-PERSONNEL SERVICES: $165,533
  - AUDITING SERVICES (INCLUDING ANNUAL COMPREHENSIVE FINANCIAL REPORT AND SMART AUDIT): $150,000
  - EMPLOYEE TRAINING AND TRAVEL: $7,000
  - ADMIN (COMPUTER REFRESH, SUPPLIES): $8,533

DC HEALTH LINK
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HBX Awards and Recognition

- ✓ **Won 2019 Sustainability and Equity Award:** Amazon Web Services (AWS) City on a Cloud international competition
- ✓ **Featured in the Fall 2019 AWS City on a Cloud International Announcement For Applications:** https://aws.amazon.com/stateandlocal/cityonacloud/
- ✓ **Won 2018 & 2016 Best Practices in Innovation:** Amazon Web Services (AWS) City on a Cloud international competition
- ✓ **Ranked #1 for consumer decision support tools (ranking of State-Based Marketplaces and Federal Exchange 2018 and 2017)**
- ✓ **Five PR News Awards in 2019 and 2018**
- ✓ **2017 AWS IT case study on cloud solutions:** https://aws.amazon.com/solutions/case-studies/DC-HBX/
- ✓ **First in the nation SBM partnership:** Selected by the Massachusetts Health Connector to provide IT solution and on-going operations support for the MA SHOP (Feb 2017)

DC HEALTH LINK
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greaterwashington
hispanic chamber of commerce

RAMW
RESTAURANT ASSOCIATION METROPOLITAN WASHINGTON

DC Chamber of Commerce
DELIVERING THE CAPITAL

PROTECTING THE CONSUMER'S FUTURE
NAHU
National Association of Health Underwriters
AMERICA'S BENEFITS SPECIALISTS

ATTACHMENT
D

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
PUBLIC HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH
ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Health Benefit Exchange Authority

And

Not-for-Profit Hospital Corporation (UMC)

ON

Thursday, March 30, 2023, 9:00 a.m.
Virtual Meeting via Zoom Video Conference Broadcast
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

Health Benefit Exchange Authority

1. Kimberly Perry, Executive Director, DC Action
2. Rebecca Barson, Public Witness
3. Nicole Quiroga, President and CEO, Greater Washington Hispanic Chamber of Commerce
4. Che Ruddell-Tabisola, Director, Government Affairs and Member Advocacy Restaurant Association Metropolitan Washington
5. Lisa Nipp, Public Witness

6. Angela Franco, President & CEO, DC Chamber of Commerce
7. Jaye Yarbrough, Data and Training Manager, Whitman Walker Health
8. Floyd May, Interim Executive Director, Leadership Council for Healthy Communities
9. Gabriela Morgan, Chief People Officer (CPO), CommuniKids Preschool
10. Marlene Cherry, Director, Montessori School of Chevy Chase
11. Yasmina Castellanos, Manager, Community of Hope
12. Alexandra Jellerette, President, Zane Networks, LLC
13. Danjale Williams, Teacher/Office Admin, Children Of The Future CDC

Government Witness

1. Mila Kofman, Executive Director, DC Health Benefit Exchange Authority

Not-for-Profit Hospital Corporation (UMC)

Government Witnesses

1. Dr. Jacqueline Payne-Borden, Chief Nursing Officer, United Medical Center
2. Lilian Chukwuma, Chief Financial Officer, United Medical Center

Testimony before the Committee on Health

Budget Hearing on Not-for-Profit Hospital Corporation

United Medical Center

Janet A. Phoenix, MD, MPH, MS

Assistant Research Professor

George Washington University Milken Institute of Public Health

Submitted Electronically

April 4, 2023

Greetings, Chairperson Henderson and members of the Committee of Health. I am submitting this testimony regarding recommendations for programming directed towards the social determinants of health in a not-for-profit hospital. When hospitals implement effective interventions focused on social determinants of health they can improve the health of the populations they serve and reap financial benefits in expensive forms of health care utilization averted such as overuse of the emergency room.

My name is Dr. Janet Phoenix. I am an Assistant Research Professor at the Milken Institute School of Public Health at George Washington University and a physician by training. I also chair the DC Asthma Coalition.

In 2018 Dr. LaQuandra Nesbitt, Director of DC Health, released a new report from the Office of Health Equity entitled "Social and Structural Determinants of Health in DC". One aim of the report was to combine measures to address social determinants of health with improved access to healthcare and insurance to facilitate better overall health for District residents (5). As the preamble states, "Evidence shows that just 20% of a community's health impacts are driven by clinical care, with social and economic factors, genetics and behavior accounting or the remaining 80%."

The District of Columbia has an exemplary record in terms of access to insurance, and managed care insurance companies in the District have implemented many

innovative programs targeted at social factors known to have an impact on utilization such as asthma home visiting. Yet the hospital, United Medical Center has not supported this kind of programming sufficiently, in my view. Nor have adequate plans been put in place to ensure that what efforts have been undertaken will transition to the new facility when it is built.

Housing is one social determinant clearly affecting DC residents who are served by United Medical Center. In DC, Wards 7 and 8 have the highest cost burden of housing at 49% and 52.8%, respectively, expressed as the ratio of rent to household income. Anything higher than 30% is considered a cost burden for that household (DOH Health Equity Report 2018). Cost burdened households have little income left to purchase food, let alone pay medical expenses.

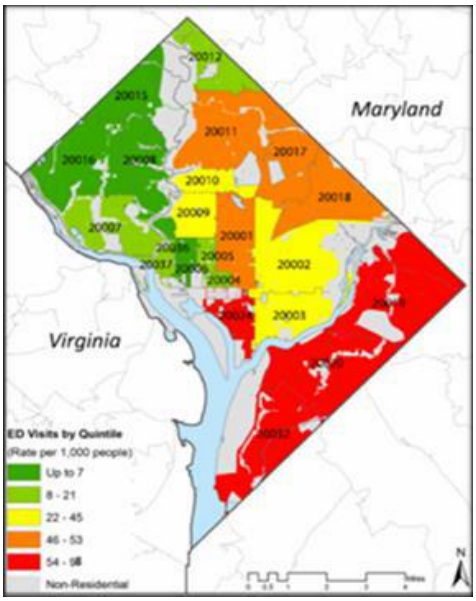
Other determinants that could be the focus of interventions are:

- Chronic Diseases: Diabetes, Prostrate Cancer, Kidney Disease, Hypertension, Mental Illness
- Childhood Trauma
- Traffic and other Accidents
- Premature Births
- Hunger

Childhood asthma rates are very high in Wards 7 and 8. Asthma is exacerbated by housing conditions and also by exposure to airborne pollutants like those that come out of the tailpipes of automobiles, trucks and motorcycles along the I-295 traffic corridor.

Wards 5, 7 and 8 have some of the highest rates of asthma emergency room visits and hospitalizations. Children living in SE Washington are 23 times more likely to be hospitalized or in the ER for their asthma than children living in Ward 3. Many children live in housing that is poorly maintained exposing them to mold and pest infestations.

I have included below a map of rates of hospital and emergency room visits for children in DC. Neighborhoods with higher rates are highlighted in red and neighborhoods with lower rates in green.



Source: Asthma Surveillance in DC Emergency Departments and Hospitals. Children's National. December 14, 2017.

One of the services addressing social determinants that has been housed at United Medical Center is a nonprofit organization that focuses on providing services to children with asthma. There have been other nonprofits assisting diabetics to manage their diabetes after discharge, organizations providing assistance to people living with HIV etc. These organizations have relied on grant funding and other soft funding sources, limiting their capacity and the continuity of the services they provide.

Other determinants that could be the focus of interventions are:

- Violence
- Homelessness
- Traffic and other Accidents
- Lack of effective and consistent prenatal care
- Food Insecurity

All of these social and structural factors are linked to poor health outcomes and a higher likelihood of developing or exacerbating acute and chronic diseases (e.g., diabetes, mental illness, premature births, kidney disease). These adverse health outcomes are costly to our health system and drain the resources of not for profits

hospitals as they are forced to expend limited resources addressing illnesses which could have been averted or addressed at an earlier, more treatable stage.

I encourage the Committee to consider how to implement and financially support a robust set of programs and services targeted at social determinants. The best way to accomplish this is to maintain and strengthen the network of organizations housed at the not-for-profit hospital and expand their number to address a broader set of conditions so that this high risk and high utilizing population can be better served.

In its recently released report "Reducing Health Inequity", the Urban Institute recommended a systematic assessment of social determinants as a way of improving patient care plans. Baseline health conditions as well as indicators of poverty and other social determinants should be measured prior to the implementation of the new facility using existing data maintained by District government agencies, including BRFSS and hospital discharge data.

Prior to the transition to the new facility, DC should engage in a baseline health assessment of this nature using existing data sources already collected by the Department of Health and its partner agencies. This could be supplemented with qualitative data from patients served at United Medical Center to assess their need for programming targeted at social determinants, the nature of services that they could benefit from and the form these services would need to take to be acceptable to them.

Additional information on promising practices implemented in other areas could provide a roadmap for what services are needed to address social determinants effectively in the new facility. Promoting better health outcomes through implementation of such practices as co-locating health services in housing facilities where low-income people is an examples of a promising practice that could benefit the population served by UMC.

I encourage the Committee to consider how to implement and financial support a robust set of programs and services targeted at social determinants. The best way to accomplish this is to maintain and strengthen the network of organizations housed at the not-for-profit hospital and expand the number to address a broader set of conditions so that this high risk and high utilizing population can be better served.

As United Medical Center transitions to the new facility it is important to ensure that there is continuity and support for this network of organizations and volunteers

who assist some of the most vulnerable populations. Addressing social needs such as safe and healthy housing, violence prevention, maternal and child health, food insecurity, employment assistance, access to and transportation to health screening, and a host of other services collocated at the hospital providing inpatient and outpatient health services can reduce the need for inpatient care. It is critical that this network of services be expanded and adequately and consistently supported.

Thank you for the opportunity to testify.

Fiscal Year 2024 Budget Oversight Hearing on the Not-for-Profit Hospital Corporation (UMC)

Before the
Committee on Health
Council of the District of Columbia

The Honorable Christina Henderson, Chairman

March 30, 2023, 11:00 a.m.

Testimony of
Angell Jacobs
Chair, Fiscal Management Board
Not-for-Profit Hospital Corporation and
Deputy Chief Financial Officer and Chief of Staff
Office of the Chief Financial Officer

Glen Lee
Chief Financial Officer
Government of the District of Columbia

Good morning, Chairman Henderson and members of the Committee on Health. I am Angell Jacobs, Chair of the Fiscal Management Board (Board) for the Not-for-Profit Hospital Corporation, commonly known as United Medical Center or UMC. I am pleased to submit my written testimony for the record.

The FY 2024 budget supports the hospital in fulfilling its mission of providing quality medical care to our residents, while acting as responsible stewards of our revenues and resources. When I appeared before you during the performance oversight hearing, I described a few challenges that UMC has faced during FY 2023, such as the lower-than-budgeted activity and staffing challenges. Since that time, additional nursing staff has been on-boarded, and efficiency in hospital operations continues to be realized through monitoring and careful management of expenses. As a result, we expect to end FY 2023 with a balanced budget, despite a recent reduction in our Disproportionate Share (DSH) payment.

The successful completion of the savings initiatives this fiscal year should also help to stabilize the hospital in FY 2023 and allow us to end the budgetary year in balance with the proposed $15 million operating subsidy.

Thank you for the opportunity to provide testimony at today's hearing. CEO Dr. Jacqueline Payne-Borden and CFO Lilian Chukwuma will provide testimony

on the FY 2024 budget, and will be available to answer questions that you or the Committee may have.

ATTACHMENT
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COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
PUBLIC HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH
ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Department of Behavioral Health (Public Witnesses Only)

ON

Thursday, March 30, 2023, 2:00 P.m.
Virtual Meeting via Zoom Video Conference Broadcast
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

1. Jamila White, Public Witness
2. Cole Wogoman, Government Relations Manager, National Council on Problem Gambling
3. Reginald Black, Public Witness
4. Shane Sullivan, Harm Reduction Coordinator, HIPS
5. Mark LeVota, Executive Director, District of Columbia Behavioral Health Association
6. Betty Gentle, Senior Advocacy Specialist, SOME, Inc.
7. Elizabeth Mohler, Social Services Director, Latin American Youth Center

8. Taylor Pinckney, Program Manager Behavioral Health for Homeless Youth, Latin American Youth Center

9. Christopher Charles, Latin American Youth Center

10. Rachel White, Senior Youth Policy Analyst, DC Action

11. Amber Rieke, Project Lead, A Path Forward, Children's Law Center

12. Justin Palmer, Vice President of Public Policy & External Affairs, DC Hospital Association

13. June Crenshaw, Executive Director, Wanda Alston Foundation

14. Rebecca Durbahn, Clinical Director, Wanda Alston Foundation

15. Danny Rodas Garcia, Deputy Director, Wanda Alston Foundation

16. Ann Chauvin, CEO, Woodley House, Inc

17. Karla Austin, Owner, Powerwithn

18. Beverly Franks, Vice President, Powerwithn

19. Eric Scharf, Depression and Bipolar Support Alliance

20. Jaclyn Verner, Staff Attorney, Disability Rights DC at University Legal Services

21. Elizabeth Davis, Government Affairs Manager, Children's National Hospital

22. Minetre Martin, Organizing Manager, Education Reform Now DC

23. Destiny Sharpe, Advocacy & Education Specialist, Fair Budget Coalition

24. Patricia Quinn, Vice President of Policy and Partnerships, DC Primary Care Association

25. Mark Miller, DC Long-Term Care Ombudsman, Office of DC Long-Term Care Ombudsman

26. Rabiatu Barrie, Public Witness

27. Kerry Savage, Director of Policy and Advocacy, PAVE

28. Gaby Fraser, Parent Leader, PAVE

29. Arthemise Cotton, Parent Leader, PAVE

30. Tamika Spellman, Policy and Community Engagement Manager, HIPS

31. Reagan Dunham, Health Equity Manager, Washington AIDS Partnership and DecrimPovertyDC

32. LJ Sislen, Campaign Organizer, DecrimPovertyDC

33. Queen Adesuyi, Campaign Organizer, DecrimPovertyDC

34. Karla Reid-Witt, Ward 7 Citywide Board Member

35. Amy Muhlbach, Program Director, Capital Clubhouse Inc.

36. Hilary Kacser, Public Witness

37. Noemie Durand, Youth Advocate, Young Women's Project

38. Nadia Gold-Moritz, Executive Director, Young Women's Project

39. Seojin Kim, Youth Justice Advocate, Young Women's Project

40. Ayoka Miller-Aganyemi, Youth Advocate, Young Women's Project

41. London Haynie, Youth Advocate, Young Women's Project

42. Mya Martin, Youth Advocate, Young Women's Project

43. Sophia Posner Brown, Youth Advocate, Young Women's Project

44. Stephanie Tran, Youth Advocate, Young Women's Project

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
PUBLIC HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH
ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Department of Behavioral Health (Government Witness Only)

ON

Thursday, April 6, 2023, 12:00 P.M.
Virtual Meeting via Zoom Video Conference Broadcast
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public witnesses testified on the Department of Behavioral Health at a public oversight hearing on March 30, 2023.

Government Witness

1. Barbara J. Bazron, PhD, Director of the Department of Behavioral Health

Service Gap & Unmet Need of District Residents Living with the Diagnosis
"Hoarding Disorder"

Testimony to the
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH,
COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON,
BUDGET OVERSIGHT HEARING
taking place on THURSDAY, MARCH 30, 2023
regarding
Department of Behavioral Health

Respectfully submitted April 13, 2023, from
Hilary Kacser, Public Witness
(she/her/hers; last name: "KACK-sir" \\ SAG-AFTRA Actor, Educator, Advocate
DisordeRThePlay.blogspot.com "DisordЯ, The Play," *about Pakrat Patty, the self-identified Hoarder who comes out of the Clutter closet, uses humor to educate about Mental Health, Stop Stigma, & Advocate Recovery. Opening keynote: http://mentalhealthsf.org/joinus-18th-conference-on-hoarding-cluttering/ *
DBH Behavioral Health Planning Council Member
BHPC Planning & Accountability Committee Member \\ DBH Stakeholders Association)

Committee on Health Chair At-Large Councilmember Christina Henderson and Committee Councilmember Zachary Parker, Committee Councilmembers, Committee Legislative Staff and Councilmember Christina Henderson Staff,

Thank you very much for your attention to us public witnesses and for this opportunity to testify before you at the Thursday, March 30, 2023, Committee on Health Budget Oversight Hearing on the Department of Behavioral Health.

Unmet Need
In the District of Columbia, an estimated over 40,000 District residents struggle with the diagnosis defined in 2013 by the American Psychiatric Association as "hoarding disorder."

Trauma Informed Language
This testimony will refer to the diagnosis alternatively, such as HD, as collecting behavior, hoarding and clutter, or HC, in the effort to stop shame and stigma often directed or implicit toward this health condition. Shame and stigma are barriers to getting help for this serious behavioral health condition and public health challenge.

Extent & Community Impact
Everyone who works in the field – outside in the community going into peoples homes – knows how widespread hoarding and cluttering are – everyone from the property manager, to the home health aide, to the cable guy, to the first responder.

DC FEMS know only too well how collecting behavior can lead to residential fires with vastly swifter burn speed, with the heavy fuel load resulting from large amounts of possessions in the home.

First Queries

Your consideration of DBH FY24 budget must include funding answers to the following minimal, preliminary questions.

1. Does DBH have anyone working on HD?

2. Does DBH have any mandate to address HD?

3. Does DBH ask about clutter in home living spaces as part of intake screening?

4. If not, what would it take for DBH to add such a question to intake screening?

5. Do DBH CSA's ask about clutter in home living spaces as part of intake screening?

6. If not, what would it take for DBH to have CSA's add such a question to behavioral health care intake screening?

Surely adding a question about clutter in home living spaces to intake screening costs precious little. Wouldn't uncovering a vast, masked area of behavioral health unmet need be cost effective?

Current DC Intervention – Not Provided by DBH

Department of Aging and Community Living is apparently devoting some resources to helping residents clean out their homes, in collaboration with Adult Protective Services. While this is perhaps better than nothing, especially in extreme cases of public safety hazard to self and others, people should not get to that extreme point in the first place. DBH should not let people get to that point. APS is extreme, crisis, triage intervention, with sometimes devastating resulting. In some DACL/APS cases, individuals – who should instead be receiving (and should ***have*** been receiving) out patient behavioral health care from DBH – these individuals end up in long term nursing care – because their behavioral health needs have for so long gone unmet.

With great gratitude to DBH, at the start of FY23, DBH worked with colleagues at Department of Aging and Community Living to bring attention to HD through a DACL presentation at the October 27, 2022, DBH MHRS/SUD Clinical Director's meeting, about DACL interventions in cases of extreme HD, featuring Elaine Murry, Program Manager, DACL Office of Community Services. DACL is to be commended for undertaking to provide support; however, a great deal more needs to be done. DACL's work is not Trauma Informed, and DACL are not providers of behavioral health care. DACL intervention commonly bringing in Adult Protective Services re-traumazes individuals and addresses only the symptoms but not the person nor their behavioral health condition.

Fund HD Now for Early Intervention & Cost Saving

DBH needs DC Council budgetary support so as to begin just to conceive of providing recovery-oriented, person-centered behavioral health care. Radical intervention for extreme triage cases does not provide access to recovery. DBH needs to address this problem long before it gets to crisis.

DBH needs to provide pathways to care, in the absence of which, we find deterrents to receiving needed and medically indicated support. Therefore, funding must be found and allocated to DBH to begin addressing providing care in this critical hoarding and collecting service gap and potentially life threatening behavioral health condition.

As to price tag and budget oversight, long term nursing care and putting out of their home an individual living in the District cannot be cost effective. Extreme intervention should be prevented before its need arises.

- We should have early intervention.

- Intervention should be trauma informed and should include behavioral health care.

Where is the early intervention?

Where is DBH in this scenario?

Equity

The HD diagnosis is very challenging, but that challenge does not justify ignoring this serious, DSM-5 behavioral health condition. HD cuts across race, socio-economic, age, ethnic, gender orientation. You daily can see the unhoused individual who is barely able to push multiple, overflowing shopping carts, and you appreciate that having too many possessions is a health condition not limited to those people with access to considerable means.

Early intervention is critical.

For the housed person, living with HD, to be put out of their home, and for them to be rehoused – not by their own choosing -- into nursing home care, is a grievous behavioral health inequity. The District residents, who experience this outrageous loss of autonomy under APS' radical intervention to address crisis collecting behavior, are only those District residents living with HD who do not have their own private means.

DBH Services in Schools

Our community needs ways to build rapport in order to build access to essential behavioral helath services in schools. Recent research indicates that symptoms of HD ("hoarding disorder") present as early as the teen years. Our youth are not only living with this untreated behavioral health issue themselves, but also are living with other individuals experiencing collecting behavior.

Something must be done.

Start This Conversation – A Possible Path

You today, to address this severe service gap and unmet need in our city, could fund one possible pathway forward, by expending a relatively small amount of money.

Evidence shows that "Peer Response Team" treatment for hoarding disorder provides a high level of effectiveness. Julian Plumadore co-authored the evidence based research published by Cambridge

University Press. Also an expert behavioral health trainer, Julian Plumadore could come to DC for a week to train stakeholders – including our well developed cohort of DBH Consumer and Family Affairs Certified Peer Specialists. (Resume and other details are here attached.)

Julian Plumadore supervised the peer arm of the 3-year "Help for Hoarding" study in collaboration with the University of California San Francisco, which demonstrated that peer-led support groups for hoarding and cluttering are therapeutically equivalent to clinician-led groups. Plumadore co-authored a peer workforce development toolkit including best practices for recruiting, hiring, and retaining peer-identified employees and integrating them into an existing team, and oversaw volunteer recruitment, onboarding, supervision, and retention.

Plumadore can provide training and ongoing consultation for the peer professional development component of an HC program in DC. Training, targeted towards peers who could actually be doing field work, benefits anyone involved, especially Program Managers/Clinical Coordinators, who should plan to attend, both to know what information a peer is receiving, and also to fill in any gaps in their own knowledge base about hoarding and cluttering services and supports.

FY24 DBH Budget Cost: Under $30,000

Your investment of the fee of $17,500 + travel and lodging at 2023 IRS rates for a 5-day DC DBH training is provides extreme value to District residents in the form of evidence based, effective results that help people recover from HD. Full week of training includes technical support on establishing the DC Peer Response Team. Community Engagement and Development Director of Peers Envisioning & Engaging in Recovery Services (PEERS https://peersnet.org), Julian Plumadore promotes innovative peer-based wellness strategies and creates culturally rich, community based mental health programs that honor diverse experiences to eliminate stigma and discrimination.

Plumadore is even happy to follow up with DC DBH via virtual consultation for up to one hour, free of charge, to answer any questions and explore next steps.

Talk about value return on investment.

Conclusion

This DC behavioral health problem is not going away just because it is closeted. Many District residents silently struggle in secret with collecting behavior, a behavioral health condition potentially life threatening. Long before that crisis point, HD affects quality of life and mental health for many, many residents in the District of Columbia.

HD is a behavioral health challenge particularly drenched in shame and stigma. Same and stigma we know deter getting needed help and care.

Silencing the problem does not make it go away.

Thank you again to the Committee and Chair At-Large Councilmember Christina Henderson for this opportunity.

Some Data Points:

"Randomised Clinical Trial of Community-Based Peer-Led and Psychologist-Led Group Treatment for Hoarding Disorder" 2018 scientifically reviewed, academic journal study, co-authored by Julian Plumadore published by Cambridge University Press, on evidence based, effective protocol.
Abstract: https://www.cambridge.org/core/journals/bjpsych-open/article/randomised-clinical-trial-of-communitybased-peerled-and-psychologistled-group-treatment-for-hoarding-disorder/5804DDCE80DB0294AC378B6280CFB413
Full article: https://www.cambridge.org/core/services/aop-cambridge-core/content/view/5804DDCE80DB0294AC378B6280CFB413/S2056472418000303a.pdf/randomised_clinical_trial_of_communitybased_peerled_and_psychologistled_group_treatment_for_hoarding_disorder.pdf
Article concludes: "**Peer-led groups were as effective as psychologist-led groups**, providing a novel treatment avenue for individuals without access to mental health professionals."
Co-author Plumadore is available to train DC stakeholders, as outlined above, as well as in **attached support materials about Mr. Plumadore**.)

"Hoarding is a Serious Disorder — And it's Only Getting Worse" – ***The Washington Post***, states six percent of people struggle with HD – that equals over 40,000 District residents – plus countless additional friends, family, neighbors, and service providers affected by relationships with people living with Collecting Behaviors. http://www.washingtonpost.com/national/health-science/hoarding-is-serious-disorder--and-its-only-getting-worse-in-the-us

"**1 dead in Hillcrest Heights house fire" –** tragic civilian death in Hillcrest house fire involved **"excessive storage conditions"** according to Alan C. Doubleday, Assistant Fire Chief, Prince George's County. (Helpful language demonstrates the Fire Chief's person centered sensitivity to challenges experienced by people living with this diagnosis.) http://wtop.com/prince-georges-county/2017/09/1-dead-fire-hillcrest-heights

DBH MHRS/SUD Clinical Directors' Meeting October 27, 2022, DACL presentation on HD
Elaine Murry, MSW, LICSW, LCSW-C, Program Manager, Office of Community Services, Department of Aging and Community Living, 202-730-1741, www.dacl.dc.gov Ms. Murry shared that in some cases DACL's only recourse, for somebody who cannot change their behavior to prevent public safety risk, is for that individual to be placed – not by that person's own individual free choice –- in nursing home care. The risk of exposing oneself to a charge of self neglect and the consequent loss of autonomy and self determination, to this witness' anecdotal knowledge, has deterred multiple District residents from seeking support.

"HOARDING: A Dangerous Secret" – Metropolitan Washington Council of Governments In 2006 – almost two decades ago – described HC issues region wide in a 75 page report http://www1.mwcog.org/uploads/committee-documents/tVhbWVY20061106110151.pdf

Diagnostic and Statistical Manual of Mental Disorders – 5th Edition (**DSM-5,** American Psychiatric Association, 2013) defines Hoarding Disorder (HD) and Clinical Assessment for Hoarding Disorder. https://hoarding.iocdf.org/professionals/diagnosing-hoarding-disorder/
https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t29/

American Psychiatric Association Expert Q&A: Hoarding Disorder
https://www.psychiatry.org/patients-families/hoarding-disorder/expert-q-and-a
https://www.psychiatry.org/patients-families/hoarding-disorder/what-is-hoarding-disorder

"When talking a person who hoards, focus on safety rather than the clutter. Be empathetic. Match the person's language. If they call it hoarding, then you can call it hoarding." – National Fire Protection Association (NFPA) https://www.nfpa.org/-/media/Files/Public-Education/Resources/Safety-tip-sheets/HoardingTipSheet.ashx
"Many fire departments are experiencing serious fires, injuries, and deaths as the result of compulsive hoarding behavior." – **NFPA** https://www.nfpa.org/Public-Education/Fire-causes-and-risks/Behavioral-risks/Hoarding

Let's not let HD in our DC community get that far.

How much longer must we wait for DBH to address this challenge, and with early intervention? Let it not be until more extreme urgency arises.

The District can be pro-active and progressive with effective, evidence based, early intervention by engaging our existing certified peer specialists to provide sensitive and trauma-informed response services, respecting individual autonomy and rights, for community members in the District suffering from HD. DBH must provide training about Hoarding Disorder and thereby begin the effort to address HD. This training not only helps District residents living with Hoarding Disorder, but, in addition, de-stigmatizing HD also opens up people's acceptance of talking about Mental Health and substance use conditions – across the spectrum, including even our terrible opioid crisis and rising rate of suicide – facilitating a thriving recovery-oriented system.

Thank you for the opportunity to share with you and for your attention to this tragic, closeted challenge.

Please advise how we can allocate funds to bring evidence based, effective training protocol to the District.

Wishing you and all our community members District wide
Peace, good health, & justice,

~~Hilary

Julian Plumadore Credentials (attached below)

Jules Plumadore

3515 Brighton Ave Apt 3, Oakland, CA 94602
jplumadore@gowithgoldfeather.com | 510-309-3470

Work History

Goldfeather Consulting
Oakland, CA

Senior Consultant — **10/20 - Present**

Summary

- I'm the founder of a consulting network providing person-centered, evidence-based training and technical assistance on topics related to mental health and wellness through the lens of social justice.

Achievements

- Develop and deliver original-content trainings and webinars on hoarding and cluttering supports and services; peer workforce development; community crisis response without police intervention; and other subjects relevant to behavioral health
- Offer technical assistance on behavioral health topics to nonprofits, universities, and government entities
- Provide ongoing consultation to the California Mental Health Services Authority (CalMHSA) for the development of a statewide Peer Support Specialist certification exam

Peers Envisioning and Engaging in Recovery Services (PEERS)
Oakland, CA

Interim Executive Director — **4/20 – 9/20**

Summary

- I served as Interim Executive Director for a community-based mental health nonprofit run by and for a diverse coalition of people with shared experience of mental health conditions.

Achievements

- Identified opportunities for growth and oversaw long-range organizational planning, change management. fundraising, and capacity building
- Established and maintained relationships with community leaders, partner organizations, and funders

PEERS
Oakland, CA

Community Engagement and Development Director — **1/20 – 4/20**

Summary

- I led strategic planning initiatives to expand unrestricted funding opportunities and broaden the organization's reach to program participants, donors, and community partner organizations.

Achievements

- Designed, supervised, and managed outreach strategy for a hoarding and cluttering program centered around the Buried in Treasures skill-building group
- Crafted marketing and communications strategies to improve community outreach and expand the organization's reach
- Established measurement-based practices to evaluate outcomes in outreach, training, and fundraising activities
- Developed a fee-for-service training program, including curriculum and training materials, and managed Scopes of Work for service delivery to community partners

Jules Plumadore

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PEERS
San Francisco, CA

Senior Programs Manager **2/19 – 12/19**

Summary

- I supervised and managed a team of 7 and oversaw programs including outreach and engagement, data collection and reporting, communications, and the Lift Every Voice & Speak (LEVS) mental health advocacy speakers bureau

Achievements

- Oversaw all aspects of community programs, including budget development and tracking; event coordination; vendor relations; data collection, reporting, and quality assurance; and outreach and engagement strategy and implementation
- Developed an original, evidence-based speakers bureau curriculum for the LEVS program, including a train-the-trainer process, a Facilitator's Guide, and a Speakers Manual
- Updated and standardized internal policies and procedures for participant accessibility and equitable staff recruitment, hiring, and retention

Mental Health Association of San Francisco (MHASF)
San Francisco, CA

Training and Community Engagement Manager **8/15 – 2/19**

Summary

- I developed, marketed, booked, and delivered original trainings to government agencies, secondary and post-secondary schools, and over 50 public and private sector organizations, and coordinated conferences and community events.

Achievements

- Supervised the peer arm of the 3-year Help for Hoarding study in collaboration with UCSF, which demonstrated that peer-led support groups for hoarding and cluttering are therapeutically equivalent to clinician-led groups
- Co-authored a toolkit on peer workforce development, including best practices for recruiting, hiring, and retaining peer-identified employees and integrating them into an existing team
- Co-led fundraising and grantwriting initiatives resulting in over $10 million
- Oversaw volunteer recruitment, onboarding, supervision, and retention
- Co-coordinated annual Tools for Change and International Hoarding and Cluttering conferences, including managing event logistics, speaker recruitment, communications, marketing, and registration.

MHASF
San Francisco, CA

SOLVE Program Manager **8/13 – 7/15**

Summary

- I supervised the Sharing Our Lives, Voices, and Experiences (SOLVE) mental health advocacy speakers bureau with over 75 speakers.

Achievements

- Collaborated with K-12 and post-secondary educators to ensure voices of lived experience are represented in their curricula, resulting in speaker placements at Berkeley and Galileo High Schools, the MFT and Summer Bridge programs at the California Institute of Integral Studies, and the Community Health program at San Francisco State University

Jules Plumadore

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Certifications

- Organizational Leadership in Diversity, Equity, and Inclusion (Rice University, 2023)
- Level I Certificate of Study in ADHD (Institute for Challenging Disorganization, 2019)
- Level I Certificate of Study in Time Management/Productivity (Institute for Challenging Disorganization, 2019)
- Foundation Certificate in Chronic Disorganization (Institute for Challenging Disorganization, 2019)

Publications

- "Randomised clinical trial of community-based peer-led and psychologist-led group treatment for hoarding disorder," *BJPsychOpen Press*, Vol. 4, Issue 4, July 2018, pp. 285 – 293
- "Contributions of self-criticism and shame to hoarding," Psychiatry Research, Vol. 262, 2018, pp. 488-493
- "How is hoarding related to trauma? A detailed examination on different aspects of hoarding and age when hoarding started," *Journal of Obsessive-Compulsive and Related Disorders*.,Vol. 16, 2018, pp. 81-87

Jules Plumadore

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Jules Plumadore is the Founder and Senior Consultant of Goldfeather Consulting, a network of peer-identified consultants offering mental health training and technical assistance that is both evidence-based and experience-tested. Goldfeather consultants have contributed to national conversations on mental health and bring lived experience as well as professional expertise on subjects including hoarding and cluttering challenges, peer workforce development, community crisis response, language change, and more.

Jules draws on his own lived experience of mental health challenges as well as his leadership in community-based mental health. Having worked in high-profile community-based roles at every professional level, from part-time Peer Responder to Executive Director, Jules' unique insights into mental health and workplace culture have helped to spark conversation and create change at organizations like the San Francisco Public Library system, Zuckerberg San Francisco General Hospital Psychiatric Emergency Services, the Institute on Aging, and the California Institute of Integral Studies.

Jules is an internationally-recognized peer expert in supports for hoarding and cluttering. An original member of the Mental Health Association of San Francisco's innovative Peer Response Team, Jules has been a featured presenter at the International Conference on Hoarding and Cluttering; shared his expertise with periodicals including the New York Times and Al Jazeera America; and contributed to groundbreaking research with UCSF on peer-led supports for hoarding and cluttering. He has trained hundreds of Bay Area supportive housing staff members on harm reduction practices for hoarding and cluttering, was part of the first team of Buried in Treasures skill-building group facilitators on the West Coast, and is a member of the Institute for Challenging Disorganization (ICD).

Jules works collaboratively with other values-aligned trainers, consultants, and community partners to make Goldfeather Consulting a catalyst for transformative change in mental health.

goldfeather CONSULTING

GOLDFEATHER CONSULTING FEE SCHEDULE – 2023

HOURLY CONSULTATION RATES

Tiers	Topics	Fee
Tier 1: Nonprofit Organizations (budget <$1 million)	• Hoarding and cluttering community-based program design • Integrating and supporting peer employees in an existing workforce • Peer certification, professional development, and career path planning • Developing transitional age youth/LGBTQ+ supports for hoarding and cluttering challenges • Crisis response implementation • Additional topics upon request	$75/hr
Tier 2: Nonprofit Organizations (budget >$1 million)	• Hoarding and cluttering community-based program design • Integrating and supporting peer employees in an existing workforce • Peer certification, professional development, and career path planning • Developing transitional age youth/LGBTQ+ supports for hoarding and cluttering challenges • Crisis response implementation • Additional topics upon request	$100/hr
Tier 3: • Private sector businesses • Universities • Government agencies	• Hoarding and cluttering community-based program design • Supporting organizational wellness and staff mental health • Crisis response implementation • Additional topics upon request	$135/hr

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goldfeather CONSULTING

TRAINING CREATION & DELIVERY FEES[1]

Tiers	Qualified Clients	Half-Day (3 hours)	Full-Day (6+ hours)
Tier 1	Nonprofit organizations (budget <$1 million)	$1000	$1750
Tier 2	Nonprofit Organizations (budget >$1 million)	$1500	$2250
Tier 3	• Private sector businesses • Universities • Government agencies	$2000	$3500

SPEAKERS' FEES[2]

Tiers	Qualified Clients	Per hour
Tier 1	Nonprofit organizations (budget <$1 million)	$100
Tier 2	Nonprofit Organizations (budget >$1 million)	$200
Tier 2	• Private sector businesses • Universities • Government agencies	$300

[1]Includes pre-training consultation meeting, training development, travel costs within the San Francisco Bay Area, and 1 training delivery. Additional deliveries of a previously delivered training will be assessed at a 40% discount. Travel outside the Bay Area will be assessed at 2023 IRS standard rates. Contractor retains the rights to the training.

[2] Speakers' fees are prorated at training rates for the appropriate tier; for example, a 30-minute speaking engagement at a community-based nonprofit organization would be $150 per speaker, and $300 per speaker for a private sector business.

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Testimony to the Committee on Health

For the Budget Oversight Hearing on the Department of Behavioral Health

Seojin Kim

Youth Advocate, Young Women's Project

March 30, 2023

Good afternoon members of the committee. My name is Seojin Kim. I'm a Ward 3 resident and a sophomore at School Without Walls Senior High. I'm testifying to you today as a Youth Justice Advocate for the Young Women's Project (YWP), a nonprofit that aims for the empowerment and increased leadership of D.C youth. In my work with the Young Women's Project, the main issue my peers and I have focused on, and the topic of my testimony today, is the lack of proper mental health support present in DCPS schools, as well as the measures that can be taken toward alleviating this issue.

At YWP, I work with a team of peers as part of YWP's Mental Health Campaign, launched in 2019 to strengthen school-based mental health programming, connect youth to services, reduce stigma, and expand access to mental health education. As Youth Advocates, we work 4-6 hours a week, receive 100+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and then work in our schools to collect data, educate and connect peers to resources, and work with adult leaders to address the youth mental health crisis. We recently completed a 2023 Youth Mental Health Survey Slides and Disaggregated Results and presented 37 Performance Oversight Testimonies in February and March. Last year we created the SOS Virtual Wellness Centers. Right now, we are in the process of meeting with principals, counselors, and health teachers in 10 schools to collaboration on student mental health solutions that include expanded mental health education including youth-led sessions, expanded counselor outreach and student engagement, and the development of Virtual Wellness Rooms for Counselors as a way to distribute information.

At my school the majority of students would not be able to name or point out any of the mental health professionals that work there. In this entire school year, we've probably received about an hour of education on mental health and wellness. The information and advice that we did get wasn't at all attainable. Telling students that more sleep and better time management will solve all of their stress, when most of us have to balance heavy school work with clubs, sports, or jobs, is simply ineffective. It's reached the point where whenever we are given some kind of presentation on improving our mental health, almost nobody pays attention. If none of what we're told can actually help then what's the point in listening? So many people at my school are constantly overwhelmed and burnt out but little has been done about it. In order to truly address the issues we're seeing, more has to be done.

As a step toward better addressing the mental health needs of D.C students, we are recommending that the Child Trends School-Based Behavioral Health Contract be restructured to include the creation of a School Based Behavioral Health Dashboard that has publicly available data updated quarterly. This would provide information on what is being done to meet the behavioral health needs of D.C children, what areas require greater attention, and how well current measures have been working. Specifically, the database would include annual goals and benchmarks by grade level and school, school based strengthening plans and reports, summaries of Child Trends data, reports on the number of students receiving interventions from DBH and CBO providers, reports on the number of students assessed and the results of the assessments themselves, links to OSSE student and parent needs data, reports on the content and availability of web-based mental health information, and reports on mental health education and activities provided by DBH and CBO staff. These metrics would be shown at a school and system wide level allowing us to create a comprehensive picture of the current state of school-based mental health here in the District.

At this time, there is no publicly available data on behavioral health from DCPS, the number and types of interventions DBH clinicians are doing in high schools, or the school based work being done by CBO contractors. As a result, we are forced to work with incomplete knowledge of what young people in D.C are truly going through. While information from the 2023 Young Women's Project Mental Health survey has given some insight on the issues faced by DCPS students, such as high levels of stress, depression, and suicidal ideation, without the data DBH can provide it is significantly more difficult to implement targeted, effective solutions. Simply put, keeping the public in the dark about mental health data is a disservice to students and their families. Teenagers in D.C deserve to have their needs acknowledged, and if nothing changes will only continue to suffer.

I hope that what I've said today has been able to provide some insight on the state of DC youth mental health, and what could be done about it. Thank you all for your time and attention.

YWP Department of Behavioral Health Budget Recommendations

DBH Budget Recommendation 1: Fund a Peer to Peer Pilot (P2P) to increase mental health education and support in schools: *We ask that Council direct $1 million to create a Peer to Peer (P2P) Pilot that would fund* 5-7 organizations, working in partnership with schools to provide *mental health-wellness education, support, and training to 7,000 HS and MS students at 15 public schools with Tier 1 (education & outreach) and Tier 2 (group support) interventions.* The P2P Pilot organizations would work with recruit and train students at 3 or more schools who would engage and lead one or more school-based interventions including: 1) Classroom and one on one mental health & wellness education; 2) Connecting peers to DBH and CBO providers through expanded outreach; 3) Working with DC Health School-Based Clinics to create student wellness centers; 4) Developing school-based

Virtual Wellness Centers and other on-line resources; 5) Organizing and co-facilitate peer support groups on anxiety, grief, stress, academic overload, and other student priorities; 6) Organizing events and trainings including after school trainings & support sessions by high schools for middle schools; 7) Collect data and promote universal screening; and other projects. We recommend this funding be allocated from (the likely) unspent funds to support DBH and CBO positions that remain unfilled.

Recommendation 2: Restructure the existing Child Trends School-Based Behavioral Health contract (already funded at $1 million annually) to include the creation of a School Based Behavioral Health Data Dashboard that tracks goals to outcomes and includes detailed data on youth needs, parent experience, school strengthening plans, the aggregated results of student assessments, and by school details on Tier 1-2-3 interventions.

Recommendation 3: Restructure the existing Community of Practice contract (already in the budget at $1 million annually) to include the creation of a School-Based Implementation Dashboard (including all providers, interventions, and policies), the development of a mental health certification program for non-DBH staff who are engaged in Tier 2 & 3 interventions in the schools; and the development of a volunteer recruitment and training strategy to fill critical service gaps

Testimony to the Committee on Health
For the Budget Oversight Hearing on the Department of Behavioral Health
Sophia Posner-Brown
Youth Advocate, Young Women's Project
March 30, 2023

Good afternoon, Chair Henderson, and members of the committee of the whole. Thank you for the opportunity to testify today. My name is Sophia Posner-Brown I am a Ward 3 DC resident. I am a sophomore at Jackson-Reed High School. I am a Brain Cancer survivor and after a 6 year battle, I am now 8 years treatment free. I plan on attending college when I graduate, I hope to go into the education field as well as do something with vocal music during college. In July 2022, I started as a Youth Advocate on the Mental Health Campaign Team at the Young Women's Project (YWP). YWP builds the leadership and power of DC youth so that they can improve systems and services. **Today, I want to bring your attention to the lack of ways to get in touch with counselors at Jackson-Reed and solutions to this issue. I will also make some budget recommendations about expanding Peer to Peer support and creating more counselor infrastructure and communication.**

At YWP, I work with a team of peers as part of YWP's Mental Health Campaign, launched in 2019 to strengthen school-based mental health programming, connect youth to services, reduce stigma, and expand access to mental health education. As Youth Advocates, we work 4-6 hours a week, receive 100+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and then work in our schools to collect data, educate and connect peers to resources, and work with adult leaders to address the youth mental health crisis. We recently completed a 2023 Youth Mental Health Survey Slides and Disaggregated Results and presented 37 Performance Oversight Testimonies in February and March. Last year we created the SOS Virtual Wellness Centers. Right now, we are in the process of meeting with principals, counselors, and health teachers in 10 schools to collaboration on student mental health solutions that include expanded mental health education including youth-led sessions, expanded counselor outreach and student engagement, and the development of Virtual Wellness Rooms for Counselors as a way to distribute information.

I testified before this Committee in February about counselor communication and how hard it is to reach them, know what they do, and get services. I shared survey results that confirmed that most students surveyed at Jackson Reed (87%) did not know the name of their DCPS-DCPCS mental health counselor, 92% did not know their DBH clinician. Schools need to increase the number of mental health staff so students can all get the support they need. I also shared data that demonstrated – students really need to know who their counselors are because 37% of Jackson-Reed students who took our survey reported that they were so sad that they stopped regular activities; 18 percent considered suicide in the past 3 months and 18% considered self harm.

Since that testimony me and my peers have been working with the counselors at Jackson-Reed to make change. This week we met with counselors there and identified 3 big solutions we can work on together. One solution was to expand the detail and volume of mental health information on the Jackson Reed website including who the counselors are, where their rooms are, what they provide, and how to get in touch with them, and what everyone's role is. Jackson reed has counselors, social workers and psychologies. Another solution was to have the YWP Virtual Wellness Centers on the website. My peers and I are working on updating these now.

Our last big solution was more training for students on mental health, this would include how to deal with feelings and healthy coping mechanisms but also toxic stress, academic overload, and trauma.. DC Public and Charter Schools do not educate students on mental health. We are not taught how to deal with our emotions and this contributes to why so many schools have an issue with fights. Teachers and administration just get angry at kids for fighting but no one tries to get anything resolved. If schools were to cover mental health there is a much higher chance fighting and disputes will lessen. Of students surveyed at Jackson Reed, 72% of students said they received no Mental Health education and 18 % said they receive 1 hour or less of instruction on the topic of mental health. The Covid-19 Pandemic worsened student conflicts. Students were expected to return to school as if everything was normal and get straight back to work-business as usual, without recognition of the two years of stress we were all under. Many people's mental health worsened over Covid and school does not understand that and gives us work on work giving us no time to breathe. School is supposed to teach us things but instead they are completely ignoring a huge factor in daily life. There are a couple solutions that can help students' mental health.

All of this work would be covered under our recommendation to fund a **Peer to Peer Pilot (P2P)** *Pilot that would fund 5-7 organizations, working in partnership with schools to provide mental health-wellness education, support, and training to 7,000 high school and middle schools students.* This pilot would support organizations like YWP to provide a broad range of youth-led supports that could address many of the issues I mentioned:

Support and Training on Academic Overload is another area that could be part of a Peer to Peer Pilot. School environment and workload greatly impacts teenagers mental health but is rarely noticed as a cause of stress by schools and students are not given the space to deal with that academic stress. School is at least 6 hours a day and we typically only get an hour break in the middle and even then kids are stressing over the schoolwork. It's not a surprise that in YWP's recent survey, Jackson-Reed students reported a high level of stress: 22% said their stress was "unbearable" and 27% said "too much;" 28% reported high but manageable stress. Students are expected to live each day going to

school with no issues but that is near impossible when kids are all alone or do not have the support they need. It could be that kids are struggling at home or that they just have too much going on but school is supposed to be a safe space where kids do not have to feel pressure all the time. Many go to their favorite teacher when they are feeling down, which can work but most of the time teachers do not have the resources or capability to help kids through a serious mental breakdown. 63% reported having a trusted adult to talk with at schools but 37% did not. So let me ask you-- where do these kids go? Who do they turn to for support? Only 53% of students said they were comfortable talking with counselors, 46% with social workers, 40% with psychiatrists, and 30% with DBH Clinicians.

In summary, I have three budget recommendations for the Committee on Health:

1. *We ask that Council direct $1 million to create a Peer to Peer (P2P) Pilot that would fund* 5-7 organizations, working in partnership with schools to provide *mental health-wellness education, support, and training to 7,000 HS and MS students at 15 public schools with Tier 1 (education & outreach) and Tier 2 (group support) interventions.* The P2P Pilot programs could include: 1) Classroom and one on one mental health & wellness education; 2) Connecting peers to DBH and CBO providers through expanded outreach; 3) Working with DC Health School-Based Clinics to create student wellness centers; 4) Developing school-based Virtual Wellness Centers and other on-line resources; 5) Organizing and co-facilitate peer support groups on anxiety, grief, stress, academic overload, and other student priorities; 6) Organizing events and trainings including after school trainings & support sessions by high schools for middle schools; 7) Collect data and promote universal screening; and other projects.
2. Require schools to conduct annual mental health check ins so that most students have an opportunity to check in on their mental health and counselors are able to identify youth who may be slipping through the tracks. The Adverse Childhood Experience (ACE) assessment is a simple, quick questionnaire that provides a lot of information about the stress and trauma students are dealing with. Seems like assessment would be the first step in understanding the problem youth are dealing with.
3. Next. schools should hire more guidance counselors especially for bigger schools where there is an overcrowding of students; one counselor per grade is not simply not enough. Counselors should be available to students, share contact information, and should be available to students most of the time, especially during lunch and after school. They should not refuse students in need. Almost 71% of students at Jackson Reed say they have never received check-ins or help from a counselor; this could change easily with hiring more educated counselors.

Thank you for taking the time to listen today, I hope these ideas prove useful.

Testimony to the Committee on Health
For the Budget Oversight Hearing on the Department of Behavioral Health
Noemie Durand
Youth Advocate, Young Women's Project
March 30, 2023

Hello, Chairwoman Henderson and members of the Committee. My name is Noemie Durand. Thank you for your time and the opportunity to testify today. I am from Ward 3, and I am a senior at BASIS DC, a charter school. I plan to go to college for a bachelor's degree, most likely a master's and possibly a Ph.D. as well, specifically in the field of psychology. I'd like to pursue both clinical and research psychology. Currently, I am a youth advocate at the Young Women's Project (YWP), working on the Mental Health Campaign Team. YWP is a DC nonprofit that builds the leadership and power of young people to solve community problems – especially in schools. I joined the team because I'm extremely passionate about students' access to mental health resources, and I wanted to learn more about the issues and make concrete changes. **I am here today to talk about my personal mental health journey and my work on mental health and wellness. I will also make some budget recommendations that are based on my work at YWP and with my school, BASIS Public Charter.**

At YWP, I work with a team of peers as part of YWP's Mental Health Campaign, launched in 2019 to strengthen school-based mental health programming, connect youth to services, reduce stigma, and expand access to mental health education. As Youth Advocates, we work 4-6 hours a week, receive 100+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and then work in our schools to collect data, educate and connect peers to resources, and work with adult leaders to address the youth mental health crisis. We recently completed a 2023 Youth Mental Health Survey (results here) and presented 37 Performance Oversight Testimonies in February and March. Last year we created the SOS Virtual Wellness Centers. Right now, we are in the process of meeting with principals, counselors, and health teachers in 10 schools to collaboration on student mental health solutions that include expanded mental health education including youth-led sessions, expanded counselor outreach and student engagement, and the development of Virtual Wellness Rooms for Counselors as a way to distribute information.

My mental wellness journey has been through many highs and lows, many of which due to COVID and school. In March 2019, when COVID caused school shutdowns, I found myself stuck at home and isolated. This, combined with lots of school work and activities outside of school, led to intense burnout. Now, during my senior year and for the last half of my junior year, I'm feeling the same symptoms of stress and burnout coming back. Having involved

parents who have money and resources to ensure I have access to therapy and other resources is the only reason I am able to seek out proper help- many of my friends can't because of financial restraints. They need privacy from their parents and can't pay for therapy without their insurance. My school doesn't provide many mental health resources and does not share much information about what they do have. It's baffling and incredibly frustrating that the current health and school systems create so many obstacles to receiving that help. It's hard enough to admit that there's a problem and you need help; sometimes it's hard to even identify that there is a problem if you don't have the knowledge and resources.

Although my school has a mental health counselor who is employed with a community-based organization through the Department of Behavioral Health (DBH), as well as a school psychologist, we rarely hear from them outside of occasional workshops for lower-schoolers. When surveying my peers for my statistics class, I found that 65% of 11th-grade students hadn't met or heard of either of them, and the average rating scale of 1-5 of helpfulness from those who had met them was 2.5, which is way too low. Apparently, they have open offices and you can drop by and talk one-on-one whenever necessary, but that's not helpful if most students don't know about that opportunity. Teachers are often the most consistent and visible mental health support for students, but that's not their main job, and they shouldn't be burdened with that when there are 2 people in the building whose actual job is to provide that support and those resources.

YWP also did school surveys this winter. The survey results we got from BASIS students was incredibly alarming. 1/3 of students said they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some of your usual activities, which is the typical definition for depression. 1/5 of the students said they had considered self-harming, and 1/10 said they had considered suicide. 54% of students don't know the name of BASIS' mental health counselor, and 96% don't know the name of the DBH clinician, which means these students don't know where to turn when there are issues like these that come up. 72% of students feel they have never received any mental health support at school.

These surveys' data and personal stories emphasize that the Department of Behavioral Health needs to be doing more to make resources readily available for youth.

YWP has three budget recommendations, detailed below. ***The first recommendation is to fund a Peer to Peer (P2P) Pilot that would fund 5-7 organizations, working in partnership with schools to provide mental health-wellness education, support, and training to 7,000 HS and MS students at 15 public schools with Tier 1 & 2***

Interventions. YWP youth staff have already proven that they can help their peers deal with mental health. Last year, we created a virtual hub of mental health resources for students last year that we shared with as many people as possible. Click here to see the Virtual Wellness Center for BASIS**.** I also created a non-profit organization **named Carna in order to support teens**. We have 3 core missions: the first is to sell self-care products- the second is to make those products affordable, and therefore more accessible to our teenage audience- and the third is to provide information packets for free on our website, which include information and resources related to mental health and wellness in a helpful and digestible format. Here is the link for our website.

Another example of a youth-led project that worked well at my school and could easily be replicated at other schools is a catch up day that we organized which included wellness sessions. 5 students, including myself, as well as a teacher and our head of school, created this together. We have 8 periods a day at BASIS, so the way we planned it was that during 1st period, each student receives their current grade reports, creates a to-do list, and organizes their day. 2nd period, we had the wellness sessions (led by either seniors or staff, including deans, teachers, and the psychologist) that covered topics anywhere from college preparedness to coping with stress. We also had options like "mindful walk" so students could get some fresh air and a session to relax using art. During periods 3-6, students could "pick their own adventure"- they decided which teachers they need to talk to and work with, and they would go to their class or to silent study hall to work on the work they needed to. 7th period, students took a feedback survey and reflected on the day. In the responses to the feedback survey, the average response for the questions "How was the day overall?", "How was the wellness session?", and "How useful do you think today was in terms of catching up on work, earning some extra credit, and/or preparing for Mock AP Exams?" were all above 4 out of 5, which I would consider very successful. Although this day seems to have worked very well for my school, it did take a decent amount of planning on the part of the administration. I would say that most academically rigorous schools would benefit from a day like this and that the effort was worth it to provide a wellness day for their students.

And since youth can't do everything themselves, they often also seek out help from school counselors and staff. Last week, I talked to our school counselor and through a very informative and collaborative discussion, we agreed that she would take several steps including: spreading a mental health survey from the research organization Child Trends; creating more opportunities for students to learn about mental wellness both in and out of school through different types of programming, some led by students; and adding mental health resources to our website and making herself more well-known to students through signs on her door. We were able to make the best of the limited resources we have and come up with several solutions, but it was all still spearheaded by students.

Although all of this action from youth is, as I'm sure you'd agree, inspiring and effective, it shouldn't be our responsibility to ensure that we get proper mental health support at school. That is the school's responsibility, and by extension, the Department of Behavioral Health's responsibility.

Our second recommendation to the council is restructuring the existing Community of Practice contract to coordinate training, resource sharing, and school based interventions and put together a Dashboard where we can find everything. Right now there is not one comprehensive updated website where you can out who is working on mental health and what they are doing. Every time YWP does a project, we have to track down all the names and numebrs our selves and put them in an excel spread sheet. When we were developing the VWC last year – none of that information was available through DBH or DcPS. This recommendation addresses one of the biggest issues I've seen in my school relating to mental health supports- lack of awareness of school resources. Many schools have resources that students just don't know about, and just advertising these resources in each school and making sure students are aware of where to seek help is a very important part of this

My last recommendation is to have more mental health professionals in schools-either full time, part time or even volunteer. I am well aware that they are expensive, hard to find, and even harder to keep. I also know about the current expansion project, but I wanted to reiterate the importance of it. Making students aware of resources, and having enough resources, goes hand in hand. Students can't access the resources if they don't know about them, but if they know about them but they're always overwhelmed by other students, that won't help either. My school's counselor told me during our meeting that she was already very busy just with the kids who officially needed her help- whether that be students in the 504 program, those with IEPs, or those identified by survey results. That doesn't leave much room for walk-ins who need occasional support, or other students who do need consistent support but not by a way that the school has recognized yet.

So, I recommend the council fund the Peer to Peer Pilot Program, restructure the existing community of practice contract, and add more mental health professionals in schools. Based on my experience as a student, a peer educator and advocate with the Young Women's Project, and someone generally involved in behavioral health support in schools, these are my recommendations for how schools and the Department of Behavioral Health should move forward through this epidemic of mental health in youth.

Thank you for your time and consideration.

YWP Department of Behavioral Health Budget Recommendations

DBH Budget Recommendation 1: Fund a Peer to Peer Pilot (P2P) to increase mental health education and support in schools: *We ask that Council direct $1 million to create a Peer to Peer (P2P) Pilot that would fund* 5-7 organizations, working in partnership with schools to provide *mental health-wellness education, support, and training to 7,000 HS and MS students at 15 public schools with Tier 1 (education & outreach) and Tier 2 (group support) interventions.* The P2P Pilot organizations would work with recruit and train students at 3 or more schools who would engage and lead one or more school-based interventions including: 1) Classroom and one on one mental health & wellness education; 2) Connecting peers to DBH and CBO providers through expanded outreach; 3) Working with DC Health School-Based Clinics to create student wellness centers; 4) Developing school-based Virtual Wellness Centers and other on-line resources; 5) Organizing and co-facilitate peer support groups on anxiety, grief, stress, academic overload, and other student priorities; 6) Organizing events and trainings including after school trainings & support sessions by high schools for middle schools; 7) Collect data and promote universal screening; and other projects. We recommend this funding be allocated from (the likely) unspent funds to support DBH and CBO positions that remain unfilled.

Recommendation 2: Restructure the existing Child Trends School-Based Behavioral Health contract (already funded at $1 million annually) to include the creation of a School Based Behavioral Health Data Dashboard that tracks goals to outcomes and includes detailed data on youth needs, parent experience, school strengthening plans, the aggregated results of student assessments, and by school details on Tier 1-2-3 interventions.

Recommendation 3: Restructure the existing Community of Practice contract (already in the budget at $1 million annually) to include the creation of a School-Based Implementation Dashboard (including all providers, interventions, and policies), the development of a mental health certification program for non-DBH staff who are engaged in Tier 2 & 3 interventions in the schools; and the development of a volunteer recruitment and training strategy to fill critical service gaps.

Thank you for taking the time to listen today, I hope these ideas prove useful.

Testimony to the Committee on Health
For the Budget Oversight Hearing on the Department of Behavioral Health
Mya Martin
Youth Advocate, Young Women's Project
March 30, 2023

Good morning Chair Henderson and members of the committee on health. My name is Mya Martin, and I am a senior who attends Bard High School DC. I reside in Ward 8 and am my class's valedictorian. I'll be attending college this fall and wish to become a college professor or technical writer. I joined the Young Women's Project in September of 2022. YWP is an organization that instills leadership skills into the youth so that they can improve the mental and sexual health programs in their schools. Since my freshman year, I've taken issue with the lack of known and accessible resources in my school. I want to make it apparent to you as well since the DC Heath and Department of Behavioral Health are managed by you. **I am here today to talk about some budget recommendations based on the lack of mental health support in my school.**

At YWP, I work with a team of peers as part of YWP's Mental Health Campaign, launched in 2019 to strengthen school-based mental health programming, connect youth to services, reduce stigma, and expand access to mental health education. As Youth Advocates, we work 4-6 hours a week, receive 100+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and then work in our schools to collect data, educate and connect peers to resources, and work with adult leaders to address the youth mental health crisis. We recently completed a 2023 Youth Mental Health Survey Slides and Disaggregated Results and presented 37 Performance Oversight Testimonies in February and March. Last year we created the SOS Virtual Wellness Centers. Right now, we are in the process of meeting with principals, counselors, and health teachers in 10 schools to collaboration on student mental health solutions that include expanded mental health education including youth-led sessions, expanded counselor outreach and student engagement, and the development of Virtual Wellness Rooms for Counselors as a way to distribute information.

Mental health and wellness is very important to me on account of my own experiences with it as well as the people around me. Not only are youth much more vulnerable to lower mental health which can be exacerbated by the perils of school. Siblings and parents can be an overbearing responsibility. High workloads can impede the progress of personal goals. And many teenagers leave school just to bear the hand of a job. Even just one of these things can ruin a teenger's mental health.

Schools do not have the proper resources built into the curriculums or even external helpers to address the declined mental health amongst children. We have counselors but due to their other obligations and a general unwillingness to speak to adults they can "trust", students don't pursue them. Teachers don't bring up mental health and often adhere to their planned class structure. The few which are willing to hear a student out are helpless to provide any advice. There have been attempts in the past to restore mental health school-wide but it hasn't gone far. I, myself have been in a scenario where I felt my ability to work as a machine was more important than my own humanity. Many other students feel the same way, and harbor the stress which gets expressed though fighting, crying, or other self destructive behaviors.

There is a school wide lack of mental health resources which students receive in a normal school day. It is now built into curriculums or in emails or assemblies. This mirrors the lack of physical health instruction as well, which is the only one spoken about at all. The cries for change on this go unnoticed, and the programs that had been instituted in the past are often after school. But due to the general mishandling of mental health, students would rather come to school and leave as soon as possible.

To improve the current state of mental health support in schools, **I'm recommending that the council allocate 1 million dollars in funding for a Peer to Peer Pilot program in DCPS schools that focuses around mental health education.** The funds would be sent to local organizations depending on the school, who can then provide specific resources that aid students who may be struggling. The Peer to Peer program would also encourage community by recruiting students from each one to lead the change they want to see. These changes include but are not limited to classroom education of mental health, connecting students to DBH and CBO resources, and organizing support groups to address in-school mental health perils.

As a mental health advocate myself, I've been able to come in close contact with issues my schools need fixing as a result of mental health. Unchecked mental health can spiral negatively into anger issues and depression. This showcases itself in the school system when kids have fights or worse, outside violence. It can also decrease motivation and a will to attend class or participate in general. If students were given the proper space to address these things or in general, nip them at the bud before they even start, we could drastically reduce these things. At my school, Bard DC, more than 60 percent of students reported that they received no instruction to improve mental health. Of the 33 percent of children who did, 19 percent of children received up to an hour. Right now there are strict policies which bar mental breaks from class and time with peers whom we can talk with. These strict only spur rebellion because they don't address the issue at hand. Funding the Peer to Peer pilot will allow for an outlet for students to

express their mental health. There should be at least one day out of the semester dedicated to the mental health of students. Class should be put on pause, and students should feel encouraged to express their mental turmoils without feeling the blowback of a teacher or other authority figure who doesn't seem to care about the mental health of teenagers.

Lastly, there should be meetings formulated for staff members so that they're aware of how to treat children. They're not therapists or counselors but there's no excuse for how some students dismiss the mental loads that students express to them. They need to know how to refer students to counselors and humanize their issues instead of minimizing them. Even if the Peer to Peer pilot isn't a stand alone solution, it's better than nothing, which is what we're doing right now. Thank you for your time and attention. I hope that my concerns are taken into consideration.

YWP Department of Behavioral Health Budget Recommendations

Recommendation 1: Fund a Peer to Peer Pilot (P2P) to increase mental health education and support in schools: *We ask that Council direct $1 million to create a Peer to Peer (P2P) Pilot that would fund* 5-7 organizations, working in partnership with schools to provide *mental health-wellness education, support, and training to 7,000 HS and MS students at 15 public schools with Tier 1 (education & outreach) and Tier 2 (group support) interventions.* The P2P Pilot organizations would work with recruit and train students at 3 or more schools who would engage and lead one or more school-based interventions including: 1) Classroom and one on one mental health & wellness education; 2) Connecting peers to DBH and CBO providers through expanded outreach; 3) Working with DC Health School-Based Clinics to create student wellness centers; 4) Developing school-based Virtual Wellness Centers and other on-line resources; 5) Organizing and co-facilitate peer support groups on anxiety, grief, stress, academic overload, and other student priorities; 6) Organizing events and trainings including after school trainings & support sessions by high schools for middle schools; 7) Collect data and promote universal screening.

Recommendation 2: Restructure the existing Child Trends School-Based Behavioral Health contract (already funded at $1 million annually) to include the creation of a School Based Behavioral Health Data Dashboard that tracks goals to outcomes and includes detailed data on youth needs, parent experience, school strengthening plans, the aggregated results of student assessments, and by school details on Tier 1-2-3 interventions.

Recommendation 3: Restructure the existing Community of Practice contract (already in the budget at $1 million annually) to include the creation of a School-Based Implementation Dashboard (including all providers, interventions, and policies), the development of a mental health certification program for non-DBH staff who are engaged in Tier 2 & 3 interventions in the schools; and the development of a volunteer recruitment and training strategy to fill critical service gaps.

Testimony to the Committee on Health
For the Budget Oversight Hearing on the Department of Behavioral Health
London Haynie
Youth Advocate, Young Women's Project
March 30, 2023

Hello all. Thank you so much for the opportunity to testify today. My name is London Haynie and I am currently a Ward 7 DC resident. I am a Year 1 (junior) at Bard High School Early College, where I am earning college credits toward my Associate's degree. I am the vice president of the Bard Student Government Association and a member of various clubs and committees. I have been a peer advocate with the Young Women's Project since September,. YWP builds the leadership and power of youth so we can solve community problems. One issue that we are dealing with is the lack of mental health support in schools**. I am here today to make budget recommendations based on the mental health work I've done with YWP.**

At YWP, I work with a team of peers as part of YWP's Mental Health Campaign, launched in 2019 to strengthen school-based mental health programming, connect youth to services, reduce stigma, and expand access to mental health education. As Youth Advocates, we work 4-6 hours a week, receive 100+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and then work in our schools to collect data, educate and connect peers to resources, and work with adult leaders to address the youth mental health crisis. We recently completed a 2023 Youth Mental Health Survey (results here) and presented 37 Performance Oversight Testimonies in February and March. Last year we created the SOS Virtual Wellness Centers. Right now, we are in the process of meeting with principals, counselors, and health teachers in 10 schools to collaboration on student mental health solutions that include expanded mental health education including youth-led sessions, expanded counselor outreach and student engagement, and the development of Virtual Wellness Rooms for Counselors as a way to distribute information.

Youth mental health and wellness directly impacts my peers and I. There have been many instances where my peers have complained that they are feeling extreme anxiety and burnout because of a heavy workload. No mental wellness support is being offered. As a mental health advocate with the Young Women's Project (YWP), I am learning about mental health and wellness and how to pass on this information to others. Although YWP is a tremendous space for mental health education and support, students should not have to search outside of the school building for this. It is imperative that we are taking proper care of ourselves and put our health first. We cannot do that when outlying issues are not addressed, especially when the issues live in school, where we spend most of our lives.

After gathering information from students at Bard DC, it is evident that mental health and wellness are not being paid enough attention to. Students are lacking education on mental health just as much as they are lacking mental health support from adults in the building. According to a survey we conducted on school-based mental health, 68% of Bard students did not receive any mental health and wellness instruction. 19% said that they received only an hour or less worth of instruction. This lack of knowledge leaves our students more vulnerable to mental illnesses and toxic stress because they are not equipped with the tools they need to deal with situations effectively. 76% of students said that they did not use any mental health resources offered by their school. Over half of Bard DC's students haven't reached out to any mental health employees for support. Only 9% said they were comfortable talking with their school counselor if they needed mental health support. These people have not made themselves fully available to the students because they haven't created a safe space for them.

I have a couple recommendations:

First, to increase the amount of time being spent on mental health and wellness education and support in schools, a mental health student-led support group should be held weekly during students' lunch blocks or after school. **Funding a Peer to Peer Pilot to increase mental health education and support in schools will allow students to have an opportunity in school to learn about mental health and how to upkeep it**, as well as to discuss any issues they are having and get the support they need from people they are comfortable with. The Peer to peer program should be funded because as a YWP intern, I have noticed many improvements in my knowledge and awareness of mental health by having a group of peers to discuss these topics with. It is important that youth are provided with a safe space and have the financial needs met to create this space within school environments. By funding the Peer to Peer Pilot, students will have the opportunity to discuss mental health and reduce school-induced stress which would lead to better performance in DC schools.

Another solution I would suggest is to expand DC school websites to include mental health information, resources, and school contacts. YWP youth staff reviewed 26 websites including 16 DC Public High Schools and 10 public charters. The results of our recent web analysis show that 76.92% of websites do not include any educational information on mental health issues, resources. Many schools have no information regarding mental health or how students can receive support when needed. 57.69% of websites do not include information on how to get mental health support inside the school. 73.08% of websites do not include information on how to get mental health support

outside the school. Further, many school websites do not even include contacts for the mental health faculty at schools. Only 35% of websites include contact information for the DCPS-PCS psychologist. This information should also be included on all DC school websites so that students have this information when it is needed and can reach out for help easily.

YWP Department of Behavioral Health Budget Recommendations

DBH Budget Recommendation 1: Fund a Peer to Peer Pilot (P2P) to increase mental health education and support in schools: *We ask that Council direct $1 million to create a Peer to Peer (P2P) Pilot that would fund* 5-7 organizations, working in partnership with schools to provide *mental health-wellness education, support, and training to 7,000 HS and MS students at 15 public schools with Tier 1 (education & outreach) and Tier 2 (group support) interventions.* The P2P Pilot organizations would work with recruit and train students at 3 or more schools who would engage and lead one or more school-based interventions including: 1) Classroom and one on one mental health & wellness education; 2) Connecting peers to DBH and CBO providers through expanded outreach; 3) Working with DC Health School-Based Clinics to create student wellness centers; 4) Developing school-based Virtual Wellness Centers and other on-line resources; 5) Organizing and co-facilitate peer support groups on anxiety, grief, stress, academic overload, and other student priorities; 6) Organizing events and trainings including after school trainings & support sessions by high schools for middle schools; 7) Collect data and promote universal screening; and other projects. We recommend this funding be allocated from (the likely) unspent funds to support DBH and CBO positions that remain unfilled.

Recommendation 2: Restructure the existing Child Trends School-Based Behavioral Health contract (already funded at $1 million annually) to include the creation of a School Based Behavioral Health Data Dashboard that tracks goals to outcomes and includes detailed data on youth needs, parent experience, school strengthening plans, the aggregated results of student assessments, and by school details on Tier 1-2-3 interventions.

Recommendation 3: Restructure the existing Community of Practice contract (already in the budget at $1 million annually) to include the creation of a School-Based Implementation Dashboard (including all providers, interventions, and policies), the development of a mental health certification program for non-DBH staff who are engaged in Tier 2 & 3 interventions in the schools; and the development of a volunteer recruitment and training strategy to fill critical service gaps.

Dear esteemed DC City Council Members,

I am writing to bring your attention to the pressing issue of mental health among children and youth in the District, and to request your support and funding for PowerWithn's comprehensive residential treatment program.

According to the National Report Card released by the Hopeful Futures Campaign, the District of Columbia ranks 3rd in the nation for children's mental health crisis. Mental health challenges such as anxiety, depression, trauma, loneliness, and suicidality are affecting the success of our children in school and life. Unfortunately, the lack of available resources and treatment options is making it difficult for children and their families to access the support they need as well as DC's Medicaid Program not being able to connect with out of state sources for our younger population to receive the treatment needed.

PowerWithn's residential treatment program is designed to provide a safe and supportive environment for children and youth aged 5-21 years who need longer-term care and support for their mental health concerns. We will offer a comprehensive program that addresses the needs of the youth when it comes to their mental health concerns and assist in expediting access to services and basic needs, further develop programs and opportunities, improve coordination of services for youth and families, leverage additional support, and provide wrap-around case management.

PowerWithn's wrap-around case management approach will ensure that youth and families receive individualized support and resources to address their unique situation and needs. We will work closely with families, school social workers, and health workers to identify and target youth in schools who can benefit from our services.

We are seeking your support and funding for PowerWithn's program to help ensure that every child has the opportunity to thrive and reach their full potential, regardless of their mental health challenges. Investing in children's mental health is crucial to their success in school and life, and to the future of our nation.

Thank you for your consideration of this important matter. We look forward to your support in helping to address the critical issue of mental health among our children and youth.

Kind Regards,

Karla Austin

Karla Austin

Reagan Dunham (she/her)
Health Equity Manager | Washington AIDS Partnership
Steering Committee Member | DecrimPovertyDC
March 30, 2023

Thank you for the opportunity to address the Committee on Health today. My name is Reagan Dunham and I am the Health Equity Manager at the Washington AIDS Partnership and a community organizer with the DecrimPovertyDC Coalition. I am here today to urge the City Council to address the overdose epidemic and promote racial equity by establishing two 24/7 harm reduction centers across the District.

The overdose epidemic has increasingly devastated communities in D.C. over the past five years and has disproportionately impacted communities of color. According to the D.C. Office of the Medical Examiner, Black Washingtonians have accounted for 84% of opioid deaths since 2017. These disparities are due in large part to racial inequities in the criminal-legal system - 92.6% of all Washingtonians convicted of drug possession in 2019 were Black. D.C. can address health inequities, support racial justice, and promote economic mobility among LGBTQ+ residents of color by establishing harm reduction centers and safe consumption sites around the city. Such sites have already proven successful in New York City, where centers operated by OnPointNYC have prevented over 600 overdoses in their first year of operation.

The DecrimPovertyDC coalition visited OnPointNYC in February. Their overdose prevention center contains a safe consumption site where people can use in the presence of trained health workers who can respond to emergencies. It also contains a clinical center with physicians and nurses, a drop-in center that provides food access, case management services, and a holistic healing center where people can receive massages and acupuncture to help with detox symptoms. OnPointNYC offers a model for what substance use treatment services should be – designed by and for those who have been most directly impacted by the War on Drugs. OnPointNYC's staff noted that their work would be greatly improved by the decriminalization of possession of drugs, as this would enable people to seek their services without fear of arrest and incarceration. This is the kind of center that DecrimPovertyDC and other local advocates are asking for.

I want to emphasize the fact that harm reduction centers are NOT the same as sobering centers. The Mayor's budget allocated $9 million to a "Stabilization and Sobering Center" that will be run in partnership with Community Bridges, Inc. (CBI) - an Arizona-based organization. When DBH and CBI staff met with local harm reduction leaders earlier this week, two things were abundantly clear:

1) CBI has little knowledge about where opioid overdoses have taken place in the District. The Stabilization and Sobering Center will be located in Ward 6 in NoMa. CBI noted that it chose this location based on data from DC Fire and Emergency Medical Services that analyzed where their calls for alcohol and naloxone-related calls were coming from. However, alcohol and naloxone-related calls are not the exact same as calls for fatal overdoses. A report issued by the D.C. Office of the Medical Examiner on March 17th noted that from 2017-2022, 46% of all fatal opioid overdoses took place in Wards 5, 7, and 8. DecrimPovertyDC hopes to use funding to launch two harm reduction centers, one on each side of the river, to ensure that D.C. residents who need these services the most can easily access them.

2) Police will be able to round up community members accused of creating “disturbances” and place them in the sobering center. I cannot stress enough that this is NOT what D.C. advocates and people who use drugs have asked for. As it stands right now, the D.C. government will be funding an out-of-state organization that is unfamiliar with the District’s landscape and services, instead of listening to D.C. residents that have been providing on-the-ground substance use services for decades. We urge the Council to intervene and ensure that D.C. funds go to programs designed and supported by D.C. residents.

It is imperative that the FY2024 budget includes funding for a harm reduction center and support for drug possession decriminalization.

Greetings Councilmember Henderson and Health Committee members. My name is Destiny Sharpe, and I have lived in Ward 4 for 16 years. I was born and raised in Washington D.C. I've testified for mental health services on behalf of children ages birth to three in previous years during the budget season. It's important to me that DC children have the health and educational services they need to thrive. I am the Advocacy & Education Specialist with the Fair Budget Coalition. I am very proud of the work we are doing to to build a budget where all residents thrive, not merely survive; where DC policymakers use a #WholePerson #WholeCommunity approach.

I believe that DC needs a budget that is racially equitable and invests in all communities.

Today, I am expressly advocating for $8.2M for the Department of Behavioral Health (DBH) to stabilize school-based behavioral health services in every DC public and public charter schools. According to the Center of Disease Control & Prevention, "adolescence is a time for young people to have a healthy start in life. The number of adolescents reporting poor mental health is increasing. Building strong bonds and connecting to youth can protect their mental health. Schools and parents can create these protective relationships with students and help them grow into healthy adulthood." I concur with their findings.

I graduated from Capital City Public Charter School. During my time at Capital City, we did not have access to school-based behavioral health services. I believe it would have been helpful to my peers and I to be able to speak with onsite clinicians about our mental health needs. According to the Early Childhood Innovation Network, More than half of children in Washington, DC suffer an adverse childhood experience (ACE). For children under the age of five, these experiences are particularly devastating and can have a severe effect on their development that persists across the lifespan.

It's true! We deal with constant gun violence in our neighborhoods, fighting, bullying, lack of recreation centers to have fun, food insecurity, depression, emergency rooms that barely see people and so many other issues. It's not the easiest city to live in but most of us make do by surviving and hope for a better future.

This 8.2M recommendation seeks to stabilize the services now available in schools, by covering the funding gap that exists between what the Department of Behavioral Health has budgeted and what is actually needed for the cost of mental health clinicians in 253 DC public and public charter schools. Closing the cost gap will ensure that 92,000 students have the possibility of services through their schools. I would truly love to see that change be made into effect.

Thank you so much for listening to my sentiments on school-based behavioral health for DC's children. I appreciate the thoughtful fiscal contributions the health committee will invest into the budget that will be reflective in our city's next generation of healthy adults.

Thank you.

Testimony to the Committee of the Whole
For the Performance Oversight Hearing for DC Public Schools
Stephanie Tran
Youth Advocate, Young Women's Project
March 30, 2023

Greetings members of the committee. First, I would like to thank you for the opportunity to testify today. My name is Stephanie Tran, I live in Ward 1, and I am a junior at the School Without Walls High School. In the fall of 2022, I became part of the Young Women's Project organization. The Young Women's Project focuses on developing the leadership and community outreach skills of DC Youth to solve critical issues. I am testifying today to discuss the lack of mental health resources in schools and to ask **specifically for an increase in mandatory mental health education and improvements to official DCPS and school websites to include online mental health resources accessible to students.**

Coming from a magnet-highschool, many of my peers are academically inclined and competitive. This attitude is reinforced by staff in order to provide students with a rigorous education. Although this can bring many benefits, concerns surrounding the wellbeing of student's health are rising. In data collected by the Young Women's Project, survey responses from School Without Walls show that students are often burdened and emotionally distressed through a multitude of causes, such as school or family life. Because there is a lack of outreach and mental health resources accessible to Wall's students, they are often isolated and repress their emotions, which in turn can cause detrimental effects. I too have experienced the stress and anxiety that comes with feeling alone and not feeling heard at school. And because of this, I would like to take the time to propose additional solutions to solve the lack of mental health resources in schools and advocate for those who cannot.

Although DC public and charter schools have already worked closely with central administration regarding mental health awareness, there are more solutions to ensure that students are fully taken care of emotionally. One solution – which could be part of YWP Recommendation #1 below a Peer to Peer (P2P) Pilot mentioned below – is increasing and promoting mandatory mental health education in schools. Through the promotion of mental health education in classrooms and staff training working with students, it allows for students to feel as though their emotions and struggles are acknowledged and to destigmatize mental health obstacles. Since many schools do not have health teachers or mental health & wellness curricula, YWP youth staff could help conduct these workshops, using the Resilience Building curricula that we were trained on.

Another solution that could be effective is to provide "link hubs" on official DCPS and school websites.These "link hubs" – which could be part of YWP Recommendation #2 below – would contain emails and resources personalized to each school that would give students a centralized place to access any mental health resources both in and outside of school. Mental health education provides youth with the tools to recognize when they are struggling or when their peers are struggling; the hubs provide the contact information they need to connect to the agency so they can address those needs. Schools do not provide this right now. YWP youth staff reviewed 26 websites including 16 DC Public High Schools and 10 public charters. Overwhelmingly, more than half of these did not include information on how to receive mental health support within the school and more than 75% did not share outside resources. Additionally, we found that 92% did not include the contact information for the school's DBH clinician or other mental health providers.. While a shortage of clinicians and providers is an important gap we urge you to address as well, with further funding and initiative towards these solutions I've outlined today, it can help ensure that students receive adequate help in schools now.

Mental health issues are often a silent fight that many students battle in DCPS schools. By giving students resources to be able to take initiative with their mental health allows for not only students to be able to overcome their obstacles, but to strengthen the morale and unity of a school community. Thank you for your time and I hope you will implement my solutions in the future.

YWP Department of Behavioral Health Budget Recommendations

Recommendation 1: Fund a Peer to Peer Pilot (P2P) to increase mental health education and support in schools: *We ask that Council direct $1 million to create a Peer to Peer (P2P) Pilot that would fund* 5-7 organizations, working in partnership with schools to provide *mental health-wellness education, support, and training to 7,000 HS and MS students at 15 public schools with Tier 1 (education & outreach) and Tier 2 (group support) interventions.* The P2P Pilot organizations would work with recruit and train students at 3 or more schools who would engage and lead one or more school-based interventions including: 1) Classroom and one on one mental health & wellness education; 2) Connecting peers to DBH and CBO providers through expanded outreach; 3) Working with DC Health School-Based Clinics to create student wellness centers; 4) Developing school-based Virtual Wellness Centers and other on-line resources; 5) Organizing and co-facilitate peer support groups on anxiety, grief, stress, academic overload, and other student priorities; 6) Organizing events and trainings including after school trainings & support sessions by high schools for middle schools; 7) Collect data and promote universal screening; and other projects. We recommend this funding be allocated from (the likely) unspent funds to support DBH and CBO positions that remain unfilled.

Recommendation 2: Restructure the existing Child Trends School-Based Behavioral Health contract (already funded at $1 million annually) to include the creation of a School Based Behavioral Health Data Dashboard that tracks goals to outcomes and includes detailed data on youth needs, parent experience, school strengthening plans, the aggregated results of student assessments, and by school details on Tier 1-2-3 interventions.

Recommendation 3: Restructure the existing Community of Practice contract (already in the budget at $1 million annually) to include the creation of a School-Based Implementation Dashboard (including all providers, interventions, and policies), the development of a mental health certification program for non-DBH staff who are engaged in Tier 2 & 3 interventions in the schools; and the development of a volunteer recruitment and training strategy to fill critical service gaps.

Testimony to the Committee on Health
For the Budget Oversight Hearing on the Department of Behavioral Health
Ayoka Miller-Aganyemi
Youth Advocate, Young Women's Project
March 30, 2023

Good Morning Chair Henderson and members on the committee of health. Thank you for the opportunity to testify today. My name is Ayoka Miller-Aganyemi and I am a Ward 8 DC resident. I am in the 10th grade attending Bard High School Early College DC. My aspiration is to become a hematologist. I plan on attending college and med school after graduating high school with my Associates degree. I am a Youth Advisory Board Member of the DC Girls Coalition. The DC Girls Coalition is an organization that brings the leadership of youth to solve impactful issues in the communities that affect youths lives and amplify the voices of young women, girls, femmes, gender non-conforming people of color in the District of Columbia. I'm also a youth advocate with the Young Women's Project (YWP) Mental Health Team since October 2022. The Young Women's Project is an organization that brings the leadership of youth to solve impactful issues in the communities that affect youth's lives. One issue that I and other young people are dealing with is the lack of mental health resources and awareness in DCPS schools. **I am here today to make some budget recommendations based on the mental health work I've done at YWP.**

At YWP, I work with a team of peers as part of YWP's Mental Health Campaign, launched in 2019 to strengthen school-based mental health programming, connect youth to services, reduce stigma, and expand access to mental health education. As Youth Advocates, we work 4-6 hours a week, receive 100+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and then work in our schools to collect data, educate and connect peers to resources, and work with adult leaders to address the youth mental health crisis. We recently completed a 2023 Youth Mental Health Survey Slides and Disaggregated Results and and presented 37 Performance Oversight Testimonies in February and March. Last year we created the SOS Virtual Wellness Centers. Right now, we are in the process of meeting with principals, counselors, and health teachers in 10 schools to collaboration on student mental health solutions that include expanded mental health education including youth-led sessions, expanded counselor outreach and student engagement, and the development of Virtual Wellness Rooms for Counselors as a way to distribute information.

Mental health is important to me because it has been affecting the lives of many youth in the District of Columbia and has been causing the main problem of various things in behavior, emotions, and physical health. Many people just like myself have been stressed because of the overload of academic work and making sure that school is our number 1 priority while our emotions are getting too overwhelming to bear.

Schools have been the main cause of mental health issues with youth in DC. Schools are one, not thoroughly educating students about mental health and helping resource the problem with the young people. A main problem is not knowing where to go when in need of mental health help, not all schools mental health teams are introducing themselves and getting to know each student. Because of them not doing so, students don't feel safe to go to them and rely on pressuring themself to "feel better" and it's overwhelming them at the same time. Students coming to school every week day and getting loads of work then have to deal with personal problems can be very hard to deal with, and when they ask for a little 10 minute break to calm down they get denied then expect them to do a whole assignment or other educational things while they are going through a whole break down. I also see no Mental Health activities in schools during the day, students should be getting taught these things while also having fun. Not everything should be straight work.

Schools don't provide the students verbally about the resources on mental health they have and bring to the school. Supposedly, the DBH Clinician is supposed to provide the students information and how to get in contact with them. With the organization the Young Women's Project (YWP) we have done a city wide survey on Mental Health. We asked the youth the question " Do you know the name of your DBH Clinician in your school?" and the results were so inadequate to me and others in my group. 90.7% of the students who took this survey put the answer no, 7.7% said yes, and 1.6% answered N/A. **We need to be educated of what mental health is and the people we can go to for help and guidance**.

The first recommendation is to fund a Peer to Peer (P2P) Pilot that would fund 5-7 organizations, working in partnership with schools to provide mental health-wellness education, support, and training to 7,000 HS and MS students at 15 public schools with Tier 1 & 2 Interventions. In YWP we train and learn about mental health and emotional wellness and ways to help resolve problems that can apply to youths' everyday life. The work we have done has allowed me to know how the mental health team at Bard is and connected with them. In order for every student to have the same access to support that we have, funding is needed. Schools should mandate at least 6 hours of mental health-wellness education in the school curriculum or one on one mental health and wellness education. Schools say that they care about mental health but aren't teaching about it. These solutions will allow students to properly learn about mental health-wellness, the cause and effects of it and to also embrace the importance of mental health care. It will also resolve problems by allowing students to know who they can go to for mental health help and guidance, without being confused or worried because they are not aware about who the people are. Adding more mental education in health classes and allowing students to work with health teachers to do more educational training on mental health in school will help acknowledge the importance of it.

In addition to adding more mental health education in health class, the whole mental health team at each school have a ceremony with the students (each grade level at a different time) to one, introduce themselves and why they are there and two, hear the issues at the school and talk about how they can come up with plans collectively to resolve the issues. At Bard we have not had a dedicated event or ceremony during the day to learn about who our mental health team are and share our advice for them. The council should fund the Peer to Peer Pilot Program to ensure that every student has access to their school's mental health support team as well as being educated on mental health. Thank you for your time and listening, I hope I will be able to see changes further on from now!

YWP Department of Behavioral Health Budget Recommendations

Recommendation 1: Fund a Peer to Peer Pilot (P2P) to increase mental health education and support in schools: *We ask that Council direct $1 million to create a Peer to Peer (P2P) Pilot that would fund* 5-7 organizations, working in partnership with schools to provide *mental health-wellness education, support, and training to 7,000 HS and MS students at 15 public schools with Tier 1 (education & outreach) and Tier 2 (group support) interventions.* The P2P Pilot organizations would work with recruit and train students at 3 or more schools who would engage and lead one or more school-based interventions including: 1) Classroom and one on one mental health & wellness education; 2) Connecting peers to DBH and CBO providers through expanded outreach; 3) Working with DC Health School-Based Clinics to create student wellness centers; 4) Developing school-based Virtual Wellness Centers and other on-line resources; 5) Organizing and co-facilitate peer support groups on anxiety, grief, stress, academic overload, and other student priorities; 6) Organizing events and trainings including after school trainings & support sessions by high schools for middle schools; 7) Collect data and promote universal screening.

Recommendation 2: Restructure the existing Child Trends School-Based Behavioral Health contract (already funded at $1 million annually) to include the creation of a School Based Behavioral Health Data Dashboard that tracks goals to outcomes and includes detailed data on youth needs, parent experience, school strengthening plans, the aggregated results of student assessments, and by school details on Tier 1-2-3 interventions.

Recommendation 3: Restructure the existing Community of Practice contract (already in the budget at $1 million annually) to include the creation of a School-Based Implementation Dashboard (including all providers, interventions, and policies), the development of a mental health certification program for non-DBH staff who are engaged in Tier 2 & 3 interventions in the schools; and the development of a volunteer recruitment and training strategy to fill critical service gaps.

Testimony of MBI Health Services, LLC

Department of Behavioral Health FY23 Budget Oversight Hearing

To the District of Columbia Council Committee on Health

By Marie Morilus-Black, CEO – MBI Health Services, LLC

202 820 3009

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March 30, 2023

Chairperson Henderson, Members of the Council

Thank you for the opportunity to testify at the Department of Behavioral Health Budget Oversight Hearing. My name is Marie Morilus-Black, I am the CEO of MBI Health Services, LLC. We are one of the largest behavioral health agencies in the District serving over 6000 adults and children and families in the District. MBI connects with every Human Service Agency in the District providing services to approximately 10,000 District residents in all its programs and employing over 1000 staff. We are committed to serving the people of the District by providing good customer service and quality care and achieving positive outcomes

MBI remained fully operational throughout the pandemic, but it was not without a cost. Many of our clinical staff opted for fully virtual positions, for which we are still recovering and grappling with the workforce shortage not uncommon to many of my colleagues. I am requesting that DBH and DC Health create a task force to re-assess positions that the District is currently requesting a license for that may not be necessary, for example, CBI. I would be happy to participate as a provider in that taskforce.

I want to thank Deputy Mayor Turnage for his leadership of all the Human Services Agencies and all of the Leaders of these Agencies, especially Director Barbara Bazron. I want to thank Dr. Bazron for her leadership of DBH through the pandemic. Her weekly Thursday meetings in partnership with Director Melissa Byrd of DHCF was extremely informational and kept the provider network informed with real time information from Mayor Bowser, Department of Health and decisions impacting the work so were able to quickly pivot to meet the need of our consumers, families and children. I know we are moving on from the Pandemic, but I wanted to take this opportunity to say thank to Melissa Byrd, Dr. Bazron, Mayor Bowser, Past Director Nesbitt for helping us survive the last three years. And now that we are moving beyond COVID, those meetings have been moved to monthly. I want to let them know that I find them useful and informational to keep us informed on shared issues and opportunities from DBH and DHCF. I know it takes time to plan those meetings and I want to say thank you for continuing to make them happen and hope you will keep them going.

I would like to command Dr. Bazron and the administration on the school-based expansion. It is imperative to provide mental health support to children and youth in their own natural settings making easy to access help. In addition, the school model allows for prevention work in the school that proactively addresses mental wellbeing and prevents onset of serious mental health issues. One of the challenges of the school-based expansion is the hybrid model of grant and billable services for all schools. The District schools are not all the same and a one size fits all models is not meeting the needs of all schools. I would recommend that the Department of Behavioral Health look at a budget formula to ensure the right amount of funding for the right school, based on the need of that school, to ensure equitable distribution of school base mental health professionals throughout the District.

I would like to thank Dr. Bazron for her leadership and partnership with DHCF on the initiation of a rate study for the services DBH supports which we desperately needed. Currently the rates have not kept up with inflation or the increased cost of doing business in the District. The last rate study was in 2016, I am grateful for the 6 plus % cost of living adjustment that DBH and DHCF provided us this past year, however, it has not kept up with inflation and the cost of living, leaving us with at 17% plus inflation gap on the rate. As you all know and experience daily, everything has gone up. The cost of a clinician in the city has gone up by 25% for salaries, and we need them to do the work and to supervise quality services. I am recommending that the rate study takes into consideration all of these factors and right size the rate of the providers to enable us to provide quality services and the new rates takes effect sooner rather than later. I am also asking and recommending that DBH and DHCF consider implementing an automatic inflation rate increase as part of the rate study methodology and implementation to ensure that the rates are not years behind in the future and keep up with inflation.

The provider network is being transitioned to the MCOs by October of 2023. We are only 6 months away and there are still many unanswered questions. I would like to spend my time today, however, asking DBH, DHCF with support from the Bowser administration ensure that providers are paid within 14 days at a maximum of submitting their claims, although, we would prefer it remains the same, weekly. We are a fee for service system, we are currently paid weekly. It would be challenging to move from weekly to monthly or 45 days to 60 days for some. I believe that it would adversely disrupt the provider's network and create fiscal constraints for us. I am asking that you consider requiring a 7 to 14-day payment turnaround of claims submitted to the MCOs once the transition takes place.

As a member of the DCBHA Board, I see the work we are doing as a network. I want to thank Dr. Bazron for listening to us and for being responsive to our feedback and for continuing to address providers concern and the many issues we bring to your attention to improve our system of care and services for the Districts residents. Although we do not always agree, she is there to work it out with us.

Thank Dr. Bazron for your commitment to this work. It is evident through your work with DHCF to make Wraparound/Care Coordination and Crisis Services Medicaid reimbursable, saving the District lots of money by leveraging federal funding for our system. Also, for increasing the rate for CBI which will go a long way to help recruit staff for this intensive work with children and their families.

Finally, thank you for working with DHCF to move ACT from fee for service to a Per Member Per Month, facilitating fidelity and best practices. Although the details need to be worked out, I want to thank you for those wins.

MBI is committed to providing excellent services to the District Residents and we stand ready to continue our partnership with you and the MCOs to deliver timely and quality care to the Districts resident.

Thank you very much for the opportunity to share MBIs testimony and I am open to any questions that you may have for me.

Testimony of Ann Chauvin, Chief Executive Officer,
Woodley House, Inc.
To the Committee on Health
Department of Behavioral Health Budget Oversight Hearing
March 30, 2023

Good afternoon, Chairman Henderson and members of the Committee. My name is Ann Chauvin, Chief Executive Officer for Woodley House, Inc. Thank you for the opportunity to submit this testimony to the Committee on Health for the **Department of Behavioral Health FY24 Budget Oversight Hearing**.

Woodley House has been providing supported housing and related services to residents of the District of Columbia with behavioral health disorders since 1958. Among our continuum of housing programs, we operate Mental Health Community Residential Facilities (MH CRF's) that provide housing and extensive services for vulnerable adults who need a high level of care to remain in the community and enjoy positive health outcomes.

Mental Health Community Residential Facilities (MHCRF's) have not received a rate increase since 2018, and that increase was based on a study completed in 2016. We ask to please have $3.3 million added to the DBH line item for MHCRF's. This amount is based on an 18% increase, which is the Bureau of Labor Statistics Consumer Price Index increase from December 2018 (when we received the last increase). Currently, we are reimbursed at $65/day, which is too low to meet our costs. An additional $3.3 million would increase the daily reimbursement rate for our CRF to about $79/day, compare that to $1,236/day for St. Elizabeth's, where many of our referrals come from.

We have been pleading year after year for an increase to our rates so that we can meet the needs of the residents entrusted to our care in a safe and dignified living environment. But no increase has been added and the rates have not changed, and our costs continue to skyrocket. As you can imagine, community residential facilities have been hit extremely hard by the pandemic, needing to continue to provide 24/7 staff coverage to some of DC's most vulnerable residents in congregate living facilities.

Workforce shortage issues are devastating, driving tremendous cost increases due to overtime and increased salaries. The costs are beyond what we can afford and put our programs in jeopardy. We are operating at a loss and are relying on bank loans and some private donations which are better used for expansion and innovations to meet our obligations. MHCRFs are key to the recovery and stability of hundreds of DC residents with mental health disorders. For this relatively small allocation in the budget, DC City Council and the Mayor can ensure that MHCRFs remain solvent, when so many of us are struggling to find the funds to pay the bills.

We ask that our government partners recognize these struggles and add the necessary funds so that DBH may implement a necessary daily rate increase so that we may continue to serve this vulnerable population.

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Testimony of Elizabeth Davis & Sarah Barclay Hoffman
Children's National Hospital and Early Childhood Innovation Network

Department of Behavioral Health Budget Oversight Hearing
Committee on Health
Council of the District of Columbia
March 30, 2023

Good afternoon, Chairperson Henderson and members of the Committee, my name is Elizabeth Davis and I am a Government Affairs Manager at Children's National Hospital. I am testifying today on behalf Children's National Hospital and Early Childhood Innovation Network in the absence of my colleague Sarah Barclay Hoffman, Program Manager with the Community Mental Health CORE and Director of Policy for the Early Childhood Innovation Network. At Children's National, our Community Mental Health CORE aims to improve access to and utilization of high-quality behavioral health services for children and families, advance racial and health equity, and promote sustainability and system-level change through research, policy, advocacy, and community engagement. We are also members of the Under 3 DC Coalition and Strengthening Families through Behavioral Health Coalition. Thank you for the opportunity to testify today regarding the proposed FY 2024 the Department of Behavioral Health (DBH) budget.

At Children's National, our top priority is the health and wellness of the community we serve. We support effective interventions that meet children and families where they are, such as their learning environments, and investments in advancing a high-quality mental health system, from promotion and prevention to treatment. As we emerge from the COVID-19 pandemic and children continue to struggle with their mental health, we have an opportunity to invest in our children's wellbeing, from infants and toddlers to teenagers. We thank Mayor Bowser, the Council and DBH for recognizing the importance of behavioral health across the system of care and recommend the following:

Healthy Futures. Healthy Futures is an evidence-based model that promotes positive social and emotional development in young children, as well as attending to child-specific needs. It helps to set the foundation for children to be successful in school, lead healthy lives, contribute to the economy as adults, and more. Healthy Futures, which is an early childhood mental health consultation program, build the capacity of adults who are in early learning environments, such as child care, to optimally support the healthy social and emotional development of children. Healthy Futures is an empirically successful prevention and early intervention program that is working in our DC neighborhoods.

- **We urge the Council to Restore to FY23 Funding Levels for Healthy Futures at $700,000** so infants, toddlers and young children, families and staff at child development centers will continue to have access to this critical, developmentally appropriate mental health service.

School-Based Behavioral Health Services. While Children's National is **not** a provider in DBH's School-Based Behavioral Health program, we strongly support the presence of behavioral health clinicians and services in every school in DC. This is a key component of our behavioral health continuum of care, and we hear regularly from our pediatricians and mental health clinicians the importance of children having access to services in the school environment, which facilitates access to care. Therefore, we encourage the Council to:

- **Ensure School-Based Behavioral Health Community-Based Organization (CBO) grant amounts are at $103,000 for FY24.** We must ensure that the FY24 budget supports a clinician in every school and at a CBO grant level that bolsters consistency and longevity of the program, which requires Council increase CBO grant levels to $103,000.

Community-Based Behavioral Health Services and Medicaid Rates. Children's National providers, and the children and families we serve, heavily rely on a community-based, high-quality and comprehensive behavioral health system. This requires adequate payment rates, that keep pace with both regularly anticipated inflation, and the high inflationary environment we are currently experiencing. We support:

- **The $24.4M to provide increased Medicaid rates for services in the behavioral health sector.** However, we are concerned that the budget indicates a significant reduction in children's SUD and treatment and crisis services. It is critical that children's behavioral health crisis services are available as we have a seen significant increase in behavioral health hospitalizations.

We commend DBH for areas where they continue to advance behavioral health care programs, and their commitment to children and families. Thank you for the opportunity to testify and I'm happy to answer any questions you may have.

BOARD OF DIRECTORS

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April 24, 2023

Chairperson Christina Henderson
Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue
Washington, D.C. 20004

The Committee on Health 2024 Department of Behavioral Health Budget Hearing

My name is June Crenshaw. My pronouns are she/her/hers. I am the Executive Director of the Wanda Alston Foundation, a member of the DC LGBTQ Budget Coalition, the Youth Economic Justice and Housing Coalition, and the VAN Policy Advisory Committee. As you have heard today from our Clinical Director, Dr. Rebecca Durbahn, our mission is to eradicate homelessness and poverty for LGBTQIA2S+ youth and young adults in the District and to keep our youth safe.

For over 15 years, the Wanda Alston Foundation has worked to improve the lives of LGBTQIA2S+ youth experiencing homelessness by providing 18 months to 6 years of shelter, case management, life skills training, and connections to medical and mental health care and educational and job support. We serve LGBTQIA2S+ youth from all eight wards in the City and are proud to operate our transitional housing program in Ward 7, our extended transitional housing, and our counseling center in Ward 1.

As you have heard, all of our young people have experienced high levels of trauma, discrimination, and loss of connections to family and friends. In addition, our youth have been rejected and have survived unspeakable violence and abuse. This trauma generates substantial obstacles to stable housing, employment, mental health, and behavioral health outcomes.

We are incredibly disappointed that the Mayor's FY24 budget does not allocate resources for a mobile behavioral health unit for youth experiencing homelessness. In fact, the Mayor's budget eliminates critical funding for DBH to conduct outreach for those experiencing homelessness, and this is a harmful action toward our queer youth. They need to stay connected to services, support, and community.

We know that youth experiencing homelessness, especially queer youth, have high levels of trauma and need access to quality and culturally competent behavioral health and mental health services. All of the youth in our program, 100% of them, need mental health services but struggle to access them. Statistics show that LGBTQIA2S+ youth are less likely to access mental health care.

Here is what is happening in our program; last year, we called the Comprehensive Psychiatric Emergency Program - CPEP at least 9 times in the last 12 months, and CPEP has come 0 times to our program. We have never had an actual CPEP team come to our programs. At least four other times, staff should have called CPEP, but they didn't because the staff knew there would be no response.

When we have called for CPEP, we sometimes have a Crisis Intervention Officer (CIO) respond or EMTs. CIO teams intimidate the youth and do not build the trust needed for mental health care and support to be initiated in a crisis.

For example, when one of our youth had a suicide attempt, we called CPEP, and a CIO team arrived and took our youth in handcuffs to the hospital. The youth was so traumatized that he refused to stay in the hospital for treatment and only stayed for the watch period. The youth had made other suicide attempts following that but would deny them when CIO or EMT came, so he was never connected to appropriate services in his crisis. Again, CPEP did not come for those attempts.

In a different incident of self-harm, a youth was taken to the hospital rather than assessed by CPEP. They resisted; they didn't want to go to the hospital, so they were injected with a medication that caused an allergic reaction, requiring multiple trips to the ER.

Further, it is difficult linking to CSA: At least four youth linked to CSAs had to wait over a month for intake appointments, and when they are linked, there is no connection to build trust, so our youth misses out on much-needed support, and services.

Please invest in 24-hour harm reduction centers to address the overdose crisis in the District. The Department of Behavioral Health is the city's leader in combating the overdose crisis, but the current strategies are not enough and the District needs to fund and support the creation of harm reduction centers, that includes comprehensive drug checking and safe consumption on-site, to prevent any more lives lost to overdose.

I have witnessed firsthand the devasting effects that drug use and addiction can have on our LGBTQIA2S+ youth, especially those experiencing homelessness.

Addiction is more prevalent among the LGBTQIA2S+ community than the general population, and studies have shown that individuals who identify as queer are at greater risk of developing an addiction to drugs, alcohol, and other substances. According to the national survey on drug use and health, LGBTQIA2S+ folks were more than twice as likely to have used drugs in the past year compared to heterosexual people, 39.5% versus 17.1%. Also, SAMHSA (Substance Abuse and Mental Health Services Administration) reports that transgender individuals are more likely to use drugs than non-transgender individuals.

Queer youth are also at an increased risk for substance use disorders. The Centers for Disease Control and Prevention reports that queer students are more likely to have used alcohol or drugs in the past 30 days than heterosexual students. Important to note that these statistics are not a reflection of the LGBTQIA2S+ community but rather a reflection of the societal and systemic factors that contribute to higher rates of addiction among our population

I understand our queer youth's need to utilize substances to cope with the overwhelming trauma and rejection they have experienced in their young lives. Safe drug consumption sites offer a crucial harm reduction strategy for those struggling. They provide a safe and supervised environment for individuals to consume drugs, reducing the risk of overdose and the transmission of infectious diseases. In addition, the sites offer access to medical professionals and support services that can help our youth on their path to recovery.

I urge you to consider the overwhelming evidence in support of safe drug consumption sites and to prioritize the health and safety of our queer youth and LGBTQIA2S+ community.

The mobile mental health unit and the safe consumption sites are necessary ancillary programming to the services of the Wanda Alston Foundation and to keep our LGBTQIA2S+ youth safe.

Very truly yours,

June Crenshaw she/her/hers
Executive Director
Wanda Alston Foundation

Testimony of MBI Health Services, LLC

Department of Behavioral Health FY23 Budget Oversight Hearing

To the District of Columbia Council Committee on Health

By Marie Morilus-Black, CEO – MBI Health Services, LLC

Mblack@mbihs.com

March 30, 2023

Chairperson Henderson, Members of the Council

Thank you for the opportunity to testify at the Department of Behavioral Health Budget Oversight Hearing. My name is Marie Morilus-Black, I am the CEO of MBI Health Services, LLC. We are one of the largest behavioral health agencies in the District serving over 6000 adults and children and families in its behavioral health programs in the District. MBI connects with every Human Service Agency in the District providing services to approximately 10,000 District residents in all its programs and employing over 1000 staff. We are committed to serving the people of the District by providing excellent customer service, high-quality care, and achieving positive outcomes

I am happy to inform you that MBI remained fully operational throughout the pandemic, but it was not without a cost. Many of our clinical staff left, opting for fully virtual positions, and we are still grappling with and recovering from the workforce shortage not uncommon for many of my colleagues. One solution to the workforce shortage is for DBH and DC Health to create a task force to re-assess positions that the District currently requires be staffed by licensed individuals, but for which a license may not be necessary, for example, CBI. I would be happy to participate as a provider in that taskforce.

I want to thank Deputy Mayor Turnage for his leadership of all the Human Services Agencies and all of the Leaders of these Agencies, especially Director Barbara Bazron. I want to thank Dr. Bazron for her leadership of DBH through the pandemic. Her weekly Thursday meetings in partnership with DHCF Director Melissa Byrd were extremely informative and kept the provider network informed with real time information from Mayor Bowser, the Department of Health, and other decisions impacting the work so were able to quickly pivot to meet the need of our consumers, families and children.

I know we are moving on from the pandemic, but I wanted to take this opportunity to say thank you to Melissa Byrd, Dr. Bazron, Mayor Bowser, and Past Director Nesbitt for helping us survive the last three years. And now that we are moving beyond COVID, those weekly meetings have been moved to monthly. I want them to know that I find the meetings useful and informational, keeping us informed on shared issues and opportunities from DBH and DHCF. I know it takes time to plan those meetings and I want to say thank you for continuing to make them happen and hope you will keep them going.

I would like to commend Dr. Bazron and the administration on the school-based expansion. It is imperative to provide mental health support to children and youth in natural settings making it easy to access help. In addition, the school model allows for on-site prevention work that proactively addresses mental health wellbeing and prevents the onset of serious mental health issues. One of the challenges of the school-based expansion is the hybrid model of grant and billable services for all schools. Many schools do not have enough referrals to support the billable services requirement for the provider. The District schools are not all the same and a one size fits all models is not meeting the needs of all schools. I would recommend that the Department of Behavioral Health look at a budget formula to ensure the right amount of funding for each school, based on the needs of each school, to ensure the equitable distribution of school-based mental health professionals throughout the District.

I would also like to thank Dr. Bazron for her leadership and partnership with DHCF for initiating a desperately-needed rate study for DBH services. Currently, the rates have not kept up with inflation or the increased cost of doing business in the District. The last rate study was completed in 2016; I am grateful for the over 6% cost of living adjustment that DBH and DHCF provided us this past year, however, it has not kept up with inflation and the cost of living, leaving us with a greater than 17% inflation rate gap. As you all know and experience daily, everything has gone up. The salaries for clinicians alone has gone up 25%, and we obviously need them to do the work and to supervise quality services. I recommend that the rate study take into consideration all of these factors and right size the provider rates to enable us to provide quality services, and that the new rates take effect sooner rather than later. I also ask and recommend that DBH and DHCF consider implementing an automatic inflation rate increase as part of the rate study methodology and implementation to ensure that the rates keep up with inflation and not fall years behind again.

As you know, the provider network is being transitioned to the MCOs by October of 2023. We are only 6 months away and there are still many unanswered questions. I would like to spend my time today, however, to ask DBH and DHCF, with active support from the Bowser administration, to ensure that providers are paid in no more than 14 days of claims submission; although, we would prefer it remains the same, weekly. We are a fee-for-service system, currently paid weekly. It would be challenging to move from weekly to monthly or even 45 to 60 days for some claims. I believe that it would negatively disrupt the provider's network and create fiscal constraints for us. I ask that you consider mandating payments be paid within 7 to 14 days for claims submitted to the MCOs.

As a member of the DCBHA Board, I see the work we are doing as a network. I want to thank Dr. Bazron for listening to us and for being responsive to our feedback, for continuing to address providers' concerns, and working on the many issues we bring to her attention to improve our system of care and services for the Districts residents. Although we do not always agree, she is there to work it out with us.

I thank Dr. Bazron for her commitment to this work. It is evident through her work with DHCF to make Wraparound/Care Coordination and Crisis Services Medicaid reimbursable, saving the District lots of money by leveraging federal funding for our system. Also, for increasing the rate for CBI which will go a long way to help recruit staff for this intensive work with children and their families.

Finally, thank you for working with DHCF to move ACT from fee for service to a Per Member Per Month, facilitating fidelity and best practices. Although the details need to be worked out, I want to thank you for those wins.

MBI is committed to providing excellent services to District Residents and we stand ready to continue our partnership with you and the MCOs to deliver timely and quality care to the Districts resident.

Thank you very much for the opportunity to share MBI's testimony and I am open to any questions that you may have for me.

PAUL B. THORPE WRITTEN TESTIMONY TO DC COMMITTEE ON HEALTH

Mr. Paul B. Thorpe
Washington, DC 20001
pttassociates@gmail.com

Good Morning Councilmember Henderson and Councilmember or the Committee on Health. My name is Paul B. Thorpe. I am a native Washingtonian. I am submitting my written testimony before your committee today, because I feel that the Committee on Health, because I believe that there are some system issues that exist for patients seeking behavior health and housing.

My daughter, Brittany Thorpe has been experiencing issues with regards to both homelessness and mental health issues. Brittany is currently undergoing treatment within a local facility. My daughter became homeless on about **January 2023**. Her current status appears to be better, although I'm not certain as to the specifics of her condition. I was informed that my daughter is under a "**blackout period**". This was explained to me as a period in which patients are restricted from communicating outside of this facility. The only current means of communication can only be achieved by writing to my daughter.

I do understand this policy to a certain degree, however based on the fact that I have been the link to my daughter in ensuring that she gets the care that she needs, I would have preferred to be more apprised of her condition. I have been and am very concerned for my daughter as she has endured some very grueling experience, based on her becoming homeless due to personal issues, in addition to substance abuse and her mental instability.

Several years ago my daughter was diagnosed with being bipolar, and during that period she was hospitalized in two (2) local hospitals in the District, in addition to a brief stay at the Psychiatric Institute of Washington. During those hospitalizations, my daughter had a horrible experience at the aforementioned hospital within their Psychiatric Ward. She also had an unpleasant experience at the Psychiatric Institute of Washington.

Based on my daughter's hospitalization at the local hospital, I was compelled to meet with the hospital Administrator based on my daughter's care. I felt very strongly that my daughter was being over medicated and receiving inadequate care. Based on the environment of this ward, I strongly felt that my daughter should not have been housed at this hospital. In fact, during a visit to see my daughter during this hospitalization, upon my arrival I was shocked to discover that my daughter in the middle of the hospital ward floor in her own urine. I can't begin to even explain how I felt upon seeing my daughter in such an egregious condition?

Councilmember Henderson, as you're aware, I have been in contact with your office over the last month or so based on my concerns for my daughter's care. Thank you so kindly for the assistance that your office has provided. While I have had recent concerns regarding her care, I am at least somewhat at ease as I think that my daughter is now receiving the necessary medical and substance treatment that she need. I'm stating this based on my recent communication with a medical representative of the facility that she's currently housed. Special thanks are certainly in order for the intervention of Ms. Dena Hasan, Director, Office of Policy and Program Support. Ms. Hasan was very instrumental in facilitating a very effective plan of action which catapulted the current care and progress that my daughter is now receiving.

In my viewpoint, I feel that there should be systems in place whereby patients that are being medically assessed and don't complete the process. I think that some type of housing should be provided until that process can be completed, so that patients don't fall through the cracks. I also think that there should be better guidelines and collaboration with local hospitals for incoming and/or new patients being assessed. Some hospitals diagnosis and simply release patients experiencing mental episodes that are clearly in need of closer medical assessment. These suggestions are based on experiences that my daughter incurred.

In summary, I think that there is an absolute need for more oversight and accountability and would urge periodic hearings through your committee. Thank you for your time and the opportunity to testify before your committee.

Mr. Paul B. Thorpe

Good afternoon, **Councilmember Henderson, and members of the committee.** My name is Beverly Roberson Jackson, and I am a member of the Board of Directors of the DC Early Learning Collaborative. a resident of Ward 7, a member of Under 3 DC, a coalition which is committed to securing a strong start for every infant and toddler in DC and Adjunct Faculty in the Georgetown University School of Medicine. My testimony today will focus on the importance of the Healthy Futures Program which serves child and infant development programs throughout the city. I speak on behalf of programs that have received these assigned staff over the past few years. We applaud the Council for passing the Birth to Three for All DC Law that formalized this critical intervention.

I have served on community based early care and development program committees and teams that have benefitted from Department of Behavioral Health, Healthy Futures staff assignments. They have provided a wealth of information to aid parents, early educators who work in the classrooms and care settings with infants and young children and provided intervention to help resolve difficult situations.

As you are aware we are emerging from a pandemic that has ravaged families through sudden death, isolation depression as well as illness. This has an impact on all members of a family including infants and young children. It has exacerbated drug use, played havoc with family finances, although inflation and child oriented shortages like formula, medicine and diapers have been factors.

An additional factor has been health-oriented distancing between families and early educators. This is a critical time for many families' mental health. The Healthy Futures staffers observe

families at pick-up and drop off. They recognize those families who have been using illicit substances or behaving in problematic ways. They have observed in the classroom when health rules allow and provide ideas for preventing behavioral problems as well as catch some previously un recognized developmental issues.

This is a critical program for our child development programs that has proven itself over the years even though it is understaffed and underfunded but Healthy Futures is needed now more than ever.

357 words

Testimony of Lisa Nipp
322 12th Street SE
Washington, DC 2003
Before the
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
Budget Oversight Hearing
DC Health Benefit Exchange Authority

March 30, 2023 – 9:00 am
Live via Video Conference Broadcast

Good morning, Chairwoman Henderson and members of the Committee on Health. My name is Lisa Nipp and I am a Ward 6 resident. I thank you for allowing me to speak before you today regarding DC Health Link and the positive impact it has had on my life as a small business owner in DC. I have health insurance coverage through DC Health Link's individual marketplace.

As this is a budget oversight hearing, I want to share how DC Health Link and the Affordable Healthcare Act have allowed my family to purchase health insurance multiple times for almost a decade as my family's employment status changed. I have worked as a self-employed corporate photographer for over 20 years, and I am now a single mother after the death of my husband last year. Without DC Health Link, I would be unable to afford coverage for me and my son.

My family has been DC Health Link customers on and off since 2015. At the time we became DC Health Link customers, my late husband worked as a baseball analyst for MASN as an independent contractor and this work did not include employer-sponsored health insurance. When we reached out to DC Health Link, we were immediately offered help finding a plan. Despite not qualifying for any subsidies because of our income, we were able to afford coverage with lower deductibles at better price points as the years went on. We were very pleased with both the quality of our medical and dental plans and the customer service provided by DC Health Link.

In 2017, MASN offered my husband the opportunity to purchase insurance through their employer plan. So, we left DC Health Link because it was cheaper to take the coverage MASN offered. My husband contracted a rare form of cancer in January 2020 and passed away one year later. Over those 12 months that he was ill, this private plan paid out almost 5 million dollars in healthcare expenses. Our total out-of-pocket was less than $1000.

During the Covid 19 Pandemic, my husband's television show was canceled and he was laid off again. My photography business shut down completely. Neither of us worked during most of 2020. MASN kindly continued to allow my husband to remain on their insurance plan, but my son and I were removed from this plan in September 2020. After all I had been through dealing with insurance billing during my husband's sickness, I was terrified of being without insurance myself in case something else happened. I reached out in tears to DC Health Link, and within 24 hours they connected me with a person who helped enroll my son and me in a Medicaid plan.

With the passage of the American Rescue Plan Act, I received a notice from DC Health Link about premium reductions. This notification came around the same time that my income recovered enough that I was no longer eligible for Medicaid, but I did not think I could afford to buy a plan on the exchange. I worked with a DC Health Link representative and found that I qualified for a Silver level plan at an affordable $111/month. It was SUCH a relief to know that I had this coverage AND that I could return to the doctors and other healthcare providers I had used for years.

After the Inflation Reduction Act extended lower premiums from the American Rescue Plan last year, we were able to stay with a Silver plan My income has recovered significantly, and with help from the federal monthly tax credit, I have a plan that saves me $6,400 annually.

As a single parent to a teenage soccer player who spends his weekends at Urgent Care, our healthcare plan is always at the forefront of my mind. I have seen firsthand that good insurance prevents financial ruin during times of life-changing illness. The Silver Plan I have through DC Health Link allows me to sleep at night without worry because I know that I have coverage that will provide for the care I need, a deductible that I can afford, and the support of the customer service representatives at DC Health Link.

Thank you for the opportunity to share my healthcare journey. I am happy to answer any questions you have.

DISABILITYRIGHTSDC

TESTIMONY FOR BUDGET HEARING REGARDING THE PROPOSED FISCAL YEAR 2024 BUDGET FOR THE DEPARTMENT OF BEHAVIORAL HEALTH (DBH)
COMMITTEE ON HEALTH

Jaclyn Verner, Staff Attorney

March 28, 2023

Disability Rights DC at University Legal Services (DRDC) appreciates the opportunity to submit written testimony regarding the Department of Behavioral Health's (DBH's) proposed budget for FY24. DRDC is the designated protection and advocacy program for people with disabilities in the District of Columbia. Pursuant to our federal mandate, DRDC advocates for hundreds of DC residents with mental illness each year. I would also like to thank the DC Bar Foundation for supporting DRDC's efforts to address housing barriers experienced by District residents living with mental illness.

My testimony is focused on the necessity of DBH increasing the monthly personal needs allowance (PNA) for individuals residing in DBH-certified Mental Health Community Residential Facilities (CRFs). Currently, individuals residing in the District's CRFs solely retain $100 each month from their Social Security benefits payment as their personal needs allowance (PNA). The remainder of the benefits payment covers the cost of care of residing in the CRF and is distributed to the CRF operator. The cost of care includes three meals per day, basic hygiene products such as soap and laundry detergent, and support staff in the home that assist with cooking and cleaning[1]. However, it does not cover other important necessities such as a clothing

[1] *See* 22-A DCMR §§ 3832, 3834.7, 3836, 3852.

allowance, an additional food budget, an additional budget for other hygiene products including toothpaste and shampoo, or a transportation allowance. As a result, CRF residents are expected to pay for many aspects of daily living with a very minimal $100 per month. One of the most common concerns that DRDC hears from CRF residents is that they do not have enough spending money each month. This current amount for the PNA was put into place in 2007 and has not been increased since that year. Moreover, the District has chosen to provide the entire cost of living allowance (COLA) increase to providers each year, rather than giving a portion of the COLA to the residents that these homes exist to serve. As the Council knows, the cost of living in the District has sky-rocketed since 2007 and thus, an increase in CRF residents' $100 monthly PNA, as well as an annual COLA allowance, is long overdue.

Both the Department of Health Care Finance (DHCF) and the Department on Disability Services (DDS) have recently acknowledged the importance of raising the PNA for District residents with disabilities in other care settings and have chosen to implement the change. At the end of January 2023, DHCF announced it is raising the PNA for people in Intermediate Care Facilities for People with Intellectual and Developmental Disabilities (ICF-IDD) and nursing facilities from $70 to $100 and will provide the people living in these facilities with a portion of the COLA moving forward.[2] Similarly, DDS' proposed FY24 budget includes a one-time enhancement of $744,600 to increase the PNA for people in DDA-supported residences. Director Reese has elaborated that with this enhancement, DDA will be increasing the monthly PNA from $100 to $150 and beginning in January 2024, residents will also receive a portion of the COLA increase moving forward.

[2] D.C. Department of Health Care Finance Transmittal No. 23-13, Personal Needs Allowance Increase, dated January 31, 2023.

As a matter of equity, DBH must increase the monthly PNA for its CRF residents and must begin to provide them with a portion of the COLA moving forward, just as DHCF and DDS have chosen to do for individuals with disabilities residing in other settings. In order to implement this change, DRDC urges DBH to include an enhancement in its FY24 budget, just as DDS has done, and urges the District to amend regulations governing the amount of the monthly PNA.[3] If DBH chooses not to do so, CRF residents will soon be one of the only categories of individuals with disabilities residing in homes and facilities licensed by District government who are not afforded the opportunity of this increase in funds that are used to purchase basic necessities and to exercise daily autonomy.

Thank you for the opportunity to submit testimony on this important issue.

For further information:

Jaclyn Verner, Staff Attorney
202-547-0198 ext. 112
jverner@uls-dc.org

[3] *See* 29 DCMR § 1450.

District of Columbia Behavioral Health Association
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Washington, DC 20033-0515
202-929-3757

Testimony of the District of Columbia Behavioral Health Association
Department of Behavioral Health FY '24 Budget Oversight

To the District of Columbia Council Committee on Health
March 30, 2023

Chairperson Henderson and Members of the Council,

Thank you for the opportunity to testify today. My name is Mark LeVota. I am the Executive Director of the District of Columbia Behavioral Health Association and a Ward 2 homeowner. The District of Columbia Behavioral Health Association works to advance high-quality, whole-person care for all District residents with mental illness or substance use disorders, including the 30,000 District residents our 31 member organizations serve annually. The Mayor's proposed budget for fiscal year 2024 for the Department of Behavioral Health reflects awareness of the significant behavioral health needs faced by District residents but omits information needed for the Council or the public to understand how the agency will operate in a year scheduled to include significant changes. The Council needs to scrutinize with care whether the proposed budget provides adequate support for the transition of Department of Behavioral Health services to managed care and the extent of support for school behavioral health or residential services for people with behavioral health conditions. The Council also needs to understand how the agency proposes to meet other resident behavioral health needs despite reductions in funding and agency staffing for several important programs, including many of DBH's services for children and adolescents.

In a particularly challenging budget environment, topline growth in the Department of Behavioral Health operating budget and funding to support a new stabilization and sobering center in the capital budget appears to reflect overall concern from the administration to meet the needs of District residents with behavioral health conditions. Review of the proposed operating budget by activity provides a more meaningful understanding of what led to topline growth. A substantial $17.8M increase in Medicaid matching payments, with additional increases in information technology, financial management, and residential services spending, is balanced against $14.3M in cuts in six of the Department's divisions.

As the District prepares to move DBH-certified provider services into managed care on October 1, 2023, the Department of Behavioral Health budget needs to be understood jointly with the Department of Health Care Finance Budget. Unfortunately, as I have confirmed with staff members from both agencies, there is not yet an integrated document that shows how spending from both agencies combines. The

projected number of beneficiaries who will receive care, the projected utilization of specific services, and the projected payment rates for services are not presented in the budget books and are not yet available from either agency, but might be sometime soon. For enrollment, the Department of Behavioral Health's Fiscal Year 2022 MHEASURES report shows DBH-certified provider organizations served 3,115 more people in FY '22 than in FY '21 – and over 10,000 more people than in 2018.[1] For utilization, the same report shows that expenditures were $65.8M more in FY '22 than in FY '21 – and $168.1M more than in FY '18. For payment rates, as we testified during agency performance oversight, provider organization payment rates are 17.5% less than what would have been needed to keep pace with inflation since the last rate setting work done based on 2016 costs. If we presume that people sick enough to need rehabilitative behavioral health services will not lose their eligibility for Medicaid or the DC Healthcare Alliance, the Mayor's proposed FY '24 budget understandably requires substantially more funding just to meet higher enrollment and utilization. It remains unclear whether there is also room in the proposed budget to adjust provider payment rates to close the gap from inflation. A structured Alternative Payment Methodology (APM) for DBH-certified providers including annual inflationary adjustments supported by audited cost reporting and periodic rebasing would help to smooth the trajectory of Medicaid and Alliance spending for behavioral health services.

The Council needs to take a careful look at what the budget chapter does not show about school behavioral health services. This year, the Department of Behavioral Health issued total grant awards to community-based organizations of $99,371 per clinician per school. Community-based organizations were told that approximately $29,000 of those awards was from one-time funding, with base awards of $70,334. The Council approved funding for FY '23 to increase recurring spending to $80K per school, so the base award description is inconsistent. Either way, the proposed FY '24 budget appears level with the approved FY '23 budget, and there are no indications of available one-time funds in some other line item to keep FY '24 total grant award amounts the same size as FY '23 total grant award amounts. Despite the line item increase of $113,000, the total funding instead appears set to lead to a reduction from FY '23 grant award amounts of between $19,000 and $29,000 per school for school behavioral health expansion grants. The Council should ask the Department of Behavioral Health what total grant award amounts it has budgeted per clinician per school, and the Council then appears to face the hard choice of finding additional funding to keep total grant awards level or to risk that community based organizations will determine they are no longer willing or able to participate in the program or only at a fewer number of schools. Given continuing inflation, we join the Strengthening Families Coalition and the Fair Budget Coalition in calling for level funding from FY '23 to FY '24 with an inflationary adjustment that sets total grant amounts of $103,000 per clinician per school for each public and public charter school.

[1] MHEASURES Annual Report Fiscal Year 2022 (Oct 1, 2021-Sept 30, 2022). District of Columbia Department of Behavioral Health. Available online 3/29/2023. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/MHEASURES%20Report%20January%202023.pdf

The Council should also take time to assess the funding added to residential services spending. As we testified during performance oversight, Mental Health Community Residential Facility operators, like the treatment provider network, have gone years without an inflationary adjustment to operator contract payment amounts. Unlike many District contracts, operators are not provided an opportunity to bid for contracts with their own price proposals and instead face a binary choice to accept the contract rates proposed by DBH or to forfeit payment entirely. In this case, the entire chapter of regulations governing these services has been substantially amended, and operators have not even received payment adjustments to help match updated regulatory expectations. We estimate that $3.3M would be needed to increase operator payment rates commensurate with inflation since those rates were last updated, likely more to correspond with changed regulatory performance expectations. The Council should ask the Department of Behavioral Health how much of the $1.2M increase in housing support services goes toward increasing operator payment rates and look for funding to close any gap. The Council should also encourage the Department of Behavioral Health to develop a process for making annual inflationary adjustments to Community Residential Facility operator payment rates supported by audited cost reporting and periodic rebasing, including exploring with the Department of Health Care Finance whether the services component of the contract – distinct from the room and board component – could be converted to Medicaid reimbursable services to help subsidize operations.

Reductions in funding and FTEs for other Department of Behavioral Health units are more obvious in the budget chapter but still deserve assessment. Is this the right time for the District to reduce its planned staffing compared with FY ’23 for both adult and children’s crisis services? What impact does the Department of Behavioral Health expect from reductions to children’s substance use prevention and treatment or court assessment services? Does the $655K reduction in early childhood services claw back the deployment of Healthy Futures, or only delay its expansion to additional child development centers?

Thank you again for the opportunity to testify today. I look forward to answering any questions that you might have.

Written Testimony of Cole Wogoman
On Behalf of the
National Council on Problem Gambling

DC Council Health Committee
March 30, 2023

Dear Chairperson Henderson and Members of the Committee:

I am here today to speak on behalf of the National Council on Problem Gambling (NCPG), the sole national advocate for problem gamblers and their loved ones. NCPG's mission is to lead state and national stakeholders in the development of comprehensive policy and programs for all those affected by problem gambling. NCPG is neither for nor against legalized gambling.

Let me be very clear. There are currently between 12,000 and 15,000 residents of the District suffering from a gambling addiction; however, the government has zero resources for those residents to seek help. Unlike drug and alcohol addiction, the Department of Behavioral Health has no programs for those suffering from gambling addiction. They are left to suffer on their own, often with disastrous consequences, such as bankruptcy or even suicide.

There is now a sports book at Nationals Park, one at Capital One Arena, and one at Audi Field. The District also runs a sports betting app and there are multiple restaurants in the District with sports betting kiosks. This is of course all in addition to the lottery. When sports betting was first being legalized, we testified at the bill's hearing on best practices for jurisdictions that legalize sports gambling. Following the hearing, the Council agreed to devote the first $200,000 in revenue from sports gambling to "fund programs through the Department of Behavioral Health to prevent, treat, and research gambling addiction[.][1]" The amount is much less than we requested, and we believe any future sports betting legislation in the District should designate at a minimum $1,000,000 annually for problem gambling.

However, rather than asking for a budget increase, we are begging the Council to maintain the $200,000, as the Mayor's budget sweeps the money and uses a subtitle to eliminate the funding provision. This would make the District one of nine states that have zero dollars for problem gambling. Maryland spends over 4 million dollars a year on resources for gambling addiction and Virginia over $2 million. The Mayor is proposing the District spend zero.

This is profoundly distressing to us. After more than two and a half years of legalized sports betting in the District, DBH made almost no effort to spend the $200,000 that it had for problem

[1] See D.C. Code § 36–621.15(c)(1).

gambling. Last fall, DBH issued an RFQ that remained open for less than two weeks before it was closed and DBH reported that there were no satisfactory quotes. Outside of that, DBH has made no effort to spend the money. And now, instead of being told to use the money as it was appropriated for by the Council, the Mayor is just giving up on helping people with gambling addiction so she can spend the money elsewhere.

These programs serve as lifelines for individuals with gambling addiction. We know from operating our National Problem Gambling Helpline that 4,892 calls to the helpline were made from the District in 2022, a 35% increase from 2021. We also know that those with gambling problems are at higher risk of suicide, drug or alcohol dependence, and bankruptcy. I ask the Committee to use this budget to maintain this funding so that comprehensive programs can be developed. Lives depend on it.

I would be happy to answer any and all questions that you may have. Thank you for the opportunity to testify today.

Cole Wogoman

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March 30, 2023

Chairperson Christina Henderson
Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue
Washington, D.C. 20004
The Committee on Health 2024 Department of Behavioral Health Budget Oversight Hearing

Tamika Spellman, Policy and Community Engagement Manager with HIPS

Councilmember Henderson and members of the Committee on Health:

As HIPS and many other service organizations, stakeholders, community leaders and concerned residents of DC are balking at the forced on DC Sobering Centers, I feel sorry for DBH because they are stuck between the mayor's office and the reality of what is critically wrong with these centers and what is needed on the ground. Not one organization locally even considered applying to operate these sobering centers because it is not what any of us envisioned because of the N.E.A.R Act and Live Long DC requirements. What came from us is the 24 hour harm reduction center's budgetary request that has monumental support because it not only supersedes what these sobering centers offer, but is what is needed to properly address substance use, the epic overdose crisis and the increased health disparities Washingtonians have experienced since COVID 19. All delivered by us for us in culturally competent ways that only people with lived experience can provide. As we move into conversations about how to divide up the "opioid settlement funds" and fulfilling the needs of Washintonians with community based solutions for those experiencing overdoses, we need to serious look at the grant that was given to the contractor from Arizona that should be funding the harm reduction center proposal led by HIPS. This budget request is supported by the Fair Budget Coalition, the LGBTQ budget coalition and a few dozen local orgs plus individual activists and organizers who are from DC and have the interest inherently in and of those in need of these tangible services led by and for

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Washingtonians. The funds the mayor allocated should be in the hands of local organizations because 24 hour harm reduction centers are the health based approach that is community inspired, needed and desired, first and foremost. As for the allocation that will come from the opioid settlement funds: there's no set office to disburse the funds, but those funds should be available through procurement contracts similar to what is given to EMT'S to be the service provider/providers that are part of the 24 hour harm reduction centers budget request. 2 centers in crucial areas, 1 east of the river and the other in a centrally located area west of the river. As a leader in service provision, we know from decades of experience that we all already have drug use in our backyards, for that reason we offer these harm reduction centers to address using in public by offering a safe space to do so without it being public facing. For these reasons it's a solid no to the sobering center because this idea was never once discussed with stakeholders, community leaders, service organizations or the people in need of services. However, the harm reduction centers are something the people want, need and desire. It is unimaginable to think a sobering center, or as I call it a glorified drunk tank with the limited purpose of pushing a narrative of abstinence only would be the offering from the mayor since it has been proven that is not the only answer, that those who offer both culturally competent harm reduction services and make available connection to 12 step programs are more effective. Especially when they have the wrap-around services we know are needed, which are part of the harm reduction centers budget request, and something the sobering center can't or won't do. We also have to come to the realization that if we do not push for living wages, affordable housing, and a serious commitment to ending homelessness, we will keep kicking these same cans down the road forever, as they are critical elements to chaotic substance use. We know the people, the nuances of the culture, and understand their struggles because we are who we serve. Knowing our client base is a huge part in rendering the services they need. We don't need to learn who to refer people to because we already know what services exist, unlike these outside contractors attempting to serve local needs by referring these same folks right back to us-who already work to solve problems for, advocate on the behalf of and serve these people regularly. And it's insulting to people because everyone who uses substances is not experiencing chaotic using behaviors and 'sobering up' does not stop people from dying, reversing or preventing an

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overdose. Providing drug checking services does, which the sobering center does not do, and will never do. Providing safer using equipment improves health, again something the sobering centers don't do. Is the point of this place to save lives or make it look like we are? Doing something isn't always what is right and these sobering centers certainly aren't the thing to do. The thing to do is meet the people where they are at and get it right the first time. This 24 hour harm reduction budget request was developed over 4 years. It was originally crafted to be funding for HIPS specifically, but grew to be the District's first offering of a safe consumption space. This budget request has been carefully crafted to be the all encompassing center for services and resource connections to meet the N.E.A.R. Act and Live Long DC goals of community solutions for community members led and implemented by Washingtonians, for Washingtonians. This is also the necessary infrastructure needed for the future of DC, as we continue the fight to increase the healthy outcomes for all of Washington's residents. The opioid settlement fund should be handled by an independent office and disbursed to DC organizations to operate harm reduction centers and mobile units, via procurement contracts. This will meet and exceed the needs as the centers will be open to anyone at any given moment, using or not. Services will be available 24 hours a day, 7 days a week, medical staff included. Critical services that will keep people alive. All staffed by people who have lived experience and the cultural competence to meet people where they are at. All done without police involvement unlike the sobering centers. The corporatized entity from Arizona who has come with an offering that falls way short of what is needed, that carries the same decades old narrative of abstinence is the only way when the reality is overdoses are killing people regularly here and now. We can change this if we do this right the first time and stop experimenting with saving lives with public funds. The 24 hour harm reduction centers are the only answer that centers the people's needs, not this horse and pony show to say we did a thing. Let's do right by our people the first time and give them true 24 hour harm reducing service centers tailored to their needs.

Honoring Individual Power & Strength

Good afternoon,

My name is Shane Sullivan and I'm the Harm Reduction Coordinator at HIPS. We're a community-based organization that provides direct services to sex workers, people who use drugs, people who are unhoused, and people engaged in street economies under the guiding harm reduction principle that everyone deserves to live healthy, self-determined lives, including sex workers and drug users marginalized by carceral policies and State violence enacted through moral panics and the War on Drugs.

I've occupied a lot of different roles at HIPS since I began volunteering a decade ago in 2013 before becoming staff in 2019, but my primary commitment has always been to outreach on our mobile services van. The HIPS outreach van has been a staple in my life amidst constant change, including change in the ways we engage in outreach in response to the context of DC's ever-escalating overdose crisis fueled by a poisoned drug supply. When I began at HIPS in 2013, we lost 98 community members to preventable overdose. In 2021, we lost 567 people to overdose and the toll of lives lost is projected to be a record-high yet again for 2022.

On one of my first overnight outreach shifts on the van, I remember our team of volunteers distributing pamphlets warning folks we saw on the street about a large batch of heroin that was adulterated with fentanyl and was estimated to have killed 41 people along the East Coast. It's now common knowledge by drug users and people working in this field that heroin on its own is virtually non-existent and that street opioid users are largely fentanyl-dependent. Because of Prohibitionist policies that persist just as alcohol Prohibition did in the 1920s, because we value carceral approaches like arresting drug users or mandating that methadone patients arrive every morning to the clinic at 6am for their daily dose or requiring abstinence for services as basic as shelter beds over community-based systems of care, we've created a highly volatile, unregulated market that has caused mass death and trauma among entire communities. We've been in a sustained public health emergency for years, and the only reason that this city refuses to treat it as such is that 85% of people who die from overdose here are Black and the vast majority are low-income.

I said earlier that the overdose deaths we've experienced are preventable because we have decades of public health research and real-world examples that prove that to be true. In 2021, New York City established the country's first legal overdose prevention site, OnPoint, which prevented or reversed over 600 hundred overdoses on-site within a single year. They continue to do lifesaving work and DC urgently needs to follow their lead by

investing $15 million to both expand our existing mobile outreach programs as well as establish two 24/7 harm reduction centers that include a safe consumption component. My Councilmember here in Ward 4, Janeese Lewis George, made this same request in her budget proposal to Mayor Bowser after visiting OnPoint with her staff late last year. OnPoint is a model that DC can replicate and while it was groundbreaking for the United States, we know it will continue to be successful because there are over 120 overdose prevention sites worldwide, many of which have operated for decades, and no one has ever fatally overdosed at any site. InSite in Vancouver was North America's first overdose prevention site that has been replicated across Canada and has been in operation since 2003.

The Mayor's own Live.Long.DC initiative, a multi-stakeholder group led by DBH and DOH that was established in 2018 to cut opioid-related overdose deaths in half by 2020, recently re-released a report recommending that DC establish, at minimum, 4 fixed overdose prevention sites and 1 mobile site. The report was originally drafted in 2019, and released earlier this year. I've attached it to my written testimony for reference. It acknowledges that the proliferation of fentanyl in the unregulated drug market requires the type of comprehensive, wraparound services that overdose prevention sites offer - medical staff onsite to provide wound care and intervene in overdoses when necessary, case management, linkage to treatment, showers, HIV/Hep C care, to name a few services that harm reduction organizations like HIPS already offer, but simply need an additional clinical component that allows people to test their drugs for adulterants and to safely use them on-site.

Live.Long.DC did not achieve its goal of reducing opioid-related deaths by half in that timeframe. Instead, they nearly doubled, from 213 in 2018 to 411 in 2020, and reached a new-record high of 448 opioid-related overdose deaths in 2022. Despite this, under Dr. Bazron's leadership during this public health crisis, DBH has taken no action to move towards establishing overdose prevention sites.

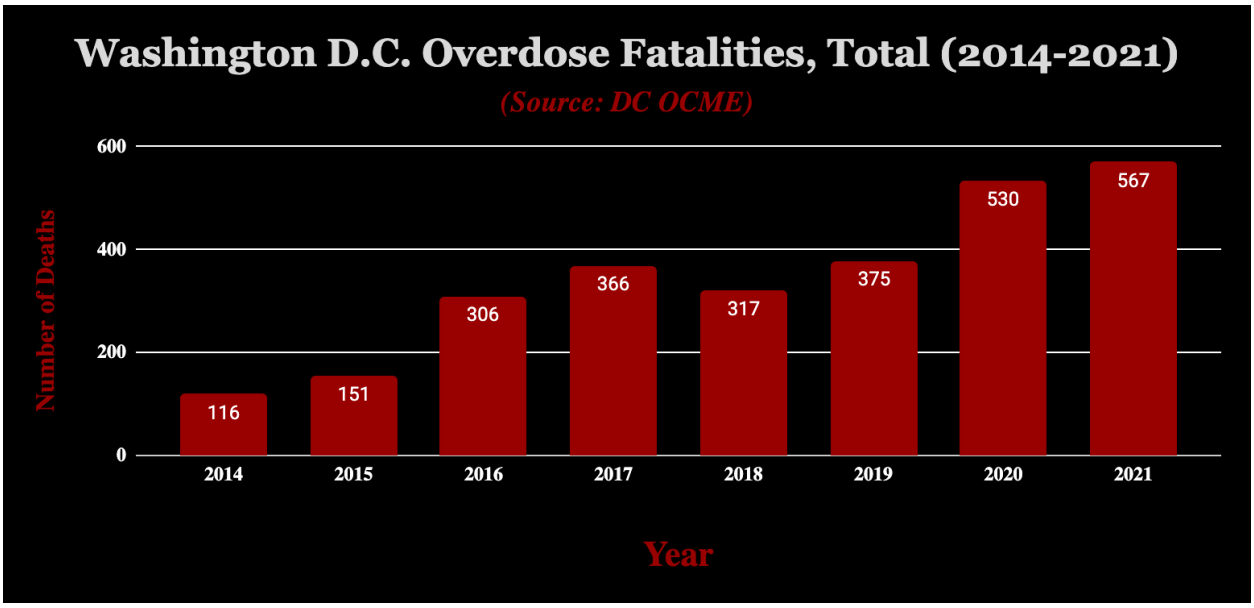
For the sake of time, there are a few things I want to briefly touch on that support my ask for the DC Council to invest in expanded mobile outreach programs and two 24/7 harm reduction centers that have an explicit overdose prevention component for people using drugs on-site:

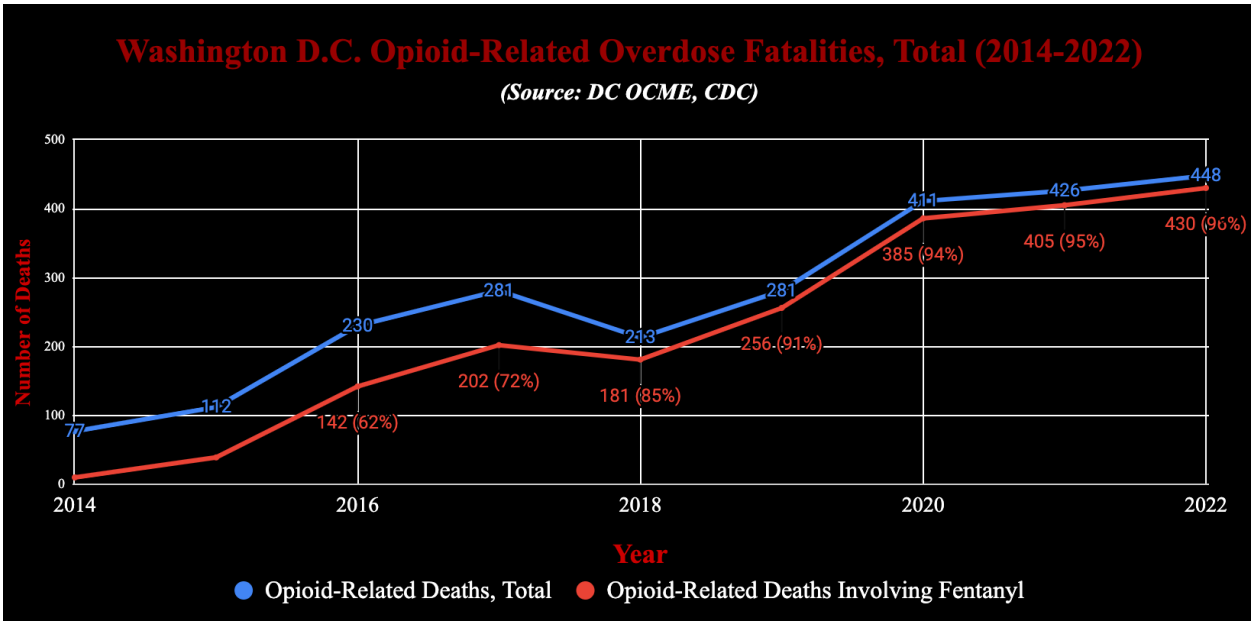
-People already regularly use in harm reduction drop-in centers like HIPS; it is not uncommon for drop-in staff to reverse overdoses and we have a policy of knocking on our bathroom doors after 5 minutes for this reason
-The defense against innovating to respond to this escalation in overdose deaths by DBH leadership has been to point to the expansion of naloxone distribution. Naloxone is essential, and I'm grateful that DC is probably the most well-saturated place in the entire country for naloxone, but it's not enough. In 2013 when I started doing outreach, access to naloxone was so restricted it was illegal for CBOs like HIPS to distribute naloxone. The

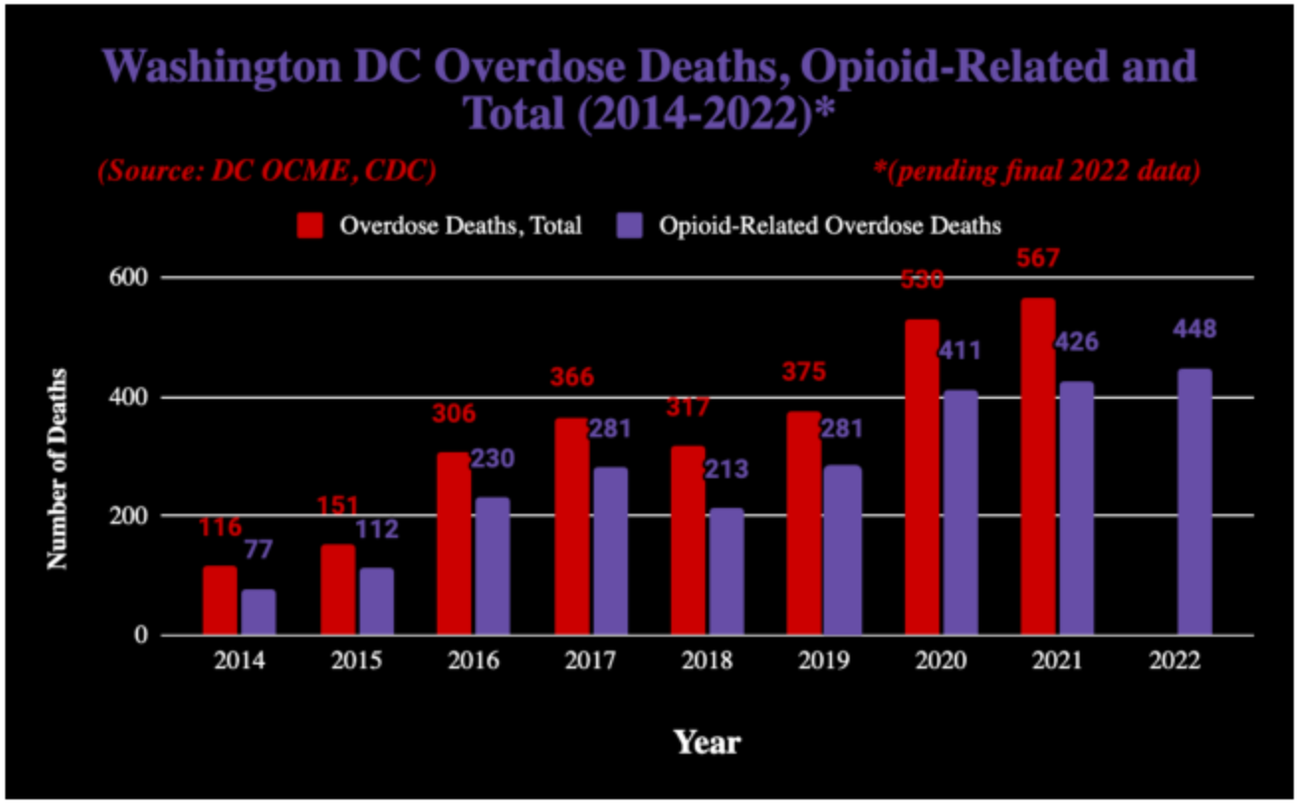
60,000 doses collectively distributed by dozens of organizations last year is laudable, but the growing death toll makes it obvious that that's not enough. I personally know multiple HIPS participants who've reversed hundreds of overdoses of friends and loved ones. A lot of them are traumatized, and people who use drugs are bearing the brunt of this crisis. The CDC estimates that 80-90% of overdoses are reversed by people who use drugs.
-Part of the reason why naloxone is not sufficient on its own is that the drug supply is so adulterated that xylazine, an animal tranquilizer, is prolific in the fentanyl supply and people are experiencing permanent brain damage or dying despite someone administering naloxone at the scene of an overdose because xylazine requires rescue breathing at minimum. OnPoint's clinical staff monitor people's oxygen levels and administer oxygen in many instances where overdoses are prevented before they actually need to occur. I love being an outreach worker, but there is only so much we can provide as non-clinical workers providing mobile services. I say worker, but we are so under-funded that most shifts I lead are with 2-3 HIPS volunteers.
-Harm reduction work is work. If this city has over half a billion dollars to pay police officers who regularly murder civilians with impunity - a police department that has more money per capita and more officers per capita than anywhere else in this country - it has the resources to fund community organizations like HIPS so that we do not rely on the unpaid labor of 50+ volunteers who regularly do heavy-lifting, traumatic work.
-DC's full overdose death rate that I referenced includes people who die every year from drugs besides fentanyl. DC has the highest rate per capita of crack-cocaine-related deaths caused by overamping, which is a cardiac emergency that OnPoint staff have also successfully prevented or reversed for people using stimulants like cocaine, crack, and/or methamphetamine. Overdose prevention sites are necessary for people who use stimulants as well, especially crack-cocaine here in DC.
-We surveyed over 100 HIPS participants who use drugs and there was unanimous support for overdose prevention sites. The vast majority of participants said they would use a site if it were easily accessible by transportation, and nearly all said that they know someone who would use a site.
-Lastly, like many people I know, I entered harm reduction as a person using drugs, in community with people who use drugs. One of them was one of my closest friends, who was justifiably distrustful of systems because she was also a sex worker, who I grew up with and who was a Ward 1 resident when we lost her in 2019.
-I have lost track of how many friends, loved ones, and participants I've lost to overdose and the collateral consequences of the War on Drugs and this city's housing crisis since 2013. Healthcare workers in this country who have continued working through this pandemic are treated with zero regard for our well-being. I don't mean to minimize the grief and trauma healthcare workers in other contexts are experiencing, but there is a particular type of grief that harm reduction outreach workers experience because we often build close relationships with the people we serve. When I leave my apartment, I regularly

run into HIPS participants in my neighborhood and I'm proud to be in community with them. People who use drugs are beautiful and caring and resilient in ways they should have never had to be. It's almost exactly 4 years to the day that I lost my friend in 2019. She should still be here, and so should so many other people I've known in my personal life and through doing this work. They all deserved better and they are why I'm here testifying today.

[Live.Long.DC. Report and Recommendation for Establishing Overdose Prevention Sites in DC]






Washington DC Overdose Deaths, Opioid-Related and Total (2014-2022)*
(Source: DC OCME, CDC)
*(pending final 2022 data)
Overdose Deaths, Total
Opioid-Related Overdose Deaths
Number of Deaths
600
400
200
0
116
77
151
112
306
230
366
281
317
213
375
281
530
411
567
426
448
2014
2015
2016
2017
2018
2019
2020
2021
2022
Year

LIVE.LONG.DC.

OVERDOSE PREVENTION CENTER REPORT FOR THE DISTRICT OF COLUMBIA

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DATE:

December 2019

Updated December 2022

LIVE LONG DC

Saving lives from the opioid epidemic

Executive Summary

In 2019, a workgroup of the LIVE.LONG. DC. (LLDC) Harm Reduction Opioid Strategic Group was tasked with researching the feasibility of implementing Overdose Prevention Centers (OPCs) in the District of Columbia. The workgroup produced a report and this updated report includes their work as well as updates from The Clearing, a DBH contractor, around recent research and developments in the overdose prevention field. As stated by Strategy HR. 3 in the *LIVE. LONG. DC 2.0: The District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths (LLDC 2.0.)*, The District should discuss the feasibility of establishing OPCs with the following issues to be addressed: medical supervision, the definition of a site, location of a site, requirements for other services, and understanding with local law enforcement.[1] OPCs are legally sanctioned facilities for individuals to use illicit substances (obtained off the premises by the individual) under the supervision of trained staff. The first authorized OPC in the United States opened in November 2021 with early indications showing both a decline in syringes found in public spaces in the vicinity and a direct prevention of 124 overdoses in the facility's first two months of operation. Studies on OPCs in other countries have shown that OPCs can reduce the number of fatalities from overdose, reduce the spread of infectious disease, and create needed pathways to treatment and support. The Federal Controlled Substances Act prohibits the management of places for the purpose of using a controlled substance; however, a federal judge in 2019 ruled that OPCs do not violate this law, thus creating a legal precedent and possible pathway for OPCs to open in the United States. There have since been several cities, and the state of Rhode Island, that have expressed intention to establish OPCs. Representatives from the jurisdictions of Rhode Island, New York City, and Philadelphia provided insights to the District in January 2022 on the challenges and strategies they formulated in their effort to establish OPCs. In October of 2021, the US Supreme Court let stand a lower court ruling that a planned Philadelphia site was illegal under a 1986 federal law against running a venue for illicit drug use. However, despite winning the Philadelphia case, the U.S. Justice Department indicated in February 2022 that it might stop fighting such sites, saying it was evaluating them and discussing "appropriate guardrails."[2] This report summarizes the current research on OPCs, discusses potential program models, and outlines possible next steps for the District to undertake.

Background

This report was initially produced in December 2019 through research by a multi-stakeholder group including representatives from DC Health, DC Department of Behavioral Health, HIPS, Whitman-Walker Health, and the DC Department of Human Services. This report has since been updated in October 2022 following the recommendation of the District of Colombia Opioid Fatality Review Board to reconsider the feasibility of overdose prevention sites in the District. The following report provides information and next steps for considering OPCs in the District as laid out in Strategy HR. 3 of *LIVE. LONG. DC 2.0: The District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths (LLDC 2.0)*. This report will address: literature about OPCs, the potential benefit for the District, and practical implementation needs such as medical supervision, location of a center, requirements for other health and social services, and partnerships with law enforcement and public safety partners.

Definition of an Overdose Prevention Center

OPCs are legally sanctioned facilities that provide a space for individuals to consume pre-obtained drugs under the supervision of trained staff. Staff who work or volunteer at centers provide: sterile consumption supplies, first aid, wound care, monitoring for and reversal of overdoses, and guidance and information on safe administration of drugs. They engage in important conversations about reducing harms associated with use. Staff members typically do not handle pre-obtained drugs or directly assist with consumption. By providing supplies and supervision, these centers are able to

[1] LIVE.LONG.DC (District of Columbia Government). "LIVE.LONG.DC Strategic Plan 2.0.: The District's Plan to Reduce Opioid Use, Misuse, and Related Deaths," August, 2021.
https://livelong.dc.gov/sites/default/files/dc/sites/opioid/page_content/attachments/DC_Opioid_Strategic_Plan_2.0_FINAL.pdf
[2] Peltz, Jennifer. "'They Make Sure You Don't Die': Inside NYC's Drug Use Sites." *New York Amsterdam News*, March 9, 2022.
https://amsterdamnews.com/news/2022/03/09/they-make-sure-you-dont-die-inside-nycs-drug-use-sites/

mitigate public health and safety concerns connected with illicit drug consumption, such as risk of overdose or transmitting infectious disease through the use of contaminated syringes.[3]

There are three (3) models of OPCs: integrated, stand alone, and mobile. For any of the models, a participant in the program will go through a low-barrier registration and check-in process and have access to a divided space, a sharps container, and ability for staff monitoring. Staff at any of these models would be trained to offer services such as harm reduction counseling, appropriate hygienic consumption materials (e.g., sterile syringes), and overdose intervention.

- **Integrated model:** an integrated OPC would combine safer consumption services with other social services, including access to food, showers, counseling, healthcare navigation, drug treatment, basic clinical services, etc. The benefit of the integrated model is that OPC clients will have easier access to other supportive services. The downside is that other clients of those services [especially clients in recovery] may object to receiving services so close to drug use.
- **Standalone:** a stand-alone OPC creates a separate physical space exclusively for individuals to consume substances in a supervised and safe setting. The benefit of this model is that it can add a level of privacy to assist individuals to feel more comfortable, and therefore, more inclined to use the facility; however creating a separate space may require additional time and resources.
- **Mobile:** a mobile OPC would bring trained harm reduction staff to meet people where they are physically and could meet the needs of communities spread out across the city. A mobile unit could offer HIV/HCV testing, wound care services, a space to engage in injection drug use (IDU), harm reduction counseling, hygienic materials, and overdose intervention.

Evidence On Overdose Prevention Centers

Currently, there are 120 OPCs operating in ten countries around the world, with two now operating in the United States as of March 2022, both in New York City. According to the Drug Policy Alliance, there has not been a single fatal overdose in any of those 120 facilities.[4] The issue of legality concerning OPCs, especially with regard to Federal law, often causes municipalities to table the conversation. However, on October 2, 2019, a federal judge in Philadelphia ruled that a proposed OPC in the city would not violate a provision of the Controlled Substances Act, a federal law that aimed at closing crack houses.[5] The judge argued that the primary focus of the proposed center is to reduce overdose deaths and provide critical medical care to Philadelphians who use drugs and not to facilitate drug use. This ruling signals that there is support in the judicial system for other cities that are considering, have approved, or have implemented OPCs (New York City, Denver, and Seattle), despite the US Department of Justice's stance against the centers. Additionally, the proposed center in Philadelphia has received support from the Attorney Generals of seven states (Michigan, New Mexico, Oregon, Delaware, Minnesota and Colorado) and the District, as well as city leaders in Maryland, New York, Seattle, and San Francisco.[6] Not only are there studies on the impacts of OPCs in Canada, Australia, and Europe that have been very promising, but New York City's OPCs prevented 124 individual overdoses in just under two months of operation -

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[3] Drug Policy Alliance. "Overdose Prevention Centers Services." Accessed December 2, 2022. http://www.drugpolicy.org/issues/supervised-consumption-services

[4] Alfonseca, Kiara and Mary Kekatos. "Why Opioid Overdose Prevention Programs Work as NYC Leads Nation with 1st Center." *ABC News*, Feburary 19, 2022. https://abcnews.go.com/Health/opioid-overdose-prevention-programs-work-nyc-leads-nation/story?id=82835105#:~:text=There%20are%20currently%20two%20sites,and%20Washington%20Heights%20Corner%20Project

[5] Bernstein, Lenny. "Judge Rules Philadelphia Supervised Injection Center Does Not Violate Federal Law." *Washington Post*, October 2, 2019. https://www.washingtonpost.com/health/judge-rules-philadelphia-supervised-injection-site-does-not-violate-federal-law/2019/10/02/7f2cd210-e569-11e9-b403-f738899982d2_story.html

[6] Allyn, Bobby. "Leaders From 13 States Urge Federal Court To Allow Supervised Injection centers," *NPR*, July 11, 2019. https://www.npr.org/sections/health-shots/2019/07/11/740621736/leaders-from-13-states-urge-federal-court-to-allow-supervised-injection-centers

essentially achieving the city's goal of 130 overdose deaths averted in the entire first year of operation. The available evidence indicates the following:

1. **OPCs Reduce Fatal Overdoses –** Since the 2003 opening of *Insight*—a safe injection center in Vancouver, Canada—the city saw a 35% reduction in the mortality rate within 500 meters of the center within 3 years of opening, while the rest of the city saw a 9% reduction of the mortality rate.[7] In addition, there are about 100 OPCs that exist around the world, and in the last 30 years there has not been a single reported fatal overdose at a center.[8] A 2021 report that compiled multiple studies found that there is evidence connecting OPCs to fewer overdose deaths and ambulance calls in their respective neighborhoods.[9]
2. **OPCs Reduce Risk of Infectious Disease and Risk Behaviors –** Evidence shows that OPCs reduce risk behaviors, infectious disease prevalence, and related harms. OPCs are able to provide harm reduction tools (e.g., sterile syringes and condoms), early identification of serious injuries or infections, and education regarding safer drug use practices, including safer injection. People who use drugs (PWUD) report significant behavior changes based on utilization of OPCs, resulting in better health outcomes for the group.[10] For example, since OPCs opened in Spain, new HIV infections among people who utilize the OPCs reduced from 19.9% in 2004 to 8.2% in 2008.[11]
3. **OPCs Reduce Drug Use and Link PWUD to Treatment Services –** OPCs provide an avenue for marginalized groups to utilize social services. For example, multiple studies have shown a relationship between attending an OPC and entry into a an SUD treatment program. One study evaluating *Insight* demonstrated a decreased the length of time of injection drug use among participants and accelerated entry into SUD treatment, particularly methadone maintenance treatment.[12] Furthermore, the study demonstrated a statistically significant relationship between entry into substance use treatment for those who attended the OPCs, and complete cessation of injection drug use for at least six months.[13]
4. **OPCs Do Not Increase Public Disorder –** OPCs do not increase public disorder and, over time, can be accepted by community members and law enforcement.[14] Research from Vancouver, Copenhagen, and Sydney demonstrate that OPCs reduce public consumption of drugs and discarded syringes in public spaces in the blocks surrounding the OPCs.[15] OnPoint NYC, the operator of the nation's first and only sanctioned OPCs, cited data provided to them from New York City Police indicating a drastic drop off in syringes found in public spaces as a result of their centers.[16] Moreover, evaluations of *Insight* report no increase in crime or drug sales within the surrounding area.[17]

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[7] Marshall, Brandon DL, M-J Milloy, Evan Wood, Julio SG Montaner and Thomas Kerr. "Reduction in Overdose Mortality after the Opening of North America's First Medically Supervised Safer Injecting Facility: A Retrospective Population-Based Study." *Lancet,* 23, no. 377 (April 2011): 1429-37. https://doi.org/10.1016/S0140-6736(10)62353-7

[8] Sherman, Susan, Kyle Hunter and Saba Rouhani. "Safe Drug Consumption Spaces: A Strategy for Baltimore City." *The Abell Report*, 30, no. 2 (February 2017): 1-16. https://www.abell.org/centers/default/files/files/Sherman Full length Report _final (002).pdf.

[9] Peltz, "'They Make Sure You Don't Die.'"

[10] Larsen, Sharon, Norma Padron, Jennifer Mason, and Tyler Bogaczyk. "Supervised Consumption Facilities – Review of the Evidence." *Philadelphia Department of Behavioral Health and Intellectual Disability Services*, December, 2017. https://dbhids.org/wp-content/uploads/2018/01/OTF_LarsonS_PHLReportOnSCF_Dec2017.pdf

[11] Ibid.

[12] DeBeck, Kora, Thomas Kerr, Lorna Bird, Ruth Zhang, David Marsh, Mark Tyndall, Julio Montaner, and Evan Wood. "Injection Drug Use Cessation and Use of North America's First Medically Supervised Safer Injecting Facility." *Drug Alcohol Depend,* 113 no. 2-3 (January 2011): 172-76.
https://doi.org/10.1016/j.drugalcdep.2010.07.023

[13] Ibid.

[14] Larsen et al., "Supervised Consumption Facilities – Review of the Evidence."

[15] Wood, Evan, Thomas Kerr, Julio S Montaner, Steffanie A Strathdee, Alex Wodak, Catherine A Hankins, Martin T Schechter, and Mark W Tyndall. "Rationale for Evaluating North America's First Medically Supervised Safe-Injection Facility." *Lancet Infect Dis*, 4 no. 5 (May 2004): 301-6. https://doi.org10.1016/S1473-3099(04)01006-0

[16] Invisible People. "America's First Supervised Drug Consumption Site: OnPoint NYC." March 10, 2022. Fundraiser, 13:11. https://www.youtube.com/watch?v=h4nMm8dJH8g

[17] Larsen et al., "Supervised Consumption Facilities – Review of the Evidence."

5. **OPCs Reduce Healthcare Costs -** Though there are costs affiliated with starting and running OPCs, OPCs have reduced overall healthcare costs. The operational costs of an OPC ranges based on the size, location, and services offered. New York State estimates the minimum cost to be $250,000 if located within an existing harm-reduction facility and with limited hours.[18] Expanding the hours or creating a stand-alone location may increase costs but may also produce even more benefits. For example, a 2013 study found that an OPC that has 13 injection booths, is open 18 hours per day, and serves about 1,700 individuals per month would cost about $2 million annually.[19] The authors estimate a net savings of $3.5 billion based on averting HIV and HCV infections, preventing overdose deaths, and uptake in MOUD. Another study found that a 13 booth fixed-site SIF in San Francisco would result in a projected annual $3.5 million dollar savings in net health care expenditures due to reduced infectious disease transmission, and fewer ambulance rides and hospital stays for injection-related soft tissue infections.[20] A similar cost-benefits analysis in Baltimore estimated an annual net health care expenditure savings of $1.8 million dollars per year, and would result in 121 more people entering SUD treatment.[21] One particular analysis into an OPC in Calgary, Canada, indicated approximately $1,600 CAD in cost savings for each overdose that occurs, with a savings of over $2.3 million for the lifetime of the program.[22] While a similar cost-benefit analysis has not yet been conducted for the District, studies from other jurisdictions suggest OPCs have high return on investment due to reductions in health care expenditures.

The Need for an Overdose Prevention Center in the District of Columbia

The District of Columbia has been heavily impacted by the opioid crisis and has seen a rapid rise in opioid-related deaths. The affected populations are primarily black men, between the ages of 40 and 69, and located in wards 5, 6, 7, and 8. Responding to the unique crisis here in the District will require innovative and tailored approaches. The District has been combating the opioid epidemic with initiatives such as expanding Syringe Service Programs (SSPs) to provide street-level care and harm reduction services for people who inject drugs (PWID). Providing PWID with syringe exchange services has made a significant impact on reducing overall transmission of infectious diseases, bringing the number of new HIV infections due to injection drug from 150 in 2007 to two in 2019.[23] Naloxone distribution programs have also made an impact on reducing the number of overdose deaths in the District.

Nevertheless, there remains a lack of immediate care for PWUD, especially for those who have been using illicit street opioids for more than twenty years and are now being decimated by the adulteration of opioids with fentanyl or fentanyl analogs. The District has taken several steps to address opioid-related mortality such as significantly expanding the naloxone program and passing The Opioid Overdose Treatment and Prevention Omnibus Amendment Act in 2020, which decriminalized the use of fentanyl test strips - a key tool in the fight against Opioid overdoses.[24] However despite these efforts, opioid-related overdoses in the District have continued to increase each year due to a drug supply increasingly contaminated with fentanyl and other powerful synthetics, and increased social isolation and solitary drug use due to the COVID-19 pandemic. An OPC offers an opportunity to not only combat the epidemic of opioid-related overdose deaths in the District, but also go even further to reduce broader health disparities for residents who use drugs. Empowering people who use drugs with the tools and information to use more safely can improve outcomes for infectious disease

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[18] New York City Department of Health. "Overdose Prevention in New York City: Supervised Injection as a Strategy to Reduce Opioid Overdose and Public Injection," May 3, 2018. https://www1.nyc.gov/assets/doh/downloads/pdf/public/supervised-injection-report.pdf

[19] Irwin, Amos, Ehsan Jozaghi, Ricky N Bluthenthal, and Alex H Kral. "A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA." *Journal of Drug Issues,* 47, no. 2 (December 2016): 164-8. https://doi.org/10.1177/0022042616679829

[20] Ibid.

[21] Sherman et al., "Safe Drug Consumption Spaces: A Strategy for Baltimore City," 1-16.

[22] Khair, Shahreen, Cathy A Eastwood, Mingshan Lu, and Jennifer Jackson. "Supervised Consumption Site Enables Cost Savings by Avoiding Emergency Services: A Cost Analysis Study." *Harm Reduct J,* 19 no. 32 (March 2022). https://doi.org/10.1186/s12954-022-00609-5

[23] DC Health "Annual Epidemiology & Surveillance Report: Data through December 2019." Accessed December 2, 2022. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2020-HAHSTA-Annual-Surveillance-Report.pdf

[24] Opioid Overdose Treatment and Prevention Omnibus Amendment Act of 2020, D.C. Law 23-182 (2020), https://code.dccouncil.gov/us/dc/council/laws/23-182.

transmission, vein care, avoiding/providing care for wounds acquired during use, and strategies for safer consumption based on the individual's specific health care concerns and needs.

Vision For An Overdose Prevention Center In The District Of Columbia

Harm reduction advocates and other stakeholders as well as the District of Columbia Opioid Fatality Review Board have requested that the District government research the feasibility of having an inclusive and holistic OPC for individuals. The vision is that PWUD must be central to the process, from development and implementation of the OPC to its continual evaluation. Should a center open, it will operate by the principle of "by community, for community" meaning that this project will be community based and relevant to the epidemic and demographics in the District. Ensuring that PWUD are integral to information gathering and decision making is critical to the success of any OPC because their life experience, particularly with drug use, provides critical insight to the services required by an OPC and the buy-in of other PWUD.

Over the past decade, fentanyl, a drug that can be up to 100 times stronger than heroin, has become very present in the local illicit drug supply, and in 2017 overtook heroin as the opioid attributed to the greatest number of overdose fatalities.[25] In the District, fatal overdoses in the past five years have been directly related to the increase of fentanyl and its analogs in the drug supply.[26] According to the District's Chief Medical Examiner, in 2021, 75% of all fatal opioid overdoses occurred among adults between the ages of 40-69 years old, with fatal overdoses most prevalent in Wards 5, 6, 7, or 8, among African-American/black (84%), males (73%).[27] Prior to the introduction of fentanyl, a majority of PWUD had been using heroin or other illicit street drugs for over 20 years and have lived resilient lives, even with a chronic disease such as opioid use disorder.

With this information, the OPC will be more prepared to prioritize PWUD who experience the highest mortality rates caused by the opioid epidemic in the District. After considering the research, the recommended minimum requirements for an OPC include: a sterile area for an individual to consume the substance and staff who can provide medical care, harm reduction resources, education, and referrals to treatment, and other social services. Individuals with lived experience and ties to communities of PWUD should be prioritized at all levels of staffing when possible.

Service Offerings

If an OPC is to be effective in the District, the center must focus on opioid use within the landscape of polysubstance use and will be inclusive of different types of drug administration (e.g., smoked, injected, ingested etc.). There should be a separate space or area within the OPC for injection drug to provide privacy and increased protection from exposure to potential blood-borne illnesses.[28] As Sam Rivera from OnPoint, the nation's first authorized OPC, stated, "People assume participants haven't tried treatment. Yet 100% of people who have used our program have tried detox and treatment. They are going to use … we want to keep them alive. We want to engage them in a conversation where they are." OnPoint offers various services, such as wellness rooms for participants that overdose to recover afterwards. A center in the District should likewise offer holistic services (physical and mental health) and be co-located with other harm reduction services, such as syringe service program access, HIV/HCV and STI testing, fentanyl testing strip distribution, naloxone administration, and appropriate linkages to housing, food, clothing, primary care, MOUD, and other substance use

[25] Office of the Chief Medical Examiner (Government of the District of Columbia), "Opioid-Related Fatal Overdoses: January 1, 2017 to August 31, 2022," November, 2022.
https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/Opioid%20related%20Overdoses%20Deaths%203.16.21%20FINAL%20%28002%29.pdf

[26] Office of the Chief Medical Examiner (Government of the District of Columbia), "2019 Annual Report," Accessed December 2, 2022.
https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/OCME_2019_web.pdf

[27] Office of the Chief Medical Examiner, "Opioid-Related Fatal Overdoses."

[28] Sherman et al., "Safe Drug Consumption Spaces: A Strategy for Baltimore City," 1-16.

disorder treatment services. Additionally, protocols will need to be created for how an OPC in the District will care for special populations, including pregnant women and minors, which may include linkages to outside services.

Locations

For an OPC to make a sufficient impact, it should be located in a hotspot that is strategically located near common pockets of drug consumption, with an aim to serve in diverse neighborhoods across the District and a multitude of different substances. A center should be embedded with community-based agencies familiar with harm reduction. In New York, officials such as Mayor Bill de Blasio, recommend that OPCs are co-located with SSPs.[29] In the District, which has been a leader in implementing programs such as SSPs, opportunities for multiple approaches are available. For context, there are four community-based organizations (CBOs) that currently provide syringe services, utilizing both mobile units and a fixed center. New York has also implemented a mobile prevention center and is looking to launch another one in the near future. They've instituted a virtual safe consumption center in line with "witnessed" ones via the phone that are geolocated so medical help can be provided, if needed, to the proper location. With this implementation, someone may call into the network as staff oversees the participant and if medical help is needed, the staff use geolocating to provide immediate assistance.

As mentioned in the "Background" section, Wards 5, 6, 7, and 8 have the highest numbers of fatal overdoses. Research shows that most individuals who utilize OPCs will not travel more than twenty minutes.[30] For DC to best utilize OPCs in the fight against this epidemic, there should be consideration for four fixed centers, one in each of the most burdened wards, and/or at least one dedicated mobile unit. They should have low barrier to entry, be accessible to the community (e.g., accessible via public transportation, in walking distance) , and serve co-located users.

Education and Awareness

Insight gathered from the jurisdictions of Rhode Island, New York, and Philadelphia indicate that community awareness and education are essential for success of these programs. OPCs in the District will need to provide education to PWUD to ensure safety is the top priority and that clients learn of other options to reduce their reliance on substances, such as MOUD or alternative methods for pain management. Education for the general public around what an OPC is will also be critical in making the center successful, ensuring that community stigma is reduced and its life-saving potential is understood.

Operations and Partnerships

Due to regulations and legislative guidelines, the services provided at the OPC would need to be operated by a community-based organization and supported monetarily by a public-private partnership. Ideal partners for this effort include DC Health, Mayor Bowser's office, the Metropolitan Police Department, Fire and Emergency Services, the Department of Human Services, the Department of Behavioral Health, and other community-based organizations that specialize in substance use prevention, education, harm reduction, treatment, and recovery.

Staffing Model

Staff models would depend on the type and size of the OPCs being implemented. Nevertheless, at a minimum, individuals with personal lived experience with a substance use disorder should be employed, and if a center is medical focused, a healthcare provider that could include a nurse, nurse practitioner, or a phlebotomist. An individual with lived experience, often referred to as a peer, can supervise consumption and monitor for signs of overdose, build relationships with the clients, and reverse an overdose. They can also provide harm reduction education, emotional support, and referrals or linkages to resources including treatment and recovery. Healthcare professionals can provide treatment for health issues,

[29] New York City Department of Health, "Overdose Prevention in New York City."
[30] Ibid.

respond to medical emergencies, and along with peers, can provide harm-reduction education, reverse an overdose, and refer to treatment and recovery support services.

An OPC integrated with treatment (induction) would require a health provider with prescribing authority. Healthcare providers with prescribing authority can prescribe MOUD and other medications, including HIV and HCV prevention and treatment medications.

Linkages to Other Services

For an OPC to be successful and reach its ultimate goal of reducing the harms of illicit substance use on individuals, families, and the city, various health, social, and human services must be in place. These include linkages to primary care, housing services, and food services, proper procedures and protocol for safer consumption, proper procedures and protocol for drug and paraphernalia disposal, education around safer practices for drug administration, syringe exchange services, access to or referral to MOUD, vein and wound care, HIV and Hepatitis C testing, individuals who can provide linkages and referrals to longer-term treatment , and mental health services, either onsite or available referrals to a mental health specialist or counseling services.

Legal Considerations

The question of whether OPCs violate federal law is still being determined by the courts. Until recently, states and cities believed that OPCs would violate the Federal Controlled Substances Act, which prohibits the possession of illicit substances and the management of places for the purpose of using a controlled substance. However a recent federal ruling [10/2/19] has refuted that assumption, finding that a proposed safe injection center in Philadelphia would not violate the law because, "No credible argument can be made that facilities such as safe injections center were within the contemplation of Congress" when lawmakers adopted the initial drug law.[31] This ruling signals that there is support in the judicial system for other jurisdictions to mimic the ways of New York City —Denver, and Seattle—that are considering OPCs, despite the US Department of Justice's stance against the centers. Additionally, the proposed center in Philadelphia has received support from the Attorney Generals of seven states[32] and the District, as well as city leaders in Maryland, New York, Seattle, and San Francisco.[33] There have since been several jurisdictions, including the state of Rhode Island, that have expressed their intention to establish OPCs, although as of November 2022, New York City remains the only jurisdiction in the United States with sanctioned OPCs. In October of 2021, the US Supreme Court let stand a lower court ruling that a planned Philadelphia site was illegal under a 1986 federal law against running a venue for illicit drug use. However, despite winning the Philadelphia case, the U.S. Justice Department indicated in February 2022 that it might stop fighting such sites, saying it was evaluating them and discussing "appropriate guardrails."[34]

Trust and partnership is critical with law enforcement and public safety partners so clients of the OPCs know they will not be targeted or arrested and can trust the services being provided. It is also important for staff to have an understanding with law enforcement and public safety partners, for training purposes and in the case of an emergency.

Needed Partnerships

In 2007, the DC Department of Health worked extensively with the Metropolitan Police Department (MPD) during the expansion of SSPs to develop buy-in from MPD leadership on the public health benefits of syringe exchange and to ease implementation on the streets for the programs. This included Mayoral and City Council support for the expansion, support from MPD leadership, training for officers on the syringe exchange program and how to make referrals, and safety

[31] Bernstein, "Judge Rules Philadelphia Supervised Injection Center."
[32] Allyn. "Leaders From 13 States Urge Federal Court."
[33] Ibid.
[34] Peltz, "'They Make Sure You Don't Die.'"

and protocol training for officers. A similar rollout for obtaining buy-in and support for an OPC in the District would be highly recommended.

Partnerships and potential memorandums of understanding (MOUs) will be needed between the staff of the center and the MPD, Fire and Emergency Services (FEMS), the DC Court system, and potentially the Drug Enforcement Administration (DEA). A regular working group should be convened once the proposed legislation is passed through City Council in order for key individuals and stakeholders to develop the protocols for the operation of the center and the considerations that need to be addressed. Considerations include:

- An understanding with law enforcement that they will not target, harass, or intimidate the clients and/or staff of an OPC, including exuding a visible presence outside of OPCs to deter clients' entry.
- Cultural competency trainings for law enforcement, first responders, and service providers on stigma against PWUD and how that impacts drug users' ability to access healthcare and other support services.
- Standard operating procedures for patient referrals, handling emergencies, and continuous improvement in operations.

Training

Training for local and regional law enforcement and public safety partners on overdose prevention, the District's Good Samaritan law,[35] harm reduction, and drug exemption laws for OPCs to prevent client arrest and targeting, will be critical to ensure the center operates according to the understanding developed with law enforcement. Also, training for local law enforcement on the standard operating procedures for medical emergencies, appropriate disposal of substances and related paraphernalia, and testing of substances will be needed. Equipping law enforcement and public safety partners is needed so clients of the OPCs will feel like they are in a safe space. The regular working group established between key law enforcement partners will allow for ongoing training and learning.

Conclusion

OPCs are legal facilities for individuals to use illicit substances under the supervision of trained staff. Studies on OPCs in other countries as well as evidence from New York City have shown that OPCs can reduce the number of fatalities from overdose, reduce the spread of infectious disease, and create needed pathways to treatment and support. Many factors are necessary to examine before opening an OPC in the District, including possible locations, staffing, training, and partnerships with other organizations. This report explores the possibilities of what an OPC in the District could look like and how it would benefit the PWUD in the District of Columbia.

[35] Substance Abuse and Opioid Overdose Prevention Amendment Act of 2016, D.C. Law 21-186 (2016), https://code.dccouncil.gov/us/dc/council/laws/21-186

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PARENTS AMPLIFYING VOICES in EDUCATION

Tracy Barnes
Department of Behavioral Health
Budget Hearing Testimony
Committee on Health
Thursday, March 30th, 2023

Good Morning Councilmember Henderson and members of the Committee on Health. My name is Tracy Barnes and I am a proud parent of 1 high-schooler that attends Washington Leadership Academy in Ward 5 and 1 middle-schooler that attends a private placement school in Montgomery County. I also serve with Parents Amplifying Voices in Education (PAVE) on the Ward 5 board.

First, thank you for

- ***$3.8M in additional funding for the SBMH program***
- ***$2.4M to increase grant sizes for CBO providers***
- ***$150K for a comprehensive cost study*** *to determine the true cost of the SBMH program now and in the future*

Those are important investments! I am testifying today because I want to see an expanded pipeline of mental health professionals and ensure all children have a mental health professional who is available to them. I have a question for all of the agencies present. Why does my son have to travel 34 miles to Gaithersburg, MD to receive the mental health supports that he needs to be emotionally and academically successful in school? Here's my answer -- because DC's public school system was and still is not equipped to do so.

My vision for SBMH in the city is for all kids to have access to great services and supports that my child receives at his private-placement school. Earlier I said a mental *health professional who is AVAILABLE.* By that I mean a full-time, clinically qualified staffer that is available to students that are not only in crisis mode or to a student that made an appointment but who is available at a moment's notice for a student that may need only 5 minutes to get something major or minor off of their mind & heart.

The therapist at my son's school has many roles:

- they are the caregivers main point of contact for everything SEL related.

- they conduct weekly group therapy in the classroom.

- they ensure all students get the services in their IEP and extra therapy appointments as needed.

Additionally, at my son's school, students inform the teachers that they need time with the therapist and if/when students have 'moments' in class they can immediately go see the therapist to 'process and prepare to return' not requiring a scheduled session, if they are available.

This matters to me because of how it has changed not only my son's school life, it has changed his entire life. Which has changed my entire household's life. This should matter to DC because if readily available SBMH has had such a profound effect on one family's life, imagine the effect it would have on the entire city if all students had access to this!

In order to address the issues of:

1. Students having to go so far away from home to get the needed mental health supports:

- DC leaders & agencies need to work together to figure out how to utilize these vacant, underused properties and land in and immediately around DC for private placement school buildings.
- Consider an overhaul of the OSSE & DCPS process to make sure DCPS offers this alternative to families. Students should not have to travel more than 30 miles away to get their needs met.

2. Students having readily available mental health professionals in all DC public & public charter schools, DC need to:

- Consider modeling & creating SBMH programs that I outlined above
- Improve school staff support to respond to the needs of ALL children by incorporating Social Emotional Learning into daily schedules at all schools.
- Provide resources and training to regularly assess student wellbeing with both formal and informal wellness checks by allowing students without IEPs to get therapy appointments as requested, needed or referred.
- Improve family engagement in school-based mental health care by simply allowing immediate interactions between MH professional and caregiver. (i.e. texting or calling a caregiver with a quick question or update versus going through legalities just to provide &/or obtain information.)
- Build and sustain a pipeline of diverse and competent mental health professionals by prioritizing recruitment and retention of mental health professionals that look like and come from the communities they will serve and ensuring these providers are trained to work specifically in traditional and specialized school settings.

Thank you for allowing me to testify and share what I want to see for our kids and our District. I hope you will work together to investigate and update the process of private-placement offerings with special attention to their locations.

Best,

Tracy Barnes
PAVE Ward 5 PLE Board

PARENTS AMPLIFYING VOICES in EDUCATION

Tracy Barnes
Department of Behavioral Health
Budget Hearing Testimony
Committee on Health
Thursday, March 30th, 2023

Good Morning Councilmember Henderson and members of the Committee on Health. My name is Tracy Barnes and I am a proud parent of 1 high-schooler that attends Washington Leadership Academy in Ward 5 and 1 middle-schooler that attends a private placement school in Montgomery County. I also serve with Parents Amplifying Voices in Education (PAVE) on the Ward 5 board.

I am testifying today because I want to see an expanded pipeline of mental health professionals and ensure all children have a mental health professional who is available to them. I have a question for all of the agencies present. Why does my son have to travel 34 miles to Gaithersburg, MD to receive the mental health supports that he needs to be emotionally and academically successful in school? Here's my answer -- because DC's public school system was and still is not equipped to do so.

My vision for SBMH in the city is for all kids to have access to great services and supports that my child receives at his private-placement school. Earlier I said a mental *health professional who is AVAILABLE.* By that I mean a full-time, clinically qualified staffer that is available to students that are not only in crisis mode or to a student that made an appointment but who is available at a moment's notice for a student that may need only 5 minutes to get something major or minor off of their mind & heart.

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Best,

Tracy Barnes

PAVE Ward 5 PLE Board

PARENTS AMPLIFYING VOICES in EDUCATION

Arthemise Cotton
Department of Behavioral Health
Budget Hearing Testimony
Committee on Health
Thursday, March 30th, 2023

Good afternoon, Councilmember Henderson, members of the Health Committee and Health Committee staff.

My name is Arthemise Cotton and I live in Ward 8. My kids go to Friendship Tech Prep and Templeton Academy schools. I currently serve as a PAVE parent leader on the Ward 8 PLE Board. I chose those schools because they were the best fit for my children and they both offered some of the best resources for my children to succeed in their education.

I want to thank you for your partnership and leadership on achieving reciprocity with other states so we can have more mental health professionals in schools.

I want to see an education system that prioritizes mental health, where students have the ability to receive high quality services from a licensed and trained professional in their moment of crisis to help them cope and staff have the resources they need to help them.

This matters to me because I was a child dealing with mental health issues and I had no help and no one I could talk to and it caused me to struggle drastically in school. I also have a daughter that struggled so much in school with her mental health issues and no one was really qualified in her public schools to help her.

Instead, they labeled her as a troubled kid because they didn't understand her condition and didn't even try. Finally, we put our daughter in a private school where she receives weekly therapy at school with a therapist she can go to immediately if anything goes wrong in her day. My daughter is now doing better than ever and making the honor roll. She is excelling to her whole potential instead of failing. SBMH is important for our children to have a better future.

I want to make sure we can have more workers in the school who can support student mental health. I want them to have more incentives and pay to make sure they come to DC and help our students. Even just 1-2 people can help so students have someone to talk to them the day they are having a crisis. So please make sure that CBO providers don't face cuts this year. We don't have enough information to know right now what their budget will be, but this is really

important to have School-based mental health services that can help students get the support they need.

Thank you all for your time.

Best,
Arthemise Cotton
PAVE Ward 8 PLE Board Member

PARENTS AMPLIFYING VOICES in EDUCATION

Gaby Fraser
Department of Behavioral Health
Budget Hearing Testimony
Committee on Health
Thursday, March 30th, 2023

Good afternoon, Councilmember Henderson, members of the Health Committee and Health Committee staff.

In February 2020, DC youth were suffering from Adverse Childhood Experiences (ACEs). These are potentially traumatic events that occur in childhood and can include violence, abuse, and growing up in a family with mental health or substance abuse problems. Toxic stress from ACEs can change a child's brain development and affect how their body responds to stress. Some youth are more at risk for mental health conditions than others, such as youth with disabilities, racial and ethnic minorities, LBGTQ+ youth, and other marginalized communities. The effects of mental illness can be temporary or long lasting and one can have more than one mental health disorder at the same time. Mental illness is a leading cause of disability.

Untreated mental illness can cause severe emotional, behavioral and physical health problems Prior to COVID, if a child was regularly absent from school or came to school with bruises, the teacher would report it to CFSA. However, the pandemic changed the face of child abuse and forced these children to be locked inside with their abusers or in violent households for approximately 16 to 18 months!. This was in addition to everything else COVID. Ideally, most of our children will recover, however, realistically, some may never recover. The only good thing that came out of COVID-19 was that it brought the mental health issues that our children are facing to the forefront of society where it should always have been.

As adults, we've developed coping mechanisms skills and therefore most of us were able to deal with the Pandemic and all if its ramifications: being cut off from family, friends and co-workers, staying indoors, watching the COVID numbers go up and the number of deaths continue. However, our children have not developed these coping mechanisms, so COVID was very hard on them. The sudden transition to virtual learning, staying inside, not seeing their friends, hearing and watching the fear in their Parents voices and eyes daily, and hearing the death toll rising contributed to "A" students failing, children becoming withdrawn, and children who were behind slipping more and more behind each month.

As a child growing up, the only person I ever knew who passed away with my Great Aunt. Today our youth in DC, and across the Nation face an unbelievable reality every day. Our children have

to deal with possibly knowing the person who was killed or knowing the killer, OR, knowing someone who knows either of those individuals, and being familiar with the area where the violence took place. Our Children see violence in their schools, on the bus, on the train, in their parks, on TV, and in front of their homes! That's a lot for ANYONE to deal with, especially an impressionable child or young adult. How a young person can compartmentalize, comprehend, or try to understand and deal with this is just mind-blowing!!

Today, in DC, approximately 63% of the schools now have a clinician, which means that approximately 37% do not have a clinician. THIS IS UNACCEPTABLE! We must step outside the box and explore every suggestion to rectify this. Reciprocity between the DMV is certainly a start; however, it must be done sooner rather than later. Every day that we delay costs our children. During the recent Performance Oversight Hearings, youth testified in droves about their friends who have died or are incarcerated, and how they are struggling with life. They spoke about how important it is to have someone to talk to and how social emotional learning practices were helping them to become engaged, which leads to better mental health outcomes. Additionally, restorative practices and restorative justice programs are another way for the youth to speak out, discuss how they are feeling, and be heard.

In order to ensure that our children are prepared educationally and emotionally to enter adulthood, we must ensure that any barriers they may have today are being addressed and resolved early and properly. We must provide them with the resources they need to live the lives they want. I say this so often I'm thinking about getting a tee shirt, "One day, the youth of today who grow up and choose to stay or come back to the District of Columbia, will be our Mayor, Councilmembers, Agency Heads, Principals, Lawyers, Police, Teachers and Parents." Mental health issues that are addressed and treated today, will determine the mental state of the individuals of tomorrow as they become the adults that are in charge of our City.

Best,

Gaby Fraser
Citywide and Ward 7 PLE Board Member

PARENTS AMPLIFYING VOICES in EDUCATION

Kerry Savage
Department of Behavioral Health
Budget Oversight Hearing Testimony Guide
Wednesday, March 30th, 2023

To: DC Council Committee on Health, Committee on Health Chairperson Christina Henderson, Committee on Health Members, and Committee on Health Staff
From: Kerry Savage, Director of Policy and Advocacy at PAVE (Parents Amplifying Voices in Education)
Date: March 30, 2023

Good afternoon Chairperson Henderson, members of the Committee on Health, and Committee staff. My name is Kerry Savage and I am the Director of Policy and Advocacy at PAVE. PAVE is also a member of the Strengthening Families through Behavioral Health Coalition - a coalition committed to ensuring that DC children, youth, and families have access to a fully integrated behavioral health care system that meets the needs of the whole child.

PAVE parent leaders and our partners are extremely grateful for DC's continued investments in school-based mental health. Parents have prioritized this issue for years, and because DC leaders listened, we had a very important foundation laid for school-based mental health when the pandemic hit. I do not want to minimize the trauma, heartache, and changes to our everyday way of life that will continue to unfold as a result of COVID, but I am grateful that DC had those structures and supports in place through a thoughtful model that was developed collaboratively. While we know we needed - and still need - to do more, we are serving as a model to many other states and cities of what's possible for our students.

As with any successful model or policy, our approach to school-based mental health requires rigorous attention to detail, inclusive efforts for continuous improvement, and, of course, resources. Today, you will hear from PAVE parent leaders about their powerful policy solutions and personal experiences, so I will focus my testimony on two key areas:

First, we need consistent and adequate resources:

- Community-based providers, like Mary's Center, WISE, Hillcrest, etc., are the backbone of the SBMH model. They need consistent sources of funding to be able to operate and

maintain competitive compensation for their staff so they can do their best work for kids.

- Last year they were given approximately $99,000 per clinician per school. About $29,000, or nearly one-third, of that funding was one-time, which is makes it difficult for providers to plan and increases stress. This year, we cannot tell if that one-time funding is being renewed.
- We also don't know if the grants will be adjusted for inflation, which if done in full from last year would amount to a grant of $103,000 per clinician per school.
- **Please make sure that CBOs, who are essential to this model and essential to being able to provide kids critical services where they already are, at school, don't face cuts.**
- We were ahead of the curve prior to the pandemic. As our communities recover, please don't take a step backward and reverse the progress that we all fought so hard to make possible.

Second, we need nimble ***and* inclusive strategies for evaluation and workforce pipeline development:**

- **We need(ed) a timely cost study report.**
    - Advocates and community partners understood that the cost study the Council funded last year was an important, but large undertaking. It took a long time to win that fight, and once funding was secured, the project management and the reporting of the results were slow, compounding the delay. Now, we are deciding the funding for the future of the program without a comprehensive understanding of the true costs demanded to support our students' needs. This jeopardizes continuous improvement and thoughtful budgeting based on data, as now we can only base planning on last year's rates - which likely already needed to be increased, especially with the rising cost of inflation and demand for clinicians' services.
    - Oversight from Council is needed to make sure this work is completed as soon as possible and effectively shared with a diversity of stakeholders so they can provide insights into implementation challenges and opportunities for improvement to use in tandem with the study's results.
- **Transparent evaluations are important for real change.**
    - We can't address what we don't know. The system-level SBBH program evaluation for past years hasn't been shared, and this makes it very difficult to have meaningful and inclusive conversations about how to move forward.

    - At the school level, more transparency and engagement about progress to goals (i.e. School Strengthening Tools and Workplans) are needed. While those conversations may be difficult, it is the only way to build trust with school communities and find effective ways to address gaps or challenges.
- **Let's work on workforce recruitment and retention together!**
    - We're thrilled the District was awarded the federal grant to support the recruitment and retention of school-based mental health professionals in the coming years.
    - To maximize that investment, please make sure the work includes and centers the voices and needs of students, parents, teachers, clinicians, and school leaders.
    - Let's also use every option we have in the short-term to bring in mental health professionals, like reciprocity with our neighbor states, and identify ways we can bring in other staff for supports or services that don't require full licensure or certification.

This work is only possible with leaders on the Council and in DBH who believe in the power and promise of community voice. Thank you so much for the opportunity to testify today, I hope that we can count on your leadership.

In service,

Kerry Savage
Director of Policy and Advocacy
PAVE (Parents Amplifying Voices in Education)

Testimony before the
Council of the District of Columbia
Committee on Health
FY24 Budget Oversight Hearing
for the
Department of Behavioral Health

* * *

Presented by

Justin Palmer

VP, Public Policy & External Affairs

March 30, 2023

Good Afternoon Chairperson Henderson and members of the Committee on Health, my name is Justin Palmer, and I am the Vice President for Public Policy & External Affairs with the District of Columbia Hospital Association (DCHA). I appreciate the opportunity to present testimony at the Department of Behavioral Health's FY24 Budget Oversight Hearing.

As you are aware, DCHA is the unifying voice of the District's hospitals and represents the interests of our members who provide care to residents from all eight wards, our neighbors in Maryland & Virginia, and patients from around the world.

When it comes to the Department of Behavioral Health's FY24 Budget it is critical the District continues to make the necessary investments to improve the behavioral health of our residents. This includes ensuring the investments being made in

school-based services are able to meet the needs of our youngest residents and those of the providers.

The Mayor's investment in the much-needed sobering center set to open in the coming weeks is a step forward in meeting the needs of our residents with substance use diagnoses that can be treated outside medical intervention. We believe that it will have a significant impact on our emergency rooms given the number of substance use visits we see each year.

We are encouraged with the continued funding of the Comprehensive Psychiatric Emergency Program and urge the DBH to continue its efforts to open additional CPEP facilities in order to support those residents in crisis. We know the Department shares our vision for expanded access to combined stabilization services and we appreciate their efforts to plan for

the future, even if the funding is not currently available to do so.

DCHA supports the enhancement included in agency's budget to support the Medicaid match requirements and encourage that the funding be converted to recurring should the revenue estimates improve. This funding enables access to those in need of care and is much needed to ensure that providers are paid adequately to preserve access.

The additional $1.7 million dollars included to support housing case management is critical to enabling those with behavioral health conditions to obtain and maintain housing. From a hospital standpoint, one of the greatest barriers for discharge is finding housing for those with significant mental health conditions.

Finally, we would urge the committee to ensure that Saint Elizabeths has the needed funding to enable it to continue reopening beds with the hope of being at full capacity as soon as COVID precautions safely allow. The ability to move patients into Saint Elizabeths timely is a necessity in order to increase capacity for others within the Behavioral Health units of the hospitals and to minimize boarding or awaiting transfer to an involuntary facility.

The work being done by Dr. Bazron, and her team is essential for the District, and we look forward to continuing to support the Department as they carry out their critical work.

Thank you for allowing me to testify today, and I am happy to answer any questions you may have.

Subject: Written Testimony
Date: Thursday, March 30, 2023 at 2:57:04 PM Eastern Daylight Time
From: Taylor Pinckney
To: Strange, Ashley (Council)

Hello
my name is Taylor Pinckney the program manager and mental health counselor for the Behavioral Health for Homeless Youth program at the Latin American Youth Center. I want to focus my limited time on uplifting the request by the Youth Economic Justice and Housing
Coalition that the Council add $1.7 million to create a traveling mental health unit to provide mental health support to youth where they physically congregate.
Youth experiencing or at risk for homelessness
have higher rates of mental health issues, including depression, anxiety and conduct disorders than those in stable homes.

- For example, Homeless students who were the victims of bullying were much more likely to report depression (63%) than those who were not bullying victims (34%). Depression can lead to harmful behaviors such as alcohol and substance abuse. Homeless students reporting depression were more than twice as likely to binge drink as housed students reporting depression (41% vs. 19%). In fiscal year 2022 532 young people served in DHS's youth programs reported disabling conditions including mental health concerns and substance abuse.

- According to youth experiencing homelessness and their service providers, there is a lack of accessible, youth-friendly, and culturally competent mental health services throughout the District. This gap serves as a major barrier to youth achieving long-term stability.

Lastly,
as a mental health professional working within a program providing mental health services to homeless and unstabled house youth in the district I have seen first hand the significance of providing mental health services to youth, specifically transitional
age youth, where they are located and not expect them to find their way to my office or nay other mental healthy office which often times is impossible to do, due to various barriers such as lack of finances.

--

Taylor Pinckney, LICSW (she/her)
BHHY Program Manager/Mental Health Counselor
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Youth • Family • Futures • Community

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Testimony of Karla Reid-Witt

On behalf of the Parents Amplifying Voices in Education (PAVE)

For the Budget Oversight Hearing:

Health Committee (Department of Behavioral Health)

March 30, 2023, 2:00 p..m.

Hello, My name is Karla Reid-Witt. I am a PAVE Ward 7 Citywide Parent Leadership Board Member, a co-founder of Decoding Dyslexia DC and an education, disability, mental health and literacy policy advocate. Both PAVE and Decoding Dyslexia DC are members of the Special Education Advocates Coalition (SEAC). SEAC is a coalition of several special education organizations, as well as individual members, all dedicated to advancing the rights of DC special education students. We attempt to raise awareness of systemic issues D.C. youth and families encounter when trying to obtain special education support.

My focus is access to services available under the school-based behavioral health program and I am testifying today regarding the need for the Council to increase the per school grant funding for school-based mental health providers to $103,000.00. It cost approximately $180,000.00 to fund a school-based mental health provider. The gap between what the city provides and the true cost for a school-based behavioral health provider is to be filled through Medicaid reimbursable services. However, CBO's are struggling to fill that gap. The city needs to provide funding that is stable and keeps up with the cost of living in order to make filling that gap attainable. We already struggle with being competitive enough to attract providers. Under the current budget proposal, we may be at risk of CBO's pulling out of the program altogether.

Stabilizing this funding is also important, because it only addresses part of our school-based mental health program. It is my understanding that Medicaid only pays for treatment that includes a diagnosis. Medicaid is not a good vehicle to pay for preventive services. We need to provide adequate funds outside of Medicaid, so that providers are better positioned to provide preventive services and not be completely focused on seeking Medicaid reimbursable opportunities.

We also need additional funding to support DBH efforts to innovate approaches to Tier 1 and 2 services models that don't call for the highest level of education and to immediately put in place recommendations based on the results of the DBH study of CBOs. Our difficulty with this funding is complex down to the fact that not all providers are reimbursed at the same rate for identical services due to varied license types, requirements and cost structures.

Providers in every school are absolutely needed but if we keep having to fight for this particular piece of the program year after year, we will never get to the point where we can take a step back, look at what we have learned and make needed adjustments.

Please don't wait until the next budget cycle. Losing funds for school-based providers or staying budgetarily stagnant is not good enough. I think we can all agree on what not addressing school-based behavioral health challenges aggressively is costing us individually and as a community.

I have included in my testimony some of the payment challenges that we need to resolve and a few potential solutions but again, how can we get to that if we can not pin down permanent recurring appropriate funding for the anchor component of the School-based Behavioral Health program, our clinicians?

Thank you for Your Time.

Challenges:

1. Tier 1:
    a. Medicaid Insured Children
        i. covers most services
    b. Privately Insured Children
        i. Some CBO's are able to absorb the cost
        ii. Some waive co-pays
        iii. Some CBO's charge a Out-of Network rate
        iv. Some CBO's try to sign-up with student's private insurers
            1. If successful
                a. Some parents are able to pay the copay
                b. Some parents decline service because they can not afford the copay for on-going treatment
            2. Some insurance companies are at their required provider cap and will not take on new providers.
        v. Some CBO's do not provide services to privately insured students
    c. Non-Insured Children
        i. DBH may be able to cover cost
    d. Students with IEPs and 504s
        i. May not access Tier 1 services through the school-based mental health program

1. Must get services added to IEP / 504 and access services via the LEA assigned provider
    a. LEAs must have appropriately qualified staff to meet the diverse needs of children who need temporary services.

2. Tier 1 and 2
    a. Not insurance reimbursable
    b. Medicaid reimburse requires a diagnosis
3. Cohorts 3 and 4 have a lot more privately insured students than Cohorts 1 and 2.
    a. A system heavily dependent on Medicaid reimbursement is very difficult to implement in Cohort 3 and 4 schools.
4. Provider Type Varies
    a. Not all providers are reimbursed by Medicaid at the same rate for identical services
        i. Depends on license type, requirements and cost structure

Potential Payment Solutions Routes to Varied Challenges to Condenser

1. Floating DBH team assigned to meet temporary mental health needs of students with IEPs and 504s.
2. Begin conversation with LEAs regarding the decision to set up Medicaid reimbursement for IEPs/504s and SBBH differently such that students with disabilities may not access SBBH providers for Tier 1 services.
3. Fund Private insurance co-pays for SBBH
4. Behavior health co-pays for children receiving insurance the the DC Health Benefits Exchanges should be reduced to $5 in 2024.

5. Shift to model in which Tier 1 and 2 are based on grants and Tiers 3 is paid for by insurance

Amy Muhlbach
Washington, D.C.
March 30, 2023

Testimony of Capital Clubhouse, Inc.
Regarding D.C. Mayor's FY 2024 Budget

Dear members of the council,

Thank you for the opportunity to submit a testimony today to the committee on Health regarding the DC Mayor's budget for FY2024. My name is Amy Muhlbach and I am the Program Director at Capital Clubhouse Inc, a nonprofit organization that serves adults in DC with severe mental illness.

Our program uses an evidence-based practice that focuses on a structured, work-ordered day that is utilized by over 300 Clubhouses around the world. Clubhouse members work together toward a common goal of managing and running the Clubhouse. In doing so, they regain a sense of self-worth and autonomy. This leads to enhanced employment, education, and independent living outcomes. The Clubhouse model also leads to a reduction in incarcerations, and reduced public mental health costs, largely due to a decrease in psychiatric hospitalizations.

Capital Clubhouse became certified by the Department of Behavioral Health in October 2019. It is a testament to our members and the power of the community that we were able to stay open virtually during the pandemic, and even add new members. We returned to in-person services in 2021 and continue to grow in membership.

To continue to remain open, Capital Clubhouse is in need of expanded sources of funding. Currently, we can bill through Mental Health Rehabilitation Services for members who are eligible, but we do not deny services to people if they are not eligible for MHRS. It would be a great financial help if we could bill for any Medicaid beneficiary, regardless of their eligibility for MHRS. This would not require a big shift in the budget but would make a difference in terms of being able to serve our members. We estimate that this change in billing would increase our funding by $120,000 annually so we can fill the gap and better serve 10 more people each year. For us, this would be a significant increase in our funding to help us build and expand our services.

Other cities are recognizing the importance of Clubhouse for their citizens. The mayor of Baltimore recently approved $500,000 in city funding for B'More Clubhouse. The mayor of New York announced in January he will be investing $7 million to expand the number of Clubhouses in New York City.

In 2020, the Committee on Community Investments reported that "the District should increase investments in the Clubhouse model of psychosocial rehabilitation," specifically noting that "Capital Clubhouse is D.C.'s only Clubhouse," and stressing the importance of its continued operations."

We are a small organization now, but with more support and funding, we will be able to increase our visibility, grow our membership and reach our full potential to be a more robust resource to serve DC residents with mental illness.

Statement of Need for the Clubhouse Model in D.C.

Quantitative indicators of the need for Washington DC to enlarge its panoply of mental health services to include a well-consolidated Clubhouse (viz., Capital Clubhouse, the only one currently in operation) are provided in the table below, followed by qualitative indicators.

NEED	DATA	REMARKS	SOURCE
High incidence of mental illness	129,000 DC adult residents (22.8%) live with mental illness.	7th highest in the US; national average is 19.9%.	*Mental Health America, The State of Mental Health, 2022*
Unequal distribution of need	A large part of Ward 7 and all of Ward 8 experience poorer mental health compared to the rest of the city. These residents also face elevated risks of exposure to violence and related trauma.	Some 60% of Capital Clubhouse members are from Ward 8 (vs the Ward's share in DC's population of 11%).	*DC Health Matters*
High rate of homelessness	Washington DC has an estimated 90.4 homeless individuals per 10,000 people. 1 in 6 of the homeless are likely to suffer from mental illness.	The homeless rate is well above any other state, and double that of the 2nd highest (NY).	*Statista Research Department*
Inadequate support	Support in the area is strained. DC's mental health system provides services to only 42% of resident adults with serious mental illness.	Existing programs are underfunded and largely focus on temporary treatment rather than an ongoing recovery process – the hallmark of the Clubhouse model.	*NAMI, State Statistics, District of Columbia*
Unmet needs	About one quarter of DC adults with a mental illness report unmet need, which is higher than in 42 other States and above the national average (20.8%).	As an example, some 60% of DC adults with depression have unmet need for depression services (pre-COVID).	*Rand Corporation, Behavioral Health in the DC: Assessing Need and Evaluating the Public System of Care*
Financial strain on clients	Washingtonians are over 6 times more likely to be forced out-of-network for mental health care than for primary health care. Of the 52,000 DC adults who did not receive needed mental health care, 23.5% did not because of costs.	This makes care both more difficult to find and less affordable. Against this, access to and services of a Clubhouse are free.	*NAMI, State Statistics, District of Columbia*

In addition to the above quantitative needs, there also is a qualitative need expressed directly by the community. While a relative newcomer, Capital Clubhouse has received appreciable attention in regulatory changes and in city planning documents:

- Community support for regulatory changes to promote the Clubhouse model: after the closure of the original DC Clubhouse (Green Door), existing DBH regulations hindered the opening of a new Clubhouse. The sustained advocacy of mental health activists and support by the Committee on Health generated the needed changes in May 2019.

- The need for a Clubhouse was explicitly recognized in the "Report of the Committee on Community Investments & Alternatives to the Criminal Justice System to the District Task Force on Jails & Justice" (October 29, 2020). The Report puts forth a Recommendation that "the District should increase investments in the clubhouse model of psychosocial rehabilitation," specifically noting that "Capital Clubhouse, in downtown D.C., opened in 2019 and is D.C.'s only clubhouse," and stressing the importance of its continued operations.

- Support of the clubhouse model was also provided by the District's Task Force on Jails & Justice. Its report of February 2021 advocated establishing "a second 'clubhouse'… to provide individuals with behavioral health needs, the opportunity to engage with long-term support to obtain housing, employment, and other services." This is welcome, but there is also a need to consolidate the presence of the sole existing Clubhouse, as per this Project.

- Capital Clubhouse was selected by Delegate Eleanor Holmes Norton as one of 10 candidates (out of 80 requests) for Community Project Funding in DC, and included in the final Consolidated Appropriation of 2022, ensuring its eligibility for this NOFO.

- Capital Clubhouse has a wide network of community partners. It is a member of the DC Behavioral Health Association and of the Coalition for Non-Profit Housing and Economic Development (CNHED) and partners with various volunteer organizations (notably the VISTA Americorps program and the Lutheran Volunteer Corps), local employers, colleges, and universities. It participates in the Washington Metropolitan Police Department's Crisis Intervention Officer training. Finally, has received supportive testimonials from, among others, Congressman Jamie Raskin (keynote speaker at the 2022 Benefit); former Congressman Patrick J. Kennedy, founder of the Kennedy Forum; Marilyn Benoit, Medical Director of The Devereux Foundation's Chesapeake Network; Pete Earley, mental health advocate and author; Kimberly Clark, Chief of the Mental Health Division at the DC Public Defender Service; and NAMI DC.

- On May 3, 2022, US Secretary of Health and Human Services Xavier Becerra and US Secretary of Labor Marty Walsh visited Capital Clubhouse, to kick off Mental Health Awareness month, joining Clubhouse members and staff in a roundtable discussion on the benefits of the Clubhouse model and its Employment Program.

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Districts Task Force on Jails and Justice Report (February, 2021): http://www.courtexcellence.org/uploads/publications/TransformationStartsToday.pdf

Delegate Eleanor Holmes Norton selects Capital Clubhouse for Community Project Funding in D.C.: https://norton.house.gov/media-center/press-releases/norton-announces-selections-for-community-project-funding-requests

Press Release of Baltimore Clubhouse Funding: https://mayor.baltimorecity.gov/news/press-releases/2022-07-06-mayor-scott-announces-first-round-recovery-office-awards-nonprofits

New York City Mayor's plan to fund Clubhouses: https://www.nytimes.com/2023/03/02/nyregion/eric-adams-mental-illness-plan.html

New York City Mental Health Plan: https://www.nyc.gov/assets/doh/downloads/pdf/mh/care-community-action-mental-health-plan.pdf

March 30, 2023

DC Council, Committee on Health
Budget Oversight Hearing

Minetre Martin
Organizing Manager
Education Reform Now DC

Chairperson Christina Henderson and Committee on Health Members,

My name is Minetre Martin, I have a bachelor of science in psychology, I am a former classroom teacher, a Ward 4 resident, and Organizing Manager for Education Reform Now DC (ERN DC). ERN DC is a non-partisan, nonprofit organization that advocates for a just and equitable public education system for all students in Washington, DC. Today, I am testifying to advocate for improved behavioral health resources in schools.

According to the American Foundation for Suicide Prevention (AFSP), in Washington, DC, suicide is among the leading causes of death for youth ages 10-24,[1] predominantly affecting Black youth.[2]

[1] American Foundation for Suicide Prevention. (2021). District of Columbia: Suicide and mental health fact sheet.
[2] American Academy of Child & Adolescent Psychiatry. (2022). AACAP Policy Statement: Increased suicide among Black youth in the United States.

To put more detailed data into perspective, Let's take a moment to imagine a classroom of 25 high school students in Washington, D.C. Among these students,

1. About 13-14 of them, which is more than half of the classroom, would have experienced persistent feelings of sadness or hopelessness or seriously considered attempting suicide, according to a recent survey.[3]
2. Approximately 2 students in this classroom would have witnessed or experienced violence, reflecting the 7.4% rate in DC, which is nearly double the national average of 3.8%.[4]
3. If the students come from low-income households, the number of those who have witnessed or experienced violence would increase to around 3-4 students, reflecting the 14% rate, more than twice the national average of 6.8%.[5]
4. Among LGBTQ+ students they would have twice the likelihood of reported suicidal thoughts, compared to heterosexual students, showing that LGBTQ+ youth are at a significantly higher risk.[6]

Alarmingly, one of those students could be your child, your child's friend, your neighbor, or in my case, a former student.

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[3] Office of the State Superintendent of Education. (2019). 2019 District of Columbia Youth Risk Behavior Survey: High School and Middle School Reports. Retrieved from https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2019%20DC%20YRBS%20Report.pdf

[4] Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved January 8, 2023, from https://www.childhealthdata.org/browse/survey/results?q=9535&r=10

[5] Ibid

[6] Suicide risk among LGBTQIA students in Washington D.C.: Office of the State Superintendent of Education. (2019). LGBTQ Student Report. Retrieved from https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/LGBTQ%20Student%20Report%20FINAL.pdf

These numbers demand that we prioritize the emotional and mental well-being of our children. Our youth face challenges deeply rooted in their development, and childhood trauma can profoundly impact their growth into adulthood. Yet, we are shocked that only 8 out of 100 9th graders in DC will complete postsecondary education within six years after high school.[7]

According to the Department of Behavioral Health (DBH) school-based behavioral health services have the highest utilization with 26,681 individuals served. We applaud the Mayor for not cutting school-based behavioral health services during a fiscally challenging year. However, the Mayor only proposed a $113,000 increase, which we know is not sufficient to meet the needs of all of our students. What is the strategy for improving the pipeline of clinicians?

To improve mental health support in our schools, I ask this committee to consider the following budget request and suggestions:

Increase funding for school-based behavioral health services to $5.7 million for FY 2024 to ensure stable compensation per clinician

The FY 2023 budget allotted $80,000 per clinician per school to place a community-based organization (CBO) clinician in each of DC's 253 public schools. Due to staffing cost increases, DBH increased funds for CBOs by over 40%, to $99,000 per clinician per school in December 2022. However, CBOs are still facing challenges in recruiting and retaining clinicians due to a shortage of behavioral health care professionals in the District. We applaud DBH's efforts and urge them to invest at least $5.7 million in the SBBH program to ensure stable compensation for partnering CBOs in fiscal year (FY) 2024.

[7]DC Policy Center. (2022, October 27). Schools 2021-2022: How DC students, teachers, and parents are faring. Retrieved from https://www.dcpolicycenter.org/publications/schools-21-22/

We also recommend the following:

1. **Ask the Committee of the Whole to hold a public hearing on the B25-0055, the "Pathways to Behavioral Health Degrees Act of 2023."**

Community members have been discussing this bill and believe that it is time to take action. Holding a hearing would be a step in the right direction to address the District's long-term goals. Holding a public hearing will increase awareness of the proposed legislation among the general public and stakeholders, allow for a comprehensive discussion of these provisions, ensuring they are well-designed and effective in attracting and retaining students in this field, and help to ensure that mental health professionals better reflect the communities they serve.

Thank you for your time and consideration.

DC Council, Committee on Health
Budget Oversight Hearing

Rabiatu E Barrie, PhD
Civic Leader
Education Reform Now DC

Chairperson Christina Henderson and Committee on Health Members,

I am Dr. Rabiatu Barrie, a Licensed Clinical Psychologist, Assistant Professor at the University of Maryland, and a civic leader for Education Reform Now DC. Thank you for the opportunity to testify before you today. In this testimony, I will present actionable steps to enhance mental health services in DC Public Schools, supporting the overall well-being and success of our students.

Our primary asks are:

1. Ensure stable compensation per clinician in FY 2024
2. Ask the Committee of the Whole to hold a public hearing on the B25-0055, the "Pathways to Behavioral Health Degrees Act of 2023."

We propose the following solution:

Increase funding for school-based behavioral health services to $5.7 million for FY 2024 to ensure stable compensation per clinician

The FY 2023 budget allotted $80,000 per clinician per school to place a community-based organization (CBO) clinician in each of DC's 253 public schools. Due to staffing cost increases, DBH increased funds for CBOs by over

40%, to $99,000 per clinician per school in December 2022. However, CBOs are still facing challenges in recruiting and retaining clinicians due to a shortage of behavioral health care professionals in the District. We applaud DBH's efforts and urge them to invest at least $5.7 million in the SBBH program to ensure stable compensation for partnering CBOs in fiscal year (FY) 2024.

We also recommend the following:

1. **Ask the Committee of the Whole to hold a public hearing on the B25-0055, the "Pathways to Behavioral Health Degrees Act of 2023."**

Community members and clinicians have been discussing this bill and believe that it is time to take action. Holding a hearing would be a step in the right direction to address the District's long-term goals. Holding a public hearing will increase awareness of the proposed legislation among the general public and stakeholders, allow for a comprehensive discussion of these provisions, ensuring they are well-designed and effective in attracting and retaining students in this field, and help to ensure that mental health professionals better reflect the communities they serve.

By implementing these measures, the DC Council will send a strong message about its dedication to promoting mental and behavioral health in schools.

In conclusion, investing in school-based mental health services is vital for the well-being and success of our students. The proposed solution, supported by the DC Council's commitment, can make a lasting positive impact on the lives of countless children and adolescents in the District of Columbia.

Thank you for your time and consideration. I am happy to answer any questions you may have.

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Testimony Before the District of Columbia Council
Committee on Health
March 30, 2023

Public Hearing:
Budget Oversight Hearing
Department of Behavioral Health

Amber Rieke
Project Lead, Path Forward
Children's Law Center

Introduction

Good afternoon, Chairperson Henderson and members of the Committee on Health. My name is Amber Rieke and I am testifying today on behalf of Children's Law Center. 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.

Children's Law Center co-authored a 2021 report called *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*,[1] which detailed 94 recommendations to better meet the needs of DC children and families. As the Project Lead for *A Path Forward*, my work is focused on driving forward the recommendations contained in our report.

Children's Law Center is also a Co-Chair of the Strengthening Families Through Behavioral Health Coalition, which brings together a diverse group of advocates focused on education, juvenile justice, child welfare, and health, as well as representatives of the provider community and community-based organizations who

share a commitment to improving DC's behavioral health care system for children and families. Our Coalition's mission is to ensure DC has a fully integrated behavioral health care system in which all DC students, children, youth, and families have timely access to high-quality, consistent, affordable, and culturally responsive care that meets their needs and enables them to thrive.[2] My organization is also a proud member of the Fair Budget Coalition.

Thank you for this opportunity to testify regarding the proposed FY2024 budget for the Department of Behavioral Health (DBH). Today's testimony asks the Committee to support District-wide efforts to address the youth mental health crisis by:

1. Increasing funding for School-Based Behavioral Health Expansion (SBBH) by $5.7 million, to sustain compensation for clinicians; and
2. Restoring the apparent $655,000 cut to Healthy Futures.

Symptoms of poor mental health, including depressive symptoms and suicidal ideation, have been steadily increasing among American youth for over a decade.[3] The disruption, isolation, and health impacts of the COVID-19 pandemic only exacerbated this growing crisis.[4] The results of a 2021 survey revealed that a stunning 28% of DC middle school students have seriously thought about killing themselves (18.3% for high schoolers).[5] As the U.S. Surgeon General said in 2021: "It would be a tragedy if we beat back one public health crisis only to allow another to grow in its place. Mental health

challenges in children, adolescents, and young adults are real, and they are widespread. But most importantly, they are treatable and often preventable."[6]

Unfortunately, there are also acute challenges to connecting to these treatments. At Children's Law Center, the children we work with – including those in the foster care system, receiving special education services, or dealing with unhealthy housing conditions – often have significant behavioral health needs. Their greatest obstacle to services is the lack of behavioral health care professionals practicing in the District. Our clients consistently report that they are unable to find providers offering the services they need – or if they manage to find a provider, the waitlist for an appointment is prohibitively long.

We, therefore, evaluate the Mayor's proposed DBH budget for the next fiscal year asking: how does it support youth mental health? We are pleased to see that the proposed budget includes a significant increase for behavioral health provider payments. This increase will help build an adequate network of professionals willing to participate in Medicaid and other public programs. Unfortunately, we also see reductions in essential prevention and treatment work for youth, including SBBH and Healthy Futures, as well as Child and Adolescent Mobile Psychiatric Service (ChAMPS) and substance use disorder (SUD) prevention.

We fear that reductions in SBBH, Healthy Futures and other youth-serving programs will undercut the capacity for caring professionals to deliver tailored

interventions to children and teens, at a time when public health data urges us to do the opposite.

The School-Based Behavioral Health Expansion Program Offers DC Students a Lifeline in a Time of Immense Need

The SBBH program embeds timely, high-quality, consistent, and culturally responsive behavioral health care where children spend most of their time: school. SBBH partners with Community-Based Organizations to staff skilled clinicians in every DC traditional and charter public school. Through this embedded professional, schools have a whole new avenue for improving well-being, from building skills in emotional regulation across the school population to individual therapeutic services.

Along with measures of poor mental health noted above, the YRBS revealed that not enough DC middle and high schoolers have adults in their lives to discuss their issues. Only 31.1% of middle schoolers and 21.3% of high schoolers said they would most likely talk with their parent or another adult family member about their feelings. And less than two-thirds of students said there is at least one teacher or other adult in their school that they can talk to if they have a problem (62.4% of middle schoolers and 63.3% of high schoolers.)[7]

DBH's program is among the first to break ground amid a growing nationwide movement to address mental health concerns; the pandemic was a key catalyst for efforts to expand service access in schools. During the 2021-22 school year, 67% of U.S.

schools reported increasing the type or amount of mental health services provided, 46% reported creating or expanding programs for students' social/emotional/mental well-being, and 41% reported hiring new staff to focus on student mental health and well-being.[8] Only 68% of public schools have a school- or district-employed mental health professional on staff, and even fewer (51%) employ an external mental health provider as the District does.[9]

The public health approach of co-locating mental health services with schools removes many burdens and barriers to treatment, and the use of community-based organizations creates the potential for lasting care relationships beyond the school setting. The clinicians facilitate mental health support across three tiers, such as general social-emotional lessons (Tier 1), small support groups (Tier 2), or individual therapy sessions (Tier 3).[10] In the District, CBO grants from DBH are meant to cover a part of the compensation and supervision costs for clinicians. The initial funding model and grant amount was based on early estimates regarding the costs of the program, and projections that CBO clinicians would spend at least 50% of their time on Tier 3 services reimbursable by Medicaid.[11] Since the original map was drawn, several circumstances and challenges have hampered the roll-out – not least of which was the changed educational landscape during the COVID-19 pandemic.

Despite these obstacles, the program now funds a clinician in every school and is meeting critical needs. However, as we testified during Performance Oversight, a

critical shortage of behavioral health care professionals in the District – and across the country – has been a barrier to full implementation.[12] The program is still developing, each school community is charting its needed course, and evaluation and cost studies are underway. Schools are also still building their systems for referrals; though the numbers are increasing, many clinicians reportedly haven't reached their service capacity yet.[13] In this time of hard-won growth, the District should continue to invest – not withdraw – in fully staffing SBBH.

The District Must Sustain Current Levels of Compensation for SBBH Clinicians in Fiscal Year 2024

DBH leadership has been responsive to hiring difficulties by increasing CBO grants to allow for salary increases and/or hiring and retention bonuses for clinicians.[14] In December 2022, DBH granted CBOs $99,371 per clinician for compensation and supervision. CBOs were relieved to be able to offer incentives beyond the $80,000 approved in the FY23 budget to retain and attract highly educated – and highly sought-after – licensed clinical social workers. The Strengthening Families Coalition, along with Fair Budget Coalition, are requesting the Council ensure that this compensation is stable in FY 2024, with an inflationary increase: of about $103,000 per clinician for all 253 schools. This totals $26,059,000 for CBO grants.

As the line item which contains SBBH has not significantly increased, we assume that funding has remained flat from FY23. In other words, we see a reversion to levels

before this winter's enhancements – a functional cut. We, therefore, need an additional $5.7 million to keep clinician compensation stable. We also support maintaining the investments in program evaluation and data collection, as well as the Community of Practice which brings together providers, staff and school leaders in a collaborative learning environment to share best practices, support and participate in learning activities. Continued investment in the CoP is essential to building provider capacity and maintaining consistent quality of services across the program. As we struggle to hire clinicians in the face of an unprecedented shortage of professionals, we must maintain the CBO's ability to offer competitive pay, incentives, and professional support for these essential roles. Reverting to the old grant amount will result in losing clinicians and puts the whole program at risk.

The Committee Must Restore Healthy Futures Funding to Meet the Needs of DC's Earliest Learners and Their Caregivers

Healthy Futures similarly seeks to provide access to a behavioral health professional in spaces where children already are: child development centers and home childcare. Healthy Futures serves children ages zero to five and utilizes an early childhood mental health consultant (ECMHC) model to create a collaborative relationship between a professional consultant with early childhood mental health expertise and one or more caregivers, typically the early education provider and/or family member.[15] The collaborative relationship of consultant and caregiver aims to

build the capacity of staff, families, and programs and support children's healthy development, social emotional health, and school readiness.[16]

As we discussed in performance oversight, despite numerous challenges, the number of child development centers and home childcare providers that Healthy Futures operates in has consistently grown over the past three years.[17] In FY2022 alone, the early childhood mental health specialists served 7,571 children across 102 centers, provided 65 parent workshops, 384 parent consultations and 1,354 director consultations.[18]

Last year, the Council added $700,000 to the Healthy Futures budget to support continued expansion.[19] The funding added last year in the FY2023 budget by the Committee on Health increased capacity for Healthy Futures to support 26 early childhood clinical specialists, 3 supervisors, and a Program Manager.[20] Once fully staffed at the FY2023 funding level, Healthy Futures can serve up to 182 child development centers and home childcare providers.[21] This would bring us over halfway to the original goal of having Healthy Futures in 300 child development centers and home providers as envisioned in the Birth-to-Three for All Act of 2018.[22]

The Mayor's proposed budget appears to include a $655,000 cut to Healthy Futures.[23] To the best of our understanding, we believe this money was cut because it appeared the agency did not utilize it. As explained during performance oversight,

however, this was due to a programming error and not for a lack of need or demand for these services.[24]

Restoring this funding will allow Healthy Futures to continue to hire and expand into the projected 182 child development centers and home childcare providers. We, therefore, ask the Committee to ensure the $655,000 remains in the Healthy Futures budget.

DBH Must Maintain a Framework of Support for Youth, including Crisis Response and Substance Use Disorder Prevention

Alongside the program cuts detailed above, Children's Law Center is concerned by cuts to other important services. The proposed DBH budget includes a reduction of $2,677,036 and 4.7 FTEs across divisions that include funding for mobile crisis services, for the general population through the Community Response Team (CRT) as well as for children and youth through ChAMPS,[25] in addition to cutting the budget for SUD prevention services in half.[26] Further, the budget notes it swept funding from crisis stabilization beds, pharmaceutical costs, and contracted services. We ask the Committee to clarify with the agency how these funding decreases will impact services for youth and to make changes as needed to ensure service levels are not diminished, particularly in the context of the concurrent crises of poor mental health and service shortages.

Increased Provider Payment Rates for Behavioral Health Services Will Better Support a Broad, Diverse Provider Network

The consistent theme of the work to improve mental health is the imperative to create more places and professionals to do behavioral health care. This is done, in part, through sufficient pay for providers in public programs. Just as SBBH and Healthy Futures need sufficient grant funds, providers must be sufficiently paid for services in hospitals, health centers, primary care, and private practice offices, if they are to participate in Medicaid.

Over the past few years, DHCF has initiated several major changes to the District's behavioral health system that will expand what care Medicaid will cover as it also moves toward a fully managed Medicaid program by 2024.[27] Beginning October 1, 2023, behavioral health services will be integrated into the District's managed care contracts.[28] DBH and DHCF share the responsibility to ensure there are enough providers in MCO networks to meet the needs of beneficiaries, as is required by Medicaid rules. Yet through last year's budget, DBH's reimbursement rates for behavioral health care for people enrolled in Medicaid (Behavioral Health Rehabilitation Services) and for those disqualified from Medicaid (Mental Health Rehabilitation Services) had not been adjusted beyond 2016 rates. The effect is that providers are being paid 17.5% less than if rates had increased with the Medicare Economic Index, minus 6.2%, DBH and DHCF added over 2022.

Therefore, we are heartened to see significant increases in some of the lines for provider payments in both agencies' budgets. Specifically, DBH increased the line for Behavioral Health Rehabilitation Services (Local Match) by $17,760,000 from FY23 for a total of $61 million. We need an increase of at least $7.5 million in the reimbursement levels to achieve the 17.5% inflationary increase, and we hope that this is included in the enhancement. We want to better understand the line, and whether the additional $10 million reflects further increases to rates (i.e. higher payments) and/or an anticipated increase in volume of services (i.e. more patients). In light of this enhancement, it is unclear why the line in the budget for Mental Health Rehabilitation Services (Local Only) – services for people ineligible for Medicaid – has not increased a single dollar. We believe providers for these services should also have an increase to payments of 17.5%, or about $1.9 million enhancement.

We recognize that DBH and DHCF are basing future provider payment rates on the ongoing behavioral health reimbursement rate study, which is intended to improve rates and rate-setting methodologies. We noted at oversight hearings that it is important that this rate study prioritizes reimbursement of children's behavioral health services. We expect the forthcoming rate study to reflect the realities of the workforce landscape, such as adjustments for high turnover and retention costs, and national salary data.[29] In the meantime, we wish to better understand the changes that have been made, and how they will work to improve the service network in FY 24.

Conclusion

In a year of tough choices, the District is challenged to weigh the most pressing issues and the wisest investments. We urge you to continue to prioritize the youth mental health crisis. To ensure investments lead to strong, sustainable and well-utilized programs, the District must not retract its funding or staff capacity for behavioral health programs and services. We ask the Committee on Health to maintain funding for SBBH clinicians, reverse cuts to Healthy Futures, maintain capacity for programs that prevent and respond to crises, and pay behavioral health providers sufficiently. If the District stays steadfast in its commitments, it can create systemic change, improve well-being for kids and families, and advance health equity for now and in the generations to come.

[1] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf. This report is released by Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition.

[2] Strengthening Families DC, Strengthening Families Through Behavioral Health, *available at*: https://www.strengtheningfamiliesdc.org/.

[3] U.S. Office of the Surgeon General (OSG), *U.S. Surgeon General Advisory: Protecting Youth Mental Health,* p. 8 (December 7, 2021), *available at:* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

[4] In addition to increased suicidality, the 2021 DC Youth Risk Behavior Survey (YRBS) revealed that about 12% of middle and high school students had taken prescription pain medicine without a prescription. Over 19% of middle school students and over 25% of high schoolers reported that their mental health was not good most of the time, or always (including stress, anxiety, and depression). One-fifth (20%) of high school students went without eating for 24 hours or more to lose weight or to keep from gaining weight. In the general population, only 20% of children with a behavioral health disorder will ever receive care from a specialized provider. The unmet need is worse for children of color. *See* OSSE, 2021 DC YRBS Middle School Trend Analysis Report, QN29, p. 8, QN62, p. 17, *available at*: https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2021DCBM%20Trend%20Report.pdf; OSSE, 2021 DC YRBS High School Trend Analysis Report, QN49, p. 14, QN106, p. 32, *available at*: https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2021DCBH%20Trend%20Report.pdf; 2021 American Academy of Child and Adolescent Psychiatry, Best Principles for Integration of Child Psychiatry into the Pediatric Health Home (June 2012), *available at*: https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf; Vikki Wachino, et al., *The Kids Are Not All Right: The Urgent Need to Expand Effective Behavioral Health Services for Children and Youth*, USC-Brookins Schaeffer on Health Policy (December 22, 2021), *available at*: https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/12/22/the-kids-are-not-all-right-the-urgent-need-to-expand-effective-behavioral-health-services-for-children-and-youth/.

[5] OSSE, 2021 DC YRBS Middle School Trend Analysis Report, QN14, p. 2, *available at*: https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2021DCBM%20Trend%20Report.pdf; OSSE, 2021 DC YRBS High School Trend Analysis Report, QN26, p. 6, *available at*: https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2021DCBH%20Trend%20Report.pdf.

[6] OSG, *U.S. Surgeon General Advisory: Protecting Youth Mental Health,* p. 4 (December 7, 2021), *available at:* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

[7] OSSE, 2021 DC Youth Risk Behavior Survey (YRBS) Data Files, *available at*: https://osse.dc.gov/node/1635216; OSSE, 2021 DC YRS Middle School Trend Analysis Report, QN69, p. 19, *available at*: https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2021DCBM%20Trend%20Report.pdf; OSSE, 2021 DC YRBS High School Trend Analysis Report, QN118, p. 35, *available at*:

https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2021DCBH%20Trend%20Report.pdf.

[8] Nirmita Panchal, Cynthia Cox, & Robin Rudowitz, *The Landscape of School-Based Mental Health Services*, Kaiser Family Foundation (September 6, 2022), *available at*: https://www.kff.org/other/issue-brief/the-landscape-of-school-based-mental-health-services/.

[9] *Id.*

[10] DBH, Guide to Comprehensive Behavioral Health, p. 2–4, *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/PRIMARY%20GUIDE_SCHOOL%20BEHAVIORAL%20HEALTH_JUNE%202019.pdf.

[11] Tami Weerasingha-Cote, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, p. 7 (June 2, 2021), *available* at: https://childrenslawcenter.org/wp-content/uploads/2021/07/TWeerasingha-Cote_Childrens-Law-Center-Testimony-for-June-4-2021-DBH-Budget-Oversight-Hearing_FINAL.pdf.

[12] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health (February 1, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/Amber-Rieke_CLC_Performance-Oversight-Testimony_DBH_February-1-2023_SBBH_final-1.pdf.

[13] ChildTrends data on referrals and caseloads presented at DBH Coordinating Council on School Behavioral Health on March 20, 2023.

[14] DBH Coordinating Council on School Behavioral Health slide deck shared via email on December 19, 2022.

[15] Under 3 DC Coalition, Healthy Futures Factsheet (2020), *available at*: https://under3dc.org/wp-content/uploads/2020/04/U3DC-Factsheet-Healthy-Futures.pdf; DBH, FY2022 Performance Oversight Responses, response to Q41, p. 38–39, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy-4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1.

[16] Mary Mackrain, *A Day in the Life of an Early Childhood Mental Consultant*, Center for Early Childhood Mental Health Consultation, p. 3 (December 2021), *available at*: https://www.iecmhc.org/documents/Day_in_the_Life_MH_Consultant.pdf; DBH, FY2022 Performance Oversight Responses, response to Q41, p. 38–39, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy-4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1.

[17] Sharra E. Greer, Children's Law Center, 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. On average, Healthy Futures has grown by 22 sites between FY20 and FY22 (FY21 (87 cites) - FY20 (58 cites) = increase of 29 sites between 1 year. FY22 (102 cites) - FY21 (87 cites) = increase of 15 cites between 1 year. Average = 29+15 divided by 2 = 22 sites increase on average over two years). In FY2020, Healthy Futures was working with 58 child development centers and home providers, and in FY2021, the number of child development centers and home providers grew to 87. In FY2022, Healthy Futures was working in at 102 child development centers and home providers. Additionally, Healthy Futures is expanding its programmatic reach by implementing a pilot program to expand Healthy Future services by providing beyond consultation to include on-site mental health services, including direct

clinical support to children. This pilot program is being implemented at eight child development centers that already employee the early childhood mental health consultation model piece of Healthy Futures. These additional services will help connect children with early intervention services that will serve them in the long term. Finally, as noted in performance oversight, Healthy Futures will be evaluated by Georgetown University Center for Child and Human Development (GUCCHD). This evaluation will help provide analysis of the program's successes and gaps as well as next steps to support the program's needs. *See* DBH, FY2020 Performance Oversight Responses, responses to Q54, *available at*: https://dccouncil.gov/wp-content/uploads/2021/06/dbh.pdf; DBH, FY2021 Performance Oversight Responses, responses to Q45, *available at*: ; DBH, FY2022 Performance Oversight Responses, responses to Q41 and Q43, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy-4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1.

[18] DBH, FY2022 Performance Oversight Responses, response to Q41, p. 39, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy-4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1.

[19] District of Columbia Council Committee on Health, Report and Recommendation on the FY2023 Budget and Financial Plan for Agencies Under Its Purview (April 29, 2022), *available at*: https://lims.dccouncil.gov/downloads/LIMS/49081/Committee_Report/B24-0716-Committee_Report5.pdf; FY2023 Approved Budget and Financial Plan, FY2023 DBH Budget, Table RM0-4, p. E-28 (August 1, 2022), *available at*: https://app.box.com/s/ujt3jp6ygb2o3wnf625fhjgwrruhxlm4.

[20] DBH, FY2022 Performance Oversight Responses, response to Q41, p. 38, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy-4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1.

[21] *Id* at p. 39.

[22] *Id.*

[23] Specifically, the Early Childhood Services, Line 6635, is described as, "provides in home and center-based early childhood mental health supports and child and family-centered consultation to child development center staff and families to build their skills and capacity to promote social/emotional development and to prevent, identify, and respond to mental health issues among children in their care" and has a $655,000 decrease between FY2023 and FY2024. *See* Mayor's Proposed FY 2024 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Behavioral Health, p. E-24, E-31 (March 22, 2023), *available at*: https://app.box.com/s/kabhvjznbplwq1tkwd2gv66187aw37ii/file/1170978161849.

[24] According to DBH performance oversight responses, nearly $700,000 was placed in an incorrect category (i.e., non - personnel categories - maintenance of persons and subsidies) and must be reprogrammed into the personnel category in order to be utilized by the agency. This amount appears to correspond with the $655,000 that is cut from the Early Childhood Services line in DBH's proposed budget. *See* Mayor's Proposed FY 2024 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Behavioral Health, line 6635, p. E-24 (March 22, 2023), *available at*: https://app.box.com/s/kabhvjznbplwq1tkwd2gv66187aw37ii/file/1170978161849; DBH,FY2022 Performance Oversight Responses, response to Q41, p. 38, *available at*:

https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy-4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1.

[25] Mayor's Proposed FY 2024 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Behavioral Health (March 22, 2023), *available at*: https://app.box.com/s/kabhvjznbplwq1tkwd2gv66187aw37ii/file/1170978161849.

[26] *Id.* at line 6615, p. E-24.

[27]DHCF, DHCF Announce Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts (September 11, 2019), *available at*: https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts.

[28] DHCF Office of the Senior Deputy Director/State Medicaid Director, Letter RE: Behavioral Health Transformation: Updated Timeline, Office of the Senior Deputy Director/State Medicaid Director, p. 2 (December 2, 2021), *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MDL 21-06 BH Transformation Update Timeline 20211202-signed.pdf.

[29] Presentation shared during the DHCF Public Forum on Integrated Care meeting on November 30, 2022.

Budget Hearing
Department of Behavioral Health
Before the Committee on Health
Council of the District of Columbia
March 30, 2023

Good afternoon, Chairperson Henderson and the members of the Committee on Health and thank you for the opportunity to testify. My name is Elizabeth Mohler, and I am the Social Services Director at the Latin American Youth Center (LAYC). Our mission is to empower a diverse population of youth to achieve a successful transition to adulthood through multi-cultural, comprehensive, and innovative programs that address youths' social, academic, and career needs.

We want to thank Dr. Bazron and DBH for providing funding to support National Accreditation as well as guidance as we transition to Managed Care, and we look forward to our continued partnership.

In FY22 LAYC provided behavioral health services to 442 young people, a 22% increase from the year before, and the demand for our services remains strong. LAYC participates in the School Behavioral Health

Expansion, and we are partnered with 11 schools throughout the district. We are concerned that what appears to be flat funding in DBH's FY24 budget, is actually a reduction, because we relied heavily this year on one-time funding that we received for workforce and retention. It appears that the grant per clinician is likely to be reduced from about $99K to something closer to $80K per clinician in FY24. This will have a significant impact on our ability to maintain a committed and competent workforce. We now have clinicians that have been working in schools for several years and are obtaining their independent licenses. To retain their expertise, we will need to compensate them at a higher rate and the proposed funding for FY24 will make that quite challenging.

We urge DBH to maintain their commitment to funding the School Behavioral Health Expansion at FY23 grant levels and improve data collection processes to better reflect the work that is being done by clinicians. We are very disappointed that the data being collected does not match what we know about the hard work our clinicians are doing every day. For example, sometimes progress in School Based Behavioral Health, means a

clinician sitting down with a teacher to help them understand a student's behavior in the context of mental health challenges. This understanding can transform how the teacher facilitates learning for the individual student and have a positive impact on the school culture in general. Alternatively, a clinician can be spending time helping a student de-escalate emotionally outside of a scheduled therapy session so they can return to class and continue their learning for the day. These types of intervention are classified on the data tracker as "School Activity" vs. "Tier 1" and we believe that their value is not being appropriately represented. LAYC would be happy to collaborate with DBH to help improve the tracking system to ensure that the important work of clinicians is accurately captured.

Thank you for your time. I would be happy to answer any questions you may have.

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March 30, 2023

Chairperson Christina Henderson
Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue
Washington, D.C. 20004
The Committee on Health 2024 Department of Behavioral Health Budget Oversight Hearing

Written Testimony of HIPS Advocacy Department

Councilmember Henderson and members of the Committee on Health:

Thank you for the opportunity to address this Committee and D.C. Council. The HIPS Advocacy Department submits written testimony today to support the oral testimony of activists and supporters of the DecrimPovertyDC campaign and to further raise concerns regarding the Mayor's proposed budget failure to properly fund harm reduction work in DC. The Department of Behavioral Health is the city's leader in combating the overdose crisis, but the current strategies are not enough and the District needs to fund the creation of harm reduction centers, better support existing local harm reduction organizations that are on the ground every day, and better support people with lived experiences who work to end the overdose crisis.

Washington DC Needs 24/7 Harm Reduction Centers that Include Overdose Prevention Sites.

At this moment, DC faces an overdose crisis. In 2022, there were 448 opioid-related fatal overdoses. That was an average of 37 deaths per month last year.[1] Nearly 600 Washingtonians died from accidental overdose deaths in 2021.[2] The overdose mortality rate among Black

[1] *Opioid-related Fatal Overdoses: January 1, 2017 to December 31, 2022,* Office of the Chief Medical Examiner, https://ocme.dc.gov/sites/default/files/dc/sites/ocme/Opioid%20related%20Overdoses%20Deaths%206.17.21%20FINAL.pdf (March 17, 2023).
[2] Government of the District of Columbia, Office of the Chief Medical Examiner, "Drug-related Fatal Overdoses: January 1, 2021 to December 31, 2021," https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/2021%20Drug%20related%20Overdoses%20Deaths%20 FINAL.pdf

Washingtonians is the highest in the country. At 107 deaths per 100,000 people, the Black overdose death rate is nearly 10 times higher than the white overdose mortality rate in D.C.[3]

This Council needs to push for the creation of a harm reduction infrastructure by ensuring that the 2024 budget includes funding for two harm reduction centers. The Mayor's proposed budget *failed* to include funding for these centers. **This Council has the opportunity to correct this failure by the Mayor and push for the funding of two 24/7 harm reduction centers.**

DecrimPovertyDC's proposed harm reduction center model includes a facility open 24/7 where individuals can obtain harm reduction services such as sterile equipment and information for safer use of substances, fentanyl test strips, referrals to drug treatment providers, primary health care and other social services. The centers also will provide full drug checking services, a service that is crucial given the current state of the adulterated drug supply. People who use drugs run the risk of encountering substances that contain contaminants, toxic substances, or hazardous compounds.

Further, these centers will provide overdose prevention sites, or safe consumption sites. This component features a private room with trained professionals and peers who provide sterile equipment, where people who use drugs (PWUD) can bring their pre-obtained drugs, test the supply for adulterants, safely administer their drug, and access an array of services on site or through referral. According to health workers at the first legally sanctioned overdose prevention centers in the United States, OnPointNYC, **most participants who choose to decrease their substance use and/or enter more comprehensive drug treatment do so in the safe consumption rooms at harm reduction facilities while speaking with overdose prevention trained professionals.**

By funding these centers, we will also be funding, developing, and supporting the healthcare workforce. Trained health workers will be equipped to intervene if an overdose or adverse drug interaction occurs. Staffed drug checking services will help people understand if fentanyl or other substances are in their drugs, reducing overdose death risk and empowering people to make informed decisions. Funding the centers also means expanding mobile outreach worker capacity. Trained outreach workers will lead community clean-ups, facilitate opioid-overdose reversal training, and raise general awareness about drugs, overdose, and the centers. **This proposed harm reduction infrastructure will be staffed by Washingtonians with lived experience at**

[3] Drug Overdose Death Rate (per 100,000 population) by Race/Ethnicity: 2020. Kaiser Family Foundation.https://www.kff.org/other/state-indicator/drug-overdose-death-rate-per-100000-population-by-raceethnicity/?dataView=1¤tTimeframe=0&selectedDistributions=white-non-hispanic--black-nonhispanic&sortModel=%7B%22colId%22:%22Black,%20Non-Hispanic%22,%22sort%22:%22desc%22%7D

living wages for the area - addressing a myriad of issues that our least invested in neighbors chronically face, like underemployment, housing costs, healthcare costs, and discrimination in the current systems they use to access them.

The Mayor's budget provides significant funding for a District Stabilization and Sobering Center (DCSSC) as her response to the tragedies of the overdose epidemic. We have deep concerns about the Mayor's proposed centers, which are being funded without any input from local stakeholders. We are disappointed to see the Mayor put millions of dollars into a project that is being run by a company from Arizona, which is not informed by the expertise of DC harm reduction workers or Washingtonians with lived experience and does not follow the most up to date evidence-based guidelines. **Most importantly, DC residents, harm reduction workers included, know next to nothing about how these centers intend to operate.** Our response to the overdose crisis will cost lives if we don't do every evidence-based measure at our disposal — and we cannot say in good conscience that the proposed DCSSC is good enough.

The most effective route forward must be one that is fundamentally guided by the principles of harm reduction, and the DCSSC and the city's Long.Live.DC campaign neglect the possibilities offered by this truly holistic approach.[4] The DCSSC proposal lacks a wide enough scope to fully provide the services required for people who use drugs by the proposal's failure to provide drug testing and safe consumption sites. Consequently, **if DCSSC is the city's only response to the overdose crisis, the city will not succeed in serving the needs of people who use drugs, and the overdose emergency will continue to rob vulnerable Washingtonians of their lives.**

DBH has been working to address the overdose crisis through implementing harm reduction tactics, including syringe exchange programs and providing residents with Naloxone. However, these measures have not been enough to successfully curb the number of lives lost due to overdose deaths. The District needs to do more to ensure that we do not lose another person to accidental overdose death. The District needs a much larger investment in public health than we, and other harm reduction workers in DC, can manage at our current capacity. **The proposed harm reduction infrastructure I have raised today, and that DecrimPovertyDC has been campaigning for, will save Washingtonian's lives.**

[4] "Principles of Harm Reduction", National Harm Reduction coalition. https://harmreduction.org/about-us/principles-of-harm-reduction/

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The District's Budget Needs to Better Support Existing Local Organizations that are Doing Life-Saving Harm Reduction Work Every Single Day.

In addition to funding two 24/7 harm reduction centers, this Council also has the opportunity to better support the already existing local harm reduction workers and organizations that are working non-stop to help support District residents. Organizations like HIPS are overburdened and underfunded to handle the needs of the District, and need to be better supported and funded by the government in order for us to be able to best support Washingtonians who use drugs.

After meeting with DBH representatives and the leadership of Community Bridgers, the Arizona based company that has been awarded the first DCSSC contract, local harm reductionists like us at HIPS are deeply concerned about the center and the effectiveness of the current plan. Although the people at Community Bridges seem to care deeply about their work and have done great things for their community in Arizona, they are not situated to provide the care Washingtonians need. Community Bridges plan to rely on already existing local harm reduction organizations for guidance, community connections, and to make referrals to will overburden organizations like HIPS. Instead of pushing money to develop new organizations that will heavily rely on the decades of groundwork and community building of local workers, we urge this council to instead provide adequate money to the local organizations that are run for and by Washingtonians. The District should expand funding to existing local harm reduction organizations and fund the creation of 24/7 harm reduction centers run and staffed by Washingtonians with lived experience, who know what Washingtonians who use drugs need and want.

The Mayor's proposed budget includes a line item to fund a *second* District Stabilization and Sobering Center, even before the first center opens. We urge this Committee and Council to instead of funding the DCSSC model again, to reroute this money to fund true harm reduction centers that provide drug checking services and safe consumption sites, two evidence-based interventions that save lives, improve health conditions, and better people's lives, and that Community Bridges and the DCSSC model refuse to provide. If we do not provide all evidence-based strategies known to save and improve lives, we are failing to do everything we can to stop the overdose crisis in DC. We are failing Washingtonians.

We Need to Fund the Creation of the Office of Opioid Abatement to Ensure the Opioid Litigation Proceeds Can be Utilized to Stop Overdose Deaths in the District.

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The Mayor's proposed budget has also failed to include a line item funding the establishment and maintenance of an Office of Opioid Abatement. This exclusion will mean that the Opioid Abatement Advisory Commission will not be able to be established anytime soon, barring the District's ability of utilizing the opioid litigation settlement funds to fund new strategies and interventions to combat the overdose crisis in DC. This money can be used to fund 24/7 harm reduction centers that directly work to help people who use drugs to prevent death and improve quality of life. If the 2024 budget prioritized funding for the creation and running of the Office of Opioid Abatement, then DC will have the opportunity to access these necessary funds and work to end overdoses.

Our constituents and their families are impacted daily by the harms of drug criminalization, stigma, and a failure to center public health. To save lives, use funds more efficiently, and re-imagine public safety and health, D.C. Council should urgently support the creation of harm reduction centers. I also strongly support the #DecrimPovertyDC's effort to remove criminal penalties for personal use drug possession, address life-long consequences of convictions, and invest in life-saving and stabilizing support and resources instead of punishment. Together, District residents, this Council, and the Department of Behavioral Health can end the overdose crisis through embracing and funding a harm reduction infrastructure that was created, designed, and will be run by DC residents with lived experience.

Thank you for your time and consideration. I am happy to answer any questions you have regarding the overdose crisis and/or the harm reduction centers. Additionally, we can be reached at advocacy@hips.org

Thank you,
HIPS Advocacy Department
Tamika Spellman
Chibundo Egwuatu
Mackenzie Darling

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

To: The Honorable Christina Henderson, Chair, DC Council Committee on Health
Members of the Committee on Health
From: Patricia Quinn, VP of Policy and Partnerships, DC Primary Care Association
Re: Budget Hearing for DC Department of Behavioral Health
Date: March 30, 2023

The DC Primary Care Association (DCPCA) works to build a healthier DC by sustaining community health centers, transforming DC care delivery, and advancing racial and health equity. Our collaborators in this work include community health centers, serving almost 1 in 4 District residents in every ward of the city; District government agencies including the Department of Health Care Finance (DHCF), DC Department of Behavioral Health and DC Health; as well as other providers in the DC health ecosystem. Thank you for the opportunity to provide testimony regarding the work of the District of Columbia Department of Behavioral Health (DBH.)

As the Committee on Health reviews the proposed FY24 budget for DBH, we ask that you be attentive to the following concerns:

Workforce

Between 2019 and 2021, nearly every DC health center saw significant decline in the number of Mental Health visits which FQHC CEOs attribute to the challenges in recruiting and retaining behavioral health clinicians. Health centers delivered almost 35% fewer mental health visits compared to 2019. Given what we know about rates of anxiety and depression, and the exacerbation of mental health conditions during the COVID-19 pandemic, this decline is especially alarming. We are anxiously awaiting 2022 data in the hopes of stabilization, but health centers continue to report acute behavioral health workforce shortages.

DBH and its sister health agencies should consider options that extend the workforce such as:

- reimbursing for new provider types,
- adding provider types that can bill without a supervising practitioner, or
- reimbursing for care delivered by trainees or the license-eligible workforce.

An important factor in our behavioral health ecosystem is the degree to which administrative burden impacts provider willingness to engage with insurers, especially Medicaid. Timelines for credentialing, no fewer than four different Medicaid MCO systems each with its own unique administrative requirements, claims denials, and payment delays are solvable problems that are likely contributing to workforce shortages. Standardization of administrative processes across all Medicaid MCOs should be the goal before the District fully carves in all behavioral health services in the MCO contracts.

It is unlikely that we will remedy current shortages with clinical care alone.
We also hope DBH will explore emerging models of community-based behavioral health that can broaden the base of behavioral health supports available in priority communities. Approaches to care need to build on social capital, individual and community agency, and support connections for a meaningful life.

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

Requirements for National Accreditation

DCPCA supports DBH's efforts to improve quality among District providers by advocating for national accreditations from The Joint Commission, The Council on Accreditation, or The Commission on Accreditation of Rehabilitation Facilities. However, DCPCA offers two recommendations:

- **National accreditation should replace existing DBH certification requirements.**
- **The timeline for completing the accreditation process should be extended until October 1, 2024.**

Replacing Certification Requirements

FQHCs are asked to maximize efficiency and health outcomes from limited federal funding. Establishing consistent standards across DBH and the accreditation bodies will minimize the administrative burden on FQHC compliance staff, allowing them to focus resources on patient outcomes. DBH should amend language in each Chapter affected by this proposed rulemaking by replacing its current certification requirements with those standards set forth by the national accreditation agencies in order to align both sets of evaluative standards and minimize undue burden on providers**.**

Accreditation Timeline

DCPCA urges DBH to extend the timeline to complete the accreditation process beyond October 1, 2023. The volatility in the District's Medicaid Managed Care Organization procurement in 2022 and 2023 have delayed MCO transition readiness activity. DCPCA and our member health centers know from previous managed care transitions that administrative burdens for FQHCs and their patients will be consequential. Existing treatment plans, prior authorizations for life-protecting medications, and specialist appointments are all subject to disruption, and require health centers to divert staff time to address.

Added to the MCO transition is the impact of required Alliance and Medicaid redeterminations on pause for the past three years. We cannot overstate our concern for health centers and their patients. The Geiger-Gibson Program in Community Health at George Washinton University predicts a loss of $24.2M in revenue for health centers in the District due to impact of coverage losses through the redetermination process. The combination of revenue losses and the need to step up support for patients who need assistance to stay enrolled or reenroll require a longer glide path to accreditation.

Also impacting health centers' capacity to meet the October 2023 deadline are the well-documented and significant general health care workforce shortages that predate the COVID-19 pandemic and were further exacerbated by it. All departments, both clinical and administrative, are impacted, leaving fewer staff to devote themselves to accreditation efforts.

We are grateful to DBH Director Dr. Barbara Bazron and her dedicated team for their deep commitment to the well-being of District residents. We look forward to further partnership to build and strengthen pathways to recovery for our city.

Testimony Submitted to

The Committee on Health

By

The Office of the District of Columbia

Long-Term Care Ombudsman

For

The Department of Behavioral Health

Public Budget Hearing

March 30, 2023

Mark Miller, DC Long Term Care Ombudsman
Legal Counsel for the Elderly
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Greetings Chairperson Henderson and members of the Committee on Health. I am Mark Miller, D.C. Long-Term Care Ombudsman with Legal Counsel for the Elderly (LCE). Thank you for the opportunity to provide this testimony on behalf of the approximately 9,000 District residents receiving long-term care services and supports (LTCSS) in nursing homes, assisted living residences, community residence facilities, and in their homes through the District's Elderly and Persons with Physical Disabilities (EPD) Medicaid Waiver Program.

The Office of D.C. Long-Term Care Ombudsman advocates for the rights of some of the District's most vulnerable citizens. Our mission is to promote and help ensure the highest quality of life and quality of care for these individuals.

In 2022, our Office handled 264 complaints, resolving 86% of those issues to the satisfaction of the care recipients or complainants. This resolution rate is significantly above the national average (approx. 74%). Issues involved quality of life, quality of care and residents' rights. Fifty-four (54) of those complaints concerned residents in Mental Health Community Residence Facilities (CRF's).

As a resource and advocate, our Office works to educate and empower individuals. Informed consumers make more satisfying choices and can more effectively exercise their rights to quality care. In 2022, our Office provided 574 individuals with information and consultation to help them navigate the long-term care system, understand their rights, and to assist them with self-advocacy.

I ask that my written testimony be included in the record. While the Ombudsman Program does not have specific funding amount requests, we are aware of specific

needs of the persons served by the Department of Behavioral Health which should receive budget attention. These include the following:

Funding for Substance Abuse Treatment

There is a clear need for more funding for substance abuse treatment services in the District. In the past several months, the Ombudsman Program has seen an increase in proposed evictions of residents of DBH licensed mental health community residence facilities (MHCRF's) because the resident is battling addiction. The prevailing strategy in these cases has been to discharge these vulnerable residents to a homeless shelter due to lack of beds in the District's in-patient rehabilitation centers. This is an inappropriate and unsafe response to persons who often want to seek help for their addiction. In fact, we are currently advocating for an individual who is seeking in-patient treatment but cannot find a bed. This response also runs contrary to the Mayor's priority to reduce homelessness in the District, by perpetuating the cycle of homelessness caused by addiction. Clearly, more support is needed for in-patient and outpatient treatment services. Therefore, the Ombudsman Program recommends an increase in funding for more substance abuse services and treatment centers specifically within the mental health community.

Funding for Staff Training

We have noticed a disturbing number of incidents involving violence or the threat of violence by or between residents. Effectively addressing these incidents and preventing them requires staff that are regularly trained in effective therapeutic approaches and interventions, and who actively implement resident-focused care plans.

These residents rely on and deserve staff that are adequately trained to help them in times of crisis. As I testified at the performance oversight hearing, we are not seeing therapeutic services and supports being provided to residents in homes licensed as Supportive Rehabilitative Residences (SRR's), as required under Chapter 38. This on-going problem puts residents at risk of unnecessarily cycling through crises because of a lack of trained staff to provide effective interventions and creates an unsafe environment for residents and staff. An informal survey of MHCRF operators by the Ombudsman Program indicated that while some already provide training on de-escalation techniques, most who responded would be interested in additional training. Therefore, the Ombudsman Program recommends an increase in funding to provide mandatory specialized training to MHCRF operators and staff around de-escalation techniques, person-centered planning, and crisis intervention.

Funding for Crisis Beds

Finally, we need to acknowledge that the individuals being served by DBH in MHCRF's will periodically experience mental health crises requiring temporary therapeutic intervention beyond what the CRF can provide. As I have previously testified, we are concerned about the lack of crisis beds as an alternative to psychiatric inpatient hospitalization, which may not always make the most sense from a therapeutic perspective. Therefore, the Ombudsman Program recommends consideration of funding to increase the number of crisis beds, and/or mobile crisis units, so residents with declining or escalating behaviors can receive the necessary supports to effectively address their situations.

Representatives from my Office meet and communicate on a regular basis with DBH staff to work on individual cases and systemic issues. We appreciate the partnership and support of DBH staff including Alvin Hinkle, Director of Residential Support and Continuity of Services, and his team, as we advocate for coordination of care and services as well as comprehensive discharge planning on behalf of residents. We welcome this continuing collaboration to ensure quality of care and quality of life for all CRF residents in the District.

Thank you for the opportunity to testify. I am happy to answer any questions from the Committee.

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IT'S TIME FOR A NEW APPROACH.

March 30, 2023

Chairperson Christina Henderson
Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue
Washington, D.C. 20004
The Committee on Health 2024 Department of Behavioral Health Budget Oversight Hearing

Testimony of LJ Sislen
Campaign/Community Organizer on behalf of DecrimPovertyDC

Councilmember Henderson and members of the Committee on Health:

Thank you for the opportunity to address the D.C. Council today. My name is LJ Sislen, I am a Campaign Organizer for the DecrimPovertyDC Coalition and an outreach volunteer and Board Member with HIPS. I am testifying about the need for the 2024 budget to fund 24/7 harm reduction centers with safe consumption to address the overdose crisis in the District and to effectively help people who struggle with substance use and those who would otherwise benefit from these centers. The Department of Behavioral Health is the city's leader in combating the overdose crisis, but you can do more and there's plenty of evidence to support how life changing these measures will be. Let's lead the country's approach to substance use and overdose by utilizing all of the most effective strategies together. No baby steps, no piecemeal…let's use everything we got as many of our lives depend on it. **The District needs to authorize, fund, and support the creation of harm reduction centers that includes comprehensive drug checking and safe consumption on-site, to prevent any more lives lost to overdose.**

I support DecrimPovertyDC because the coalition is fully founded on harm reduction principles and evidence-based practices. Harm reduction centers on the very real lives and authority of people who use drugs, is non-judgmental and non-coercive, boosts drug user autonomy and recognizes that poverty, class, racism, social isolation, trauma, misogyny, homophobia, citizenship status, and other social inequalities affect why people use drugs and their capacity to effectively deal with drug-related harm.[1] I bring my expertise as a medical anthropologist who

[1] https://harmreduction.org/about-us/principles-of-harm-reduction/

studies the social determinants of health and my experiences as a person who used drugs chaotically, who's been to rehab, who's lived in a recovery house for nearly a year and half, and who spent six years completely dedicated to and engulfed in a 12-step fellowship by choice.

The drug rehab, the sober living home, and the 12-step fellowship all relied on the goal of abstaining from all drugs. These spaces were founded on the idea that addiction is a disease…a spiritual disease, a malady. While I'll still credit these spaces and the community I found there for helping me save my own life, I repeatedly saw it fail my friends, peers, and family members.

Some people have no aim to stop using drugs or relapse after a time of abstinence. This is normal with drug use. Most people use drugs in some form or another to cope and medicate, to connect or seek pleasure, and for so many other reasons. But when someone has a substance use disorder, chaotically uses drugs, or just happens to prefer a drug that has been deemed illicit, returning to drugs often fills the person with shame as they are often actively shamed by family, community, and society. Facing this shame, people often isolate themselves and/or use drugs secretly.

I've seen my friends with war PTSD die from fentanyl contaminated cocaine — the only people who he knew to turn to were actively injecting drugs or fully sober. He didn't feel safe with either group. He had no way to effectively test the supply, no one to compassionately support him without judgment, and nowhere to go. My other friend struggled with chronic back pain, but the abstinence-based rhetoric was so strong that he would consistently hide his drug use and disappear for weeks on a run…one day fentanyl caught him too. I know too many other folks who have died from drug overdose or drug-related diseases, but I invoke these two men because I thoroughly believe that both of them would have used a safe consumption site and that they could still be here today — possibly testifying on their own behalf.

All of these other friends, peers, and network that I know who died…they died using alone — they were using alone because they were ashamed to tell anyone they were using. I blame the political history of drugs in the U.S. for shaming people who use drugs, for making those of us who struggle with substance use too afraid and too ashamed to ask for help. Our drug policies and drug programming teach us all to blame the individual or to even blame the disease, when in reality there are so many conditions that manifest chaotic, life-harming drug use. Drug prohibition and anti-drug — anti-people— rhetoric and antiquated policies that we've been indoctrinated with are killing our friends, families, and neighbors. So I believe it's our duty — we must undo what has been done. We cannot just add another support system like a Sobering Center. This system will continue the status quo and help a few folks here and there, but it will not meaningfully address conditions that need to change or be additive to our current tactics. There's nothing new about it. The government needs to unravel the violent web they have woven that has led to the deaths of far too many people.

In order to undo the prohibitionist, punitive approach to people who use drugs, we must decriminalize all drugs and divert resources and people to public health harm reduction resources. We must also, in tandem, create a harm reduction social safety net. We are proposing the creation of a no-barrier 24/7 holistic harm reduction center grounded in love, therapeutic support, and evidence-based strategies. European countries have had safe consumption sites since the 1980s and Vancouver has had sites since 2003. Why do we only have sites in NYC and why did it take until 2021?

Local organizations addressing drug use and overdose in the District have just been briefed on the DC Stabilization and Sobering Center endorsed by the Mayor that will be run by contractors for Arizona. We learned that the group was founded by a group of people in a back room at an Alcoholics Anonymous meeting. Abstinence-based 12-step fellowship recovery is beautiful and a wonderful space for those who it works for — but it works for very few people. Many recovering people decide to professionalize their experience and have thus thoroughly saturated the treatment industry — there is a long and fascinating history of the free, fully-self supporting 12-step groups creating and expanding into the rehabilitation, sober living home, and treatment spheres of addressing substance use. They mobilized and expanded because the government has historically turned away from people who use drugs chaotically…so that's what we're doing too, but we're doing it for the people who are not being served by the government, abstinence-based programming, or the drug treatment industry as it stands. It's time that more harm reduction strategies are welcomed into the institutional sectors of drug-related public health strategies just like methadone, suboxone, and naloxone have been adopted.

At this moment, DC faces an overdose crisis. In 2022, there were 448 opioid-related fatal overdoses. That was an average of 37 deaths per month last year.[2] Nearly 600 Washingtonians died from accidental overdose deaths in 2021.[3] The overdose mortality rate among Black Washingtonians is the highest in the country. At 107 deaths per 100,000 people, the Black overdose death rate is nearly 10 times higher than the white overdose mortality rate in D.C.[4]

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[2] *Opioid-related Fatal Overdoses: January 1, 2017 to December 31, 2022,* Office of the Chief Medical Examiner, https://ocme.dc.gov/sites/default/files/dc/sites/ocme/Opioid%20related%20Overdoses%20Deaths%206.17.21%20FINAL.pdf (March 17, 2023).

[3] Government of the District of Columbia, Office of the Chief Medical Examiner, "Drug-related Fatal Overdoses: January 1, 2021 to December 31, 2021," https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/2021%20Drug%20related%20Overdoses%20Deaths%20 FINAL.pdf

[4] Drug Overdose Death Rate (per 100,000 population) by Race/Ethnicity: 2020. Kaiser Family Foundation.https://www.kff.org/other/state-indicator/drug-overdose-death-rate-per-100000-population-by-raceethnicity/?dataView=1¤tTimeframe=0&selectedDistributions=white-non-hispanic--black-nonhispanic&sortModel=%7B%22colId%22:%22Black,%20Non-Hispanic%22,%22sort%22:%22desc%22%7D

I am here today to urge this Council to fund the creation of a harm reduction infrastructure by ensuring that the 2024 budget includes funding for two harm reduction centers. The Mayor's proposed budget *failed* to include funding for these centers. **This Council has the opportunity to correct this failure by the Mayor and push for the funding of two harm reduction centers.** Similar to the Mayor's proposed DC Stabilization and Sobering Center, the harm reduction centers will include wrap-around services. However, the centers will also advance the health and wellbeing of participants by including full-panel drug-checking machines, private safe consumption rooms for pre-obtained drugs, and expanding mobile outreach services.

I believe that the DCSSC is a welcoming model of care full of the best intentions, but it is not being spearheaded by local advocates, outreach workers, or health professionals. Community Bridgers, the Arizona contractors, will be relying on the labor and expertise of local health workers and community members — they don't know about DC's unique drug landscape. It would be far more effective to listen to local advocates and support them.

This is significant funding to funnel towards a rather conservative approach to an incredibly dire and worsening crisis. If more needle exchange and referral hubs are what the District wanted they could have helped HIPS, the local harm reduction organization, sustainably expand or support other health groups in DC. Since the Mayor clearly wants a new approach, we cannot stress enough how the sobering center is a sanitized version of our proposal for a harm reduction center. Key differences in our center are the most effective means of addressing our current drug crises — drug checking, safe consumption of pre-obtained drugs, and harm reduction informed workers.

By funding these centers, we will also be funding, developing, and supporting the healthcare workforce. Trained health workers will be equipped to intervene if an overdose or adverse drug interaction occurs. Staffed drug checking services will help people understand if fentanyl or other substances are in their drugs, reducing overdose death risk and empowering people to make informed decisions. Funding the centers also means expanding mobile outreach worker capacity. Trained outreach workers will lead community clean-ups, facilitate opioid-overdose reversal training, and raise general awareness about drugs, overdose, and the centers. **This proposed harm reduction infrastructure will be staffed by Washingtonians with lived experience at living wages for the area** - addressing a myriad of issues that our least invested in neighbors chronically face, like underemployment, housing costs, healthcare costs, and discrimination in the current systems they use to access them.

The most effective route forward must be one that is fundamentally guided by the principles of harm reduction, and the DCSSC and the city's Long.Live.DC campaign neglect the possibilities

offered by this truly holistic approach.[5] The DCSSC proposal lacks a wide enough scope to fully provide the services required for people who use drugs by the proposal's failure to provide drug testing and safe consumption sites. Consequently, **if DCSSC is the city's only response to the overdose crisis, the city will not succeed in serving the needs of people who use drugs and the overdose emergency will continue to rob vulnerable Washingtonians of their lives.**

DBH has been working to address the overdose crisis through implementing harm reduction tactics, including syringe exchange programs and providing residents with Naloxone. However, these measures have not been enough to successfully curb the number of lives lost due to overdose deaths. The District needs to do more to ensure that we do not lose another person to accidental overdose death. The District needs a much larger investment in public health than we, and other harm reduction workers in DC, can manage at our current capacity. **The proposed harm reduction infrastructure I have raised today, and that DecrimPovertyDC has been campaigning for, will save Washingtonian's lives.**

Our constituents and their families are impacted daily by the harms of drug criminalization, stigma, and a failure to center public health. To save lives, use funds more efficiently, and re-imagine public safety and health, D.C. Council should urgently support the creation of harm reduction centers. I also strongly support the #DecrimPovertyDC's effort to remove criminal penalties for personal use drug possession, address life-long consequences of convictions, and invest in life-saving and stabilizing support and resources instead of punishment. Together, District residents, this Council, and the Department of Behavioral Health can end the overdose crisis through embracing and funding a harm reduction infrastructure that was created, designed, and will be run by DC residents with lived experience.

Thank you for your time and consideration. I am happy to answer any questions you have regarding the overdose crisis and/or the harm reduction centers. Additionally, I can be reached at the contact information below.

LJ Sislen
Campaign Organizer
DecrimPovertyDC | Drug Policy Alliance
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[5] "Principles of Harm Reduction", National Harm Reduction coalition. https://harmreduction.org/about-us/principles-of-harm-reduction/

Date: March 30, 2023

RE: DC Department of Behavioral Health Budget Hearing – Written Testimony

Dear Chairperson Henderson and Members of the Council:

My name is Eric Gastfriend, and I am the CEO of DynamiCare Health, an organization that provides digital health technology to help people overcome addiction. We work across the country, including here in DC. I am a DC Resident, Ward 6.

In addition to the opioid epidemic, DC is facing a major stimulant epidemic, especially with crack cocaine. PCP use is also high in DC. For opioid use disorder (OUD), there are FDA-approved medications to treat the condition. Unfortunately, there are no FDA-approved medications to treat addiction to stimulants or PCP.

There *is* a highly effective and evidence-based psychosocial treatment for these types of substance use disorders (SUD). It is a methodology called Contingency Management (CM), which uses motivational incentives to reward patients for staying sober and staying engaged in treatment. CM has been recommended by the NIH, U.S. Surgeon General, American Society of Addiction Medicine, and validated in over 100 randomized controlled trials. Moreover, it is considered by experts to be the **most effective** and evidence-based treatment for stimulant addiction (De Crescenzo et al, 2018). It also works for other types of SUD such as opioids: "Policies facilitating integration of contingency management into community MOUD [Medication treatment for Opioid Use Disorder] services are sorely needed." (Bolivar et al, 2021). We typically see doubling of quit rates with CM, along with higher rates of attendance and retention in treatment.

Unfortunately, CM is basically unavailable in DC, because DC Medicaid does not cover it. This means that the Medicaid and public health budget is being spent on less effective treatments, and that patients are getting low-quality care with poor outcomes.

CM has been found to be highly cost effective. The Washington State Institute for Public Policy estimates that CM brings $39 in benefits to society for every $1 spent, and that direct savings to taxpayers is $3,198 per $548 spent (a 5.8 : 1 ratio).

CM is generally complementary to other forms of treatment and works well in conjunction with harm reduction models, the 12-step approach, or Medication Assisted Treatment (MAT).

Both the New York Times and the Washington Post have published articles describing the clear benefits of adopting CM.

I therefore encourage the Council to consider allocating funding to implement a CM initiative in DC. We need to give treatment providers and community organizations more powerful tools to deal with SUD. Funding sources can include: Medicaid dollars (which California and West Virginia are using); State Opioid Response grants (which New Jersey is using); and opioid settlement funds (which Rhode Island is using).

One barrier that has held back CM in the U.S. is concern about financial incentives to patients being used or considered as a kick-back or inducement. The problem of fraud, waste, and abuse (FWA) of patient financial incentives can be overcome with technology that tracks the distribution of funds and manages the CM program according to a rigorous evidence-based protocol. My organization, DynamiCare Health, has received a favorable Advisory Opinion from HHS-OIG stating that our program poses no risk of violating federal regulations, and this news was covered in the Washington Post.

I would like to offer my expertise and support in advising city leaders on this issue. My organization has deep expertise in helping states, counties, and health plans implement CM effectively.

Sincerely,

Eric Gastfriend

Eric Gastfriend
CEO
DynamiCare Health

D.C. Council Committee on Health: Department of Behavioral Health Budget Hearing
Thursday, March 30, 2023
Testimony by Christopher Charles,
Director of Wards 1 & 2 Prevention Center at Latin American Youth Center

Thank you, Councilmember Henderson and members of the Committee on Health, for allowing me to speak with you today. My name is Christopher Charles, and I am the Director of Wards 1 & 2 Prevention Center under the Department of Behavioral Health or DBH at Latin American Youth Center or LAYC. LAYC has served the District and region for over 50 years, serving over 4,000 youth and families annually and operating in the District and Prince George's and Montgomery Counties.

As we transition out of the public health emergency, LAYC remains a trusted source of health education and resources for D.C. youth. According to CDC's Drug Overdose Surveillance and Epidemiology (DOSE) system, the United States has seen a 51% increase in overdoses from 2019 to 2021. DOSE also reports that D.C. has seen a 40% increase in overdoses from December 2021 to December 2022. Wards 1 & 2 Prevention Center has worked to increase community education, gain an understanding of community needs, and keep up with the increasing demand for resources as the number of overdoses increases. The prevention center simultaneously strategizes innovative techniques to create effective prevention campaigns for high-risk populations. Additionally, all of the prevention centers under the direction of DBH have worked to create year-round drug prevention programs focused on our youth.

We expect this program to be refunded for FY24 to continue our efforts addressing substance use and overdose cases through our prevention and intervention programs for youth in D.C. I ask that additional funding be awarded to support DBH to ensure that the prevention centers and school-based therapists have the support they need to continue this vital work and support our communities in all five pillars of social determinants of health.

Thank you for your time. I am happy to answer any questions you may have.

Christopher Charles
Director of Wards 1 & 2 Prevention Center

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STRENGTHENING FAMILIES
THROUGH BEHAVIORAL HEALTH

DC's School-Based Behavioral Health Program Requires Sustained Investment to Meet Workforce Challenges

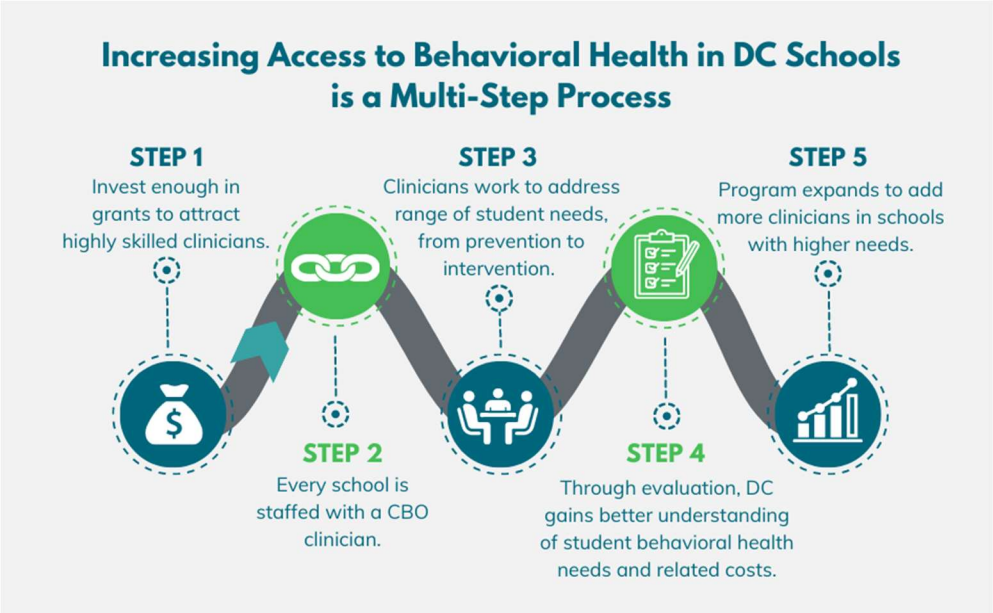
Every DC child deserves timely access to high-quality, consistent, and culturally responsive behavioral health care. The District, through the School-Based Behavioral Health (SBBH) Expansion Program operated through the Department of Behavioral Health (DBH), has been creating this access where children spend most of their time: school. Yet, there is more work to be done to meet the program's preliminary goal of at least one full-time clinician in every public and charter school.

We urge the DC Council to invest at least $5.7 million more in SBBH to ensure stable compensation for partnering community-based organizations (CBOs) in Fiscal Year 2024.

Stable and sufficient compensation for CBOs is paramount to the success of the program**.** Staffing highly sought-after Licensed Clinical Social Workers has proven even more challenging as the District's cost of living continues to rise. **Last year, DBH increased the CBO grant to $99,371 per clinician** to recruit and retain staff at a time when many are experiencing burnout and receiving competitive offers elsewhere.

The proposed FY24 budget functionally cuts compensation for CBO grants. The DC Council must now provide **an enhancement of $5.7 million** or more to provide grants of at least $103,000 per clinician—the sum of what CBOs are currently receiving plus inflation. Anything less would take the District backwards and hinder the program's long-term potential.

An investment in children's access to behavioral health is an investment in their education and future. **For more information, visit** https://www.strengtheningfamiliesdc.org/.



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Testimony Before the District of Columbia Council
Committee on Health
March 30, 2023

Public Hearing:
FY2024 Budget Oversight
Department of Behavioral Health
Supplemental Testimony

Amber Rieke
A Path Forward, Project Lead
Children's Law Center

Introduction

Hello, Chairperson Henderson, and members of the Committee. My name is Amber Rieke. I am A Path Forward[1] Project Lead at Children's Law Center. 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.

I am submitting written supplemental testimony regarding the proposed FY24 budget for the Department of Behavioral Health (DBH).[2] First, I would like to thank this Committee and its staff for their diligent and thorough work in creating greater transparency around the budget. We appreciate the Committee raising questions that help create clarity on the proposed budget and, in turn, sharing these responses with the community. Based on the responses to DBH's pre-hearing questions, we are providing supplemental testimony regarding Healthy Futures and the School Based Behavioral Health Expansion Program.

There is No Cut to Healthy Futures Funding; Therefore, We Ask this Committee to Ensure the Funding in the FY24 Budget is Maintained

On March 30, 2023, we testified to an apparent cut to Healthy Futures funding in the proposed FY24 budget.[3] However, we are glad to learn that this funding has not been cut. The reduction shown in the budget is the result of a technical error, which, we understand, will be corrected.[4] The consistent level of funding between FY23 and FY24 will allow Healthy Futures to continue to hire and expand services into the projected 182 child development centers and home childcare providers.[5] This increase will bring the District closer to having Healthy Futures in 300 child development centers and home providers as envisioned in the Birth-to-Three for All DC Amendment Act of 2018.[6] We ask this Committee to ensure the error showing a cut to Healthy Futures is corrected in the budget and that the program maintains stable funding in the FY24 budget.

We urge the Council to Invest at Least $3.45 Million More in SBBH to Ensure Stable and Sufficient Compensation for CBOs in FY24

We are pleased to be able to share some updated numbers regarding the community-based organization grant funding for the School Based Behavioral Health Expansion Program (SBBH). In our earlier testimony, we thanked DBH for responding to hiring difficulties by increasing CBO grants which allowed for hiring or retention incentives for clinicians at a time when many are experiencing burnout and receiving competitive offers elsewhere.[7] The amount reported by DBH to Coordinating Council

members as recently as February 2023 was $99,371 per clinician to recruit and retain staff.[8] Based on this number, we and Coalition members requested the Committee add $5.7 million to the budget to maintain grant amounts – plus inflation – for a total of $103,000 per clinician.[9] We based this enhancement ask on predictions that DBH would only allocate $80,000 per clinician, as had been signaled in meetings. However, DBH budget documents provided after the March 30 hearing state that the amount per clinician in the proposed FY24 budget is $89,366.[10] While this is more than we originally guessed, it still represents a $10,005 per clinician cut between the current FY23 funding and the proposed FY24 funding, and provides no inflationary increase.

We are continuing to ask the Council to ensure that CBO compensation is stable and sufficient in FY24, at a funding level of $103,000 per clinician. Meeting this goal requires $3,449,402 to make up the difference in 253 schools. As we struggle to hire clinicians in the face of an unprecedented shortage of professionals, we must maintain the CBO's ability to offer competitive pay, incentives, and professional support for these essential roles. Failing to do so will result in losing clinicians and puts the whole program at risk.

Long-Term Considerations for Program Vision, Implementation, and Oversight

We also feel that a few other key things regarding the SBBH program budget are pertinent to this testimony. First, the current increase proposed in FY24 to $89,366 relies on American Rescue Plan Act (ARPA) funds that are time limited.[11] Therefore, as we

look ahead, there will likely be another reduction in the SBBH program when those funds expire, reverting the program to the original level of $80,200 per clinician. To meaningfully ensure investment in the SBBH, we ask this Committee to look ahead and ensure this additional funding is not lost in the FY25 budget and beyond.

Second, we would like to note that the total budget for the SBBH program includes investments in program evaluation and data collection, as well as the Community of Practice, which brings together providers, staff, and school leaders in a collaborative learning environment to share best practices, support, and participate in learning activities.

Finally, Committee members have asked smart questions through the hearing process about how to bring the program to its full potential. Along with the Committee, we are looking forward to the overdue rate study and evaluations to provide a better understanding of the costs and opportunities of the program. Finally, we believe further inquiries about this program would be well-served by a dedicated hearing on SBBH following the release of the cost study.[12]

Conclusion

We appreciate the opportunity to share these updated asks and remain available to answer any questions regarding the investments needed to sustain essential programs in the DBH portfolio.

[1] Children's Law Center co-authored a 2021 report called A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia, which detailed 94 recommendations to better meet the needs of DC children and families. As the Project Lead for A Path Forward, my work is focused on driving forward the recommendations contained in our report.

[2] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 30, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf.

[3] *Id.*

[4] Budget line 6620 inadvertently includes $655,000 that was meant for Healthy Futures. See FY2024 DBH Budget Oversight Pre-Hearing Responses, response to Q8 and Q20, *available at*: https://www.dropbox.com/sh/8fmlfns6bd8b39j/AAAXaSvmR4xqGrw1xpBo53JGa/FY%2024%20Budget%20Questions.%20DBH%20Response?dl=0&subfolder_nav_tracking=1.

[5] DBH, FY2022 Performance Oversight Responses, response to Q41, p. 38, available at: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1.

[6] D.C. Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[7] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 30, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf.

[8] Coordinating Council on School Based Behavioral Health, February Meeting, on file with the Children's Law Center.

[9] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 30, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf.

[10] FY2024 DBH Budget Oversight Pre-Hearing Responses, response to Q20, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAGUOnsdH57hHf7WvWf4D55a/FY%202024%20Budget/DBH/Agency%20Responses/FY%2024%20Budget%20Questions.%20DBH%20Response?dl=0&preview=FY+24+Budget+Question+20.docx&subfolder_nav_tracking=1.

[11] *Id.*

[12] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health (February 1, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/02/AmberRieke_CLC_Performance-Oversight-Testimony_DBH_February-1-2023_SBBH_final-1.pdf.

Testimony of Betty Gentle, Senior Advocacy & Community Engagement Specialist
SOME, Inc. (So Others Might Eat)
To the Committee on Health
Department of Behavioral Health Fiscal Year 2024 Budget Oversight Hearing
March 30, 2023

Greetings, Chairperson Henderson and members of the Committee. My name is Betty Gentle. I am the Senior Advocacy and Community Engagement Specialist at SOME, Inc. (also known as So Others Might Eat). Thank you for the opportunity to submit this testimony to the Committee on Health for the **Department of Behavioral Health Fiscal Year 2024 Budget Oversight Hearing.**

Since 1970, SOME has been working to break the cycle of poverty, homelessness and hunger through our comprehensive "Whole Person" approach. Our continuum includes a full range of high-quality healthcare services that are people-centered, trauma-informed and grounded in equity. This includes behavioral health services where our staff supports adults in stabilizing and maintaining their mental health and a range of substance use disorder treatment options that empower adults to break the cycle of addiction.

SOME is a member of the SUD Provider Coalition, the D.C. Behavioral Health Association, and the Fair Budget Coalition. We strongly support the comments and recommendations presented on behalf of all DCBHA members and the Fair Budget FY23 healthcare budget priorities.

SOME understands that the FY 24 budget presents many challenges and that hard decisions must be made to maintain a balanced budget. However, this budget must meet the needs of the people and should not be balanced on the backs of the most historically marginalized and disenfranchised D.C. residents nor regress the city's movement toward racial and healthcare equity. The current proposed D.C. budget includes troubling cuts to several human services programs that likely will impact housing stability, safety and food security. Although we do not see as severe cuts across this DBH budget, we also do not see the urgent increases that have been needed for years and, especially now, as DBH-certified providers are undergoing many systems changes. Therefore, we encourage this Committee to prioritize access, quality of care and health equity, rather than scarcity, as you assess this proposed DBH budget.

SOME has many remaining questions about the DBH budget that we hope will be answered throughout the oversight period. Because providers continue to receive reimbursement rates set in 2016, we currently face a 17.5% gap. Although there is an increase of $17.8M in projected Medicaid match spending, we are unable to tell whether this increase is preparing for new increased rates and/or projected increases in enrollment and utilization. Low reimbursement rates continue to offer barriers to providing client-centered holistic care, recruiting and hiring qualified and licensed staff and to the financial and operational stabilization and needed growth of the provider network. Therefore, our gravest concern is whether the budget increases that we can see in the proposed budget will specifically increase provider rates and by how much.

Additionally, we continue to restate concerns about the additional financial and administrative burdens placed on already severely financially restricted SUD providers who are currently mandated to purchase and administer a new electronic health records system while undergoing the national accreditation process during a time when many agencies are understaffed, as they cannot fill positions requiring full licensure as candidates require salaries that agencies simply cannot afford. Therefore, we also have questions about the budget decreases in SUD treatment services and youth SUD prevention and treatment services. Without more information, we are unable to assess the actual impact of these seeming

cuts. However, with a growth in relapses since the pandemic began, a continuance of high opioid overdoses, the introduction of fentanyl in pill form spiking youth overdoses in D.C. region schools, and the need for more SUD services throughout our city, no SUD services or programming should be reduced for D.C. adults or youth and should, in fact, be increased.

Next, to ensure that the community-based providers offering mental health services in D.C. public and charter schools are financially able to continue offering these vital services to our students, we support the ask of the Fair Budget Coalition for level funding from FY '23 to FY '24 with an inflationary adjustment, which would set total grant amounts of $103,000 per clinician per school.

Last, SOME continues to support the expansion and work of the Community Response Teams and are disappointed to see that funding and FTEs were reduced. However, we understand the hiring challenges faced to fully staff those positions is likely the reasoning, and we and hope that DBH is planning and strategizing to fill those positions. We also ask that this budget include funding for stronger awareness and outreach campaigns so that D.C. residents know this service is available when their loved ones are experiencing a mental health crisis. In addition, we support the inclusion of $9.5M in the capital budget that funds a second sobering center in Columbia Heights while also strongly encouraging DBH to fund and place a sobering center East of the River, as well, where the high need for these services is documented.

SOME appreciates the opportunity to offer these comments, and we are grateful for the role we play in helping our neighbors stabilize their mental health and heal from substance abuse with respect and dignity.

STRENGTHENING FAMILIES
THROUGH BEHAVIORAL HEALTH

DC's School-Based Behavioral Health Program Requires Sustained Investment to Meet Needs of Students and Staff

In 2021, only 62% of DC middle schoolers and 63% of high schoolers said they had at least one adult in their school that they could talk to if they had a problem. (YRBS, 2021)

Through the School-Based Behavioral Health Expansion Program (SBBH), the District creates access to high-quality, consistent behavioral health care where children spend most of their time. As residents struggle to connect with timely services in the health system – and amidst a national youth mental health crisis – SBBH embeds a full array of supports in school communities. **The program is making a growing impact.**

Through the iterative roll-out, schools are still customizing their systems for referrals and outreach with community-based organization (CBO) partners. **More work remains** to meet the program's preliminary goal of one clinician to facilitate behavioral health interventions in every DC school. Most clinicians haven't reached their service capacity yet. Schools from recently-funded cohorts are still hiring. Overdue cost studies and evaluations will provide further guidance to improve the program and funding design.

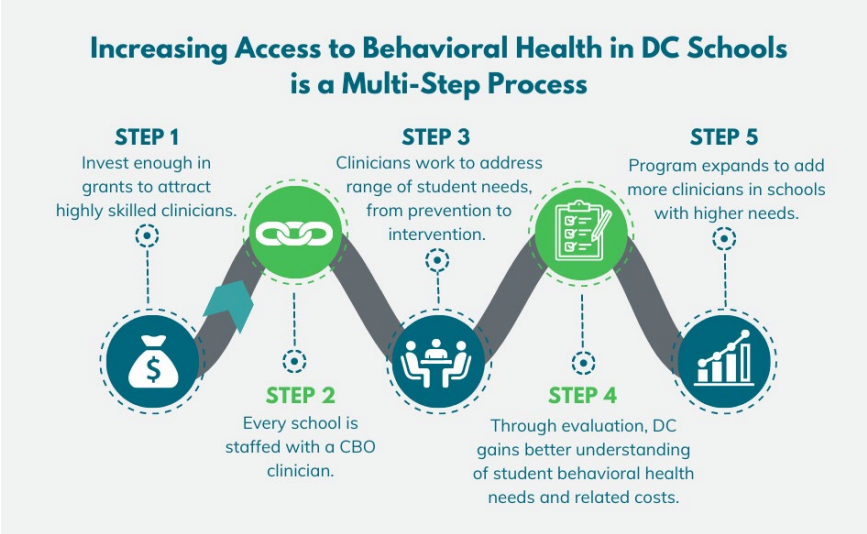
We urge the DC Council to invest at least $3.45 million more in SBBH to ensure stable compensation for CBO grants in Fiscal Year 2024.

In this period, stable and sufficient compensation is paramount to staff highly sought-after Licensed Clinical Social Workers. Many are experiencing burnout or receiving competitive offers elsewhere. Accordingly, the Department of Behavioral Health (DBH) **increased the CBO grant to $99,371 per clinician in FY2023**.

The proposed FY24 budget functionally cuts compensation for CBO grants. The DC Council must now **provide an enhancement of $3.45 million** for SBBH to provide grants of at least $103,000 per clinician—the sum of what CBOs currently receive plus inflation. Anything less would undercut the program just as schools are beginning to see the program's positive impact.

An investment in children's access to behavioral health is an investment in their education and the District's well-being.

For information, visit strengtheningfamiliesdc.org.



Traveling Behavioral Health Services for Youth Experiencing Homelessness

The State of Youth Experiencing Homelessness in the District

Youth homelessness is a significant problem throughout the District–roughly 1,934 youth (ages 16 to 24) experiencing homelessness received services from DC's Department of Human Services (DHS) in 2022 alone. Nearly 300 of those young people were parents,[1] creating a two-generational homelessness crisis. DC Action believes the number of unhoused youth is actually much higher because of the impacts of the pandemic and the inability of DHS to count youth who are not connected to existing programming.

The District's Black and LGBTQIA+ young people are disproportionately likely to experience homelessness. In 2021, 40% of all youth 18-24 in the District identified as Black, while making up 77% of the youth homelessness population. In 2022, 15% of youth experiencing homelessness identified as LGBTQ+, but this number is probably much higher, however, as gender identity or sexual orientation data was not collected for 43% of all youth.

The root causes of youth homelessness are varied, but often include an unsafe home environment due to domestic violence, parental addiction, or family conflict due to prejudice against sexual orientation or gender expression; transitions from systems involvement (foster care, detention, or other institutional placements); family poverty; undocumented status; and lack of affordable housing. This is why we need a multi-faceted approach to addressing youth homelessness. One of the solutions–improved mental health

[1] a footnote in the 2021 Youth Counts that for the 151 parenting youth their (142) households had 163 kids. Since the DHS "number served" is roughly double the YouthCounts number can estimate about 320 kids in the youth-headed households are connected to the 300 parenting youth

support–is highlighted here, but it must be advanced with other efforts, like targeted workforce support and greater access to housing.

Youth Experiencing Homelessness and Mental Health

Youth experiencing or at risk of homelessness have higher rates of mental health issues, including suicide,depression, anxiety and conduct disorders than those in stable homes. Lack of access to behavioral health care further complicates most individuals' ability to seek treatment. Increasing access to mental health supports will save lives.

Mental health outcomes for youth experiencing homelessness were worsened by the pandemic. Psychosocial outcomes included isolation, worsened mental health, and increased substance use. Impacts were magnified and distinct for subpopulations of youth, including for youth that identified as Black and LGBTQ+. To date:

- Homeless students reported significantly higher rates of depression than housed students (45% vs. 27%).[2]
- Depression can lead to harmful behaviors such as alcohol and substance abuse. Homeless students reporting depression were more than twice as likely to binge drink as housed students reporting depression (41% vs. 19%). [3]
- School-age children and youth who are homeless are three times more likely to attempt suicide than students who live at home with a parent or guardian. [4]
- Homeless students who were the victims of bullying were much more likely to report depression (63%) than those who were not bullying victims (34%).[5]

Recognizing that the children, youth and families served by the public behavioral health care system in the District are primarily individuals of color, approaching improvements to our system as a matter of equity is fundamentally necessary. Children are disproportionately at risk for developing social and emotional problems when exposed to adverse childhood experiences, and living in an adverse environment with stressors without buffers such as adequate adult support. Stressors include poverty, abuse, neglect, homelessness, foster care; developmental disabilities or delays; and racism.

Current Challenges in the District's Behavioral Health System

Improved access to behavioral health services is proven to be transformative for

[2] Id.
[3] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0273502
[4] Id.
[5] Id.

children and families, and can boost the long-term overall health and productivity of communities. Equal access to mental health is broadly acknowledged as a civil right, but this right is simply non-existent for many youth experiencing homelessness.

According to youth experiencing homelessness and their service providers, there is a lack of accessible, youth-friendly, and culturally competent mental health services throughout the District, which is also evidenced by data provided by the Department of Behavioral Health. In fact, behavioral health service access data received from DBH highlights that only 288 transition aged youth (16-24) experiencing homelessness received mental health services from DBH in 2022[6] despite close to 2,000 youth experiencing homelessness receiving services from the Department of Human Services.[7]

Youth are often assigned to behavioral health services in different wards than where they reside, which is extremely burdensome if you are experiencing homelessness. Youth have indicated they are not met with culturally competent supports, which is exacerbated for youth who identify as LGBTQ+. This gap serves as a major barrier to youth achieving long-term stability and impacts the overall health and wellness of the District.

Policy Solution: Creation of a Traveling Behavioral Health Unit and Cost Breakdown

The District needs to invest $1.7 million in funding to create a traveling behavioral health unit to bring culturally competent and trauma-responsive mental health supports to youth experiencing homelessness where they physically congregate. This investment will literally save people's lives and give people the unrestricted right to reach their full potential. In addition, by addressing the mental health needs of youth experiencing homelessness now, we are saving the District money down the line.

This investment would increase access to mental health support for the youth who need it most. A mobile unit staffed by culturally competent clinicians trained in trauma-informed care would rotate among youth homelessness services programs to provide assessments, counseling, therapy, and medication management on a weekly basis.

With $1.7 million in funding, the traveling behavioral health unit would service approximately 188 youth of the 1,934 youth experiencing homelessness receiving services at DHS over the course of a year. Youth who reside in extended transitional housing and youth who sought services at drop-in centers but are not connected to

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[6]Information provided by DBH directly to DC Action

[7] https://dccouncil.gov/wp-content/uploads/2023/03/Pre-Hearing-Question-Responses-DHS-2.20.2023.pdf

emergency housing or transitional housing supports are the target population. The idea is increasing access to mental health supports with the help of other supportive programs, youth will begin to exit the system and transition into stable adulthood and the unit will help additional participants in future years.

By addressing the mental health needs of youth experiencing homelessness now, we are saving money in the future. With $1.7 million, the Department of Behavioral Health in partnership with community based organizations with be able to hire:

- 10 provisionally licensed social workers with a caseload of 18-20 youth at a base salary of $75K[8]
    - It is important that the client to clinician ratio does not exceed 1:20 to make treatment readily available to youth, ensure youth receive individualized treatment, and deter clinician burnout.
- 2 independently licensed social workers to supervise clinicians at a base salary of $90K
- 1 psychiatrist to administer medication as needed and provide medication management at a cost of $150K.
- $1.48 million in administrative costs to support the employment of all employees of the unit.[9]
    - Administrative costs will cover retirement, health insurance, and other benefits.

Conclusion

Increasing access to mental health will not single-handedly end youth homelessness. Ending youth homelessness requires intentional investments into youth programs. Youth and young adults need access to low-barrier stable housing, supportive connections to caring adults, and access to mainstream services that will place them on a path to long-term success, including targeted educational and employment supports and accessible mental health supports.

Given the costs to those suffering from mental health disorders, which is exacerbated by lack of access to mental health supports and the costs that spill over to society as a whole, it is important to consider ways that public investments can be made most effectively to improve overall outcomes. Currently, the behavioral health system is not meeting the needs of youth experiencing homelessness. We have heard from youth who

[8] $75,000 salary per clinician is based on 2021 Department of Labor's Annual Mean Wage of DC's Mental Health and Substance Abuse Social Workers

[9]Administrative cost calculated at $21.73 per hour for government employees https://www.bls.gov/news.release/pdf/ecec.pdf

indicate more needs to be done to increase access to mental health supports paired with being met by culturally competent and trauma informed clinicians, a traveling mental health unit staffed by culturally competent and trauma responsive clinicians will do just that. This is truly a matter of life and death.

GeoComply

April 5, 2023

Committee on Health
Council of the District of Columbia
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Dear Health Committee Members:

Thank you for your leadership on the DC City Council to provide Washington DC residents with critical health services. On behalf of GeoComply, and as a resident of the District of Columbia, I urge you not to eliminate crucial funding for problem gambling services that has been earmarked since the Council passed DC Law 22-312 the Sports Wagering Lottery Amendment Act of 2018.

By background, since 2020 GeoComply has been licensed by the DC Lottery to provide geolocation compliance services that support legal sports wagering in the District of Columbia. GeoComply is proud to offer this important service that ensures authorized mobile sports betting operators comply with federal and DC laws restricting where wagers can be placed.

GeoComply is committed to advancing responsible gaming initiatives. Over the years, the company has built partnerships with the National Council for Problem Gambling, the Responsible Gaming Council, and several local organizations dedicated to serving this community. On March 29th, 2023 GeoComply announced it would fund a two-year research project for the International Center for Responsible Gaming. The grant will fund research on the long-term effectiveness of voluntary self-exclusion programs used by online and land-based gambling operators.

Not only must the gaming industry promote responsible play and fund problem gambling programs, but it is also essential that local governments provide resources to prevent and treat problem gambling. Government funding for problem gambling programs is crucial to help individuals struggling with gambling addiction receive the support and resources they need. These programs can provide counseling, therapy, and other forms of treatment to help individuals overcome their addiction and improve their quality of life.

Eliminating funding for problem gambling programs could have devastating consequences for individuals and families affected by problem gambling in DC. The City Council needs to recognize the importance of these programs and ensure that they continue to receive adequate funding.

Further, I urge the Department of Behavioral Health to utilize the existing and future problem gambling funds derived from sports wagering to fund programs specifically focused on preventing, treating, and researching gambling addiction, just as the 2018 law intended.

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GeoComply

Given the modest annual funding ($200,000) that is dedicated to problem gambling prevention under the DC law, it makes little sense to eliminate it as proposed in the DC Fiscal Year 2024 Budget. By comparison, neighboring states of Maryland and Virginia dedicate $4 million and $2 million annually to gambling addiction resources.

Please take these recommendations into consideration. Should you have any questions, do not hesitate to contact me.

Sincerely,

John A. Pappas, SVP, Government & Public Affairs
GeoComply
202-870-7777

501 3rd Street, NW · 8th Floor
Washington, DC 20001
T 202.467.4900 · F 202.467.4949
www.childrenslawcenter.org

Testimony Before the District of Columbia Council
Committee on Health
March 30, 2023

Public Hearing:
FY2024 Budget Oversight
Department of Behavioral Health
Supplemental Testimony

Amber Rieke
A Path Forward, Project Lead
Children's Law Center

Introduction

Hello, Chairperson Henderson, and members of the Committee. My name is Amber Rieke. I am A Path Forward[1] Project Lead at Children's Law Center. 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.

I am submitting written supplemental testimony regarding the proposed FY24 budget for the Department of Behavioral Health (DBH).[2] First, I would like to thank this Committee and its staff for their diligent and thorough work in creating greater transparency around the budget. We appreciate the Committee raising questions that help create clarity on the proposed budget and, in turn, sharing these responses with the community. Based on the responses to DBH's pre-hearing questions, we are providing supplemental testimony regarding Healthy Futures and the School Based Behavioral Health Expansion Program.

There is No Cut to Healthy Futures Funding; Therefore, We Ask this Committee to Ensure the Funding in the FY24 Budget is Maintained

On March 30, 2023, we testified to an apparent cut to Healthy Futures funding in the proposed FY24 budget.[3] However, we are glad to learn that this funding has not been cut. The reduction shown in the budget is the result of a technical error, which, we understand, will be corrected.[4] The consistent level of funding between FY23 and FY24 will allow Healthy Futures to continue to hire and expand services into the projected 182 child development centers and home childcare providers.[5] This increase will bring the District closer to having Healthy Futures in 300 child development centers and home providers as envisioned in the Birth-to-Three for All DC Amendment Act of 2018.[6] We ask this Committee to ensure the error showing a cut to Healthy Futures is corrected in the budget and that the program maintains stable funding in the FY24 budget.

We urge the Council to Invest at Least $3.45 Million More in SBBH to Ensure Stable and Sufficient Compensation for CBOs in FY24

We are pleased to be able to share some updated numbers regarding the community-based organization grant funding for the School Based Behavioral Health Expansion Program (SBBH). In our earlier testimony, we thanked DBH for responding to hiring difficulties by increasing CBO grants which allowed for hiring or retention incentives for clinicians at a time when many are experiencing burnout and receiving competitive offers elsewhere.[7] The amount reported by DBH to Coordinating Council

members as recently as February 2023 was $99,371 per clinician to recruit and retain staff.[8] Based on this number, we and Coalition members requested the Committee add $5.7 million to the budget to maintain grant amounts – plus inflation – for a total of $103,000 per clinician.[9] We based this enhancement ask on predictions that DBH would only allocate $80,000 per clinician, as had been signaled in meetings. However, DBH budget documents provided after the March 30 hearing state that the amount per clinician in the proposed FY24 budget is $89,366.[10] While this is more than we originally guessed, it still represents a $10,005 per clinician cut between the current FY23 funding and the proposed FY24 funding, and provides no inflationary increase.

We are continuing to ask the Council to ensure that CBO compensation is stable and sufficient in FY24, at a funding level of $103,000 per clinician. Meeting this goal requires $3,449,402 to make up the difference in 253 schools. As we struggle to hire clinicians in the face of an unprecedented shortage of professionals, we must maintain the CBO's ability to offer competitive pay, incentives, and professional support for these essential roles. Failing to do so will result in losing clinicians and puts the whole program at risk.

Long-Term Considerations for Program Vision, Implementation, and Oversight

We also feel that a few other key things regarding the SBBH program budget are pertinent to this testimony. First, the current increase proposed in FY24 to $89,366 relies on American Rescue Plan Act (ARPA) funds that are time limited.[11] Therefore, as we

look ahead, there will likely be another reduction in the SBBH program when those funds expire, reverting the program to the original level of $80,200 per clinician. To meaningfully ensure investment in the SBBH, we ask this Committee to look ahead and ensure this additional funding is not lost in the FY25 budget and beyond.

Second, we would like to note that the total budget for the SBBH program includes investments in program evaluation and data collection, as well as the Community of Practice, which brings together providers, staff, and school leaders in a collaborative learning environment to share best practices, support, and participate in learning activities.

Finally, Committee members have asked smart questions through the hearing process about how to bring the program to its full potential. Along with the Committee, we are looking forward to the overdue rate study and evaluations to provide a better understanding of the costs and opportunities of the program. Finally, we believe further inquiries about this program would be well-served by a dedicated hearing on SBBH following the release of the cost study.[12]

Conclusion

We appreciate the opportunity to share these updated asks and remain available to answer any questions regarding the investments needed to sustain essential programs in the DBH portfolio.

[1] Children's Law Center co-authored a 2021 report called A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia, which detailed 94 recommendations to better meet the needs of DC children and families. As the Project Lead for A Path Forward, my work is focused on driving forward the recommendations contained in our report.

[2] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 30, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf.

[3] *Id.*

[4] Budget line 6620 inadvertently includes $655,000 that was meant for Healthy Futures. See FY2024 DBH Budget Oversight Pre-Hearing Responses, response to Q8 and Q20, *available at*: https://www.dropbox.com/sh/8fmlfns6bd8b39j/AAAXaSvmR4xqGrw1xpBo53JGa/FY%2024%20Budget%20Questions.%20DBH%20Response?dl=0&subfolder_nav_tracking=1.

[5] DBH, FY2022 Performance Oversight Responses, response to Q41, p. 38, available at: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1.

[6] D.C. Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[7] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 30, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf.

[8] Coordinating Council on School Based Behavioral Health, February Meeting, on file with the Children's Law Center.

[9] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 30, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf.

[10] FY2024 DBH Budget Oversight Pre-Hearing Responses, response to Q20, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAGUOnsdH57hHf7WvWf4D55a/FY%202024%20Budget/DBH/Agency%20Responses/FY%2024%20Budget%20Questions.%20DBH%20Response?dl=0&preview=FY+24+Budget+Question+20.docx&subfolder_nav_tracking=1.

[11] *Id.*

[12] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health (February 1, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/02/AmberRieke_CLC_Performance-Oversight-Testimony_DBH_February-1-2023_SBBH_final-1.pdf.

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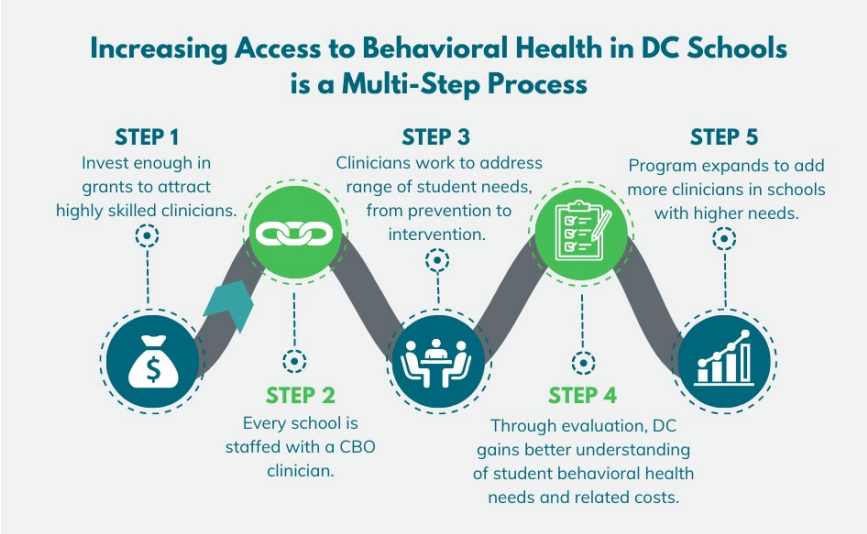

Written Testimony for the DC Department of Behavioral Health Budget Oversight Hearing Before DC Council Health Committee (03/30/23)

Committee Chair Henderson and other Health Committee Members, my name is Rosalind M. Parker, Esq., CPS and I am a DC and VA licensed attorney and a nationally certified drug use prevention specialist. I serve as the founding President & CEO of Bridging Resources in Communities, (BRIC) Inc. and as the Director of the Ward 5 Drug Free Coalition and of the Wards 7 & 8 DC Prevention Center. For close to 20 years I have been personally dedicated to providing data driven, evidenced-based drug use prevention education and related services to DC residents living primarily in Wards 5, 7 and 8.

Since 2005, BRIC Inc. has provided drug use prevention and mental health wellness education primarily to Wards 7 and 8 DC residents to empower them with information and actionable strategies to create healthier, drug-free communities thereby improving the safety and livability of these communities. Our key accomplishments include: leading the creation of and securing ten years of federal funding for the locally, nationally and internationally recognized Ward 8 Drug-Free Coalition (2006 – 2012); partnering with the DC Department of Behavioral Health (DBH) (formerly DOH/APRA) to create and operate an innovative, sustainable prevention infrastructure for the District of Columbia via four DC Prevention Centers – BRIC, Inc. has operated the Wards 7 and 8 DC Prevention Center (DCPC) since 2010; and building off of these experiences, since 2014 we have led and secured ten years of federal funding for the Ward 5 DC Drug-Free Coalition.

Our motto is: “Linking Resources in Communities for Healthier Living.” Our primary focus has been and will continue to be community-level, environmental strategies based on youth-led, adult-guided drug use prevention. Simply stated, drug use prevention is what we do and do well and our current focus is on continuing to successfully operate a sustainable Wards 7&8 DCPC with an expanded focus on combining prevention education and harm reduction strategies to work with DBH and our community partners to address the District’s ongoing Opioids misuse crisis.

In support of the DC Health Alliance Network (HAN) of which we are a founding member, BRIC, Inc. is calling upon the DC government to declare an opioid public health emergency and also to commit more dedicated funding to drug use prevention education, including at least 20% of the DC Opioids Settlement Funding. This is due to the consistently high number of annual deaths in recent years and due to the increase in opioid misuse and non-fatal and fatal overdoses in vulnerable communities and younger populations. In 2021, there were 18 non-fatal overdoses among youth from infancy to 21 years old. In 2022, there were 36 opioid deaths between ages 0-29. Moreover, since 2019 there have been close to or over 400 fatal opioid overdoses annually as compared to approximately 200 homicides annually. So there have been twice as many opioids deaths as compared to homicides. And the numbers are going

up: According to the latest Chief Medical Examiner data, there were 448 opioids related deaths for 2022, an average of 37 people each month.

Prevention education is key to addressing this issue. Unfortunately, prevention is consistently given the least amount of resources and priority along the continuum of care (prevention, treatment, recovery aka secondary prevention) in DC. Prevention should be given significantly more resources because it is the key link, the constant bridge along the continuum of care. We are known in the community and work hand in hand with our government and community partners to connect those who need resources to those resources including current and emerging drug use data, information on the harmful effects of various drugs, access to Narcan and trainings on how to safely administer it as well as direct referrals to our partners who provide treatment and recovery services. Because prevention education is universal we are the only DBH funded providers that literally serve EVERYONE. So technically each DC Prevention Center serves 145,000 DC residents (2 Wards) and yet we only have 4 FTEs and we haven't had cost of living increase in at least six years.

Drug use prevention encompasses a wide array of policies, programs, and other data driven, evidence-based strategies intended to help people make healthy choices and reduce the scope and impact of substance use. These activities seek to strengthen protective factors and weaken risk factors for substance use through positive impacts on people and communities. Substance misuse prevention seeks to prevent and reduce drug use and the consequences of use. Prevention can take many forms, ranging from environmental strategies that change the context which people live in to targeted interventions that provide education or skills training. Examples of prevention activities include: • Educational campaigns • Life and social skills training • Harm reduction activities • Problem solving and coping skills training • Family education and bonding programs • Retail advertising restrictions • Law enforcement activities.

Recently released report on 2021 CDC Youth Risk Behavioral Survey data shows that the majority of American youth are not using or misusing substances. However, the survey also highlights the risk faced by children and youth living in vulnerable communities and fragile families, where substance use is more prevalent. To address these risks, the report suggests identifying risk factors and promoting mental health, investing in training for parents, and providing evidence-based school strategies, including increasing school connectedness, and enhancing health education.

To effectively address the current DC opioid crisis, more dedicated, prevention-focused resources are needed. DC Prevention Centers are a trusted resource throughout the continuum of care, and more demands are being placed upon them by their government partners and community partners due to the crisis. Less than four percent of the current DBH budget funds prevention. BRIC, Inc. is advocating for more funding with fewer restrictions, including at least 20% of the DC Opioids Settlement Funding. The opioid crisis in DC needs immediate attention, and BRIC, Inc. believes that an opioid public health emergency is necessary to combat this issue.

2022-2023

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Improving Justice for the Community

Statement of the Council for Court Excellence
Before the Committee on Health
of the Council of the District of Columbia

Hearing on Budget Oversight for the Department of Behavioral Health

April 9, 2023

Thank you for the opportunity to submit written testimony regarding the Fiscal Year 2024 (FY24) budget for the Department of Behavioral Health (DBH) on behalf of the Council for Court Excellence (CCE). CCE is a nonpartisan, nonprofit organization with the mission to enhance justice in the District of Columbia. For over 40 years, CCE has worked to improve the administration of justice in the courts and related agencies in D.C. through research and policy analysis, convening diverse stakeholders, and creating educational resources for the public. Please note that in accordance with our policy, no judicial member of CCE participated in the formulation or approval of this testimony. This testimony does not reflect the specific views of, or endorsement by, any judicial member of CCE.

CCE's recommendations for FY24, provided in this written testimony, focus on 1) the importance of increasing the salaries of clinicians to ensure full implementation of the School-Based Behavioral Health program, 2) the need for additional investments in DBH's Community Response Team, Community-Based Behavioral Health Services, and 3) Housing Services for Justice-Involved People with Substance Use Disorders.

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School-Based Behavioral Health Program (SBBH)

CCE, along with many of our community partners, believes that robust funding and aggressive recruitment for SBBH clinicians in every school needs to be a top priority for DBH in FY24. Providing behavioral health services in a school setting will increase the quality of education for youth in schools, improve youth well-being and holistic healing in D.C., and support the city's investment in public safety.

While we know that the D.C. Council and the Mayor recognize the value of SBBH for D.C.'s children, as demonstrated by prior years' investments in the program, the urgency and importance cannot be overstated. Indeed, this is a national crisis. The American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association – which combined represent more than 77,000 physicians and 200 children's hospitals – declared a national mental health emergency in late 2021.[1] In a 2021 advisory report, the Surgeon General emphasized the urgent need to address the nation's mental health crisis among youth. The report warns of "soaring rates of depression, anxiety, trauma, loneliness and suicidality" among children, which will affect their lives for a long time to come.[2] Unaddressed mental health issues can serve as a distraction for youth, their classmates, and the classroom environment.[3]

But, in hopeful news, data also shows that providing mental and behavioral health resources in schools will improve the quality of education for youth which can lead to an improvement in their classroom performance. School-based behavioral health services improve access to care and allow for early identification and treatment of mental health issues. Having the

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[1] AAP, AACAP, CHA declaration of a national emergency in children's mental health, American Academy of Pediatrics, October 19, 2021, available at: https://publications.aap.org/aapnews/news/17718/AAP-AACAP-CHA-declare-national-emergency-in.

[2] U.S. Surgeon General Issues Advisory on Youth mental Health Crisis Further Exposed by COVID-19 Pandemic, HHS.gov, December 7, 2021, available at: https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

[3] How Mental Health Disorders Affect Youth | Youth.gov. (n.d.). Retrieved April 4, 2023, from https://youth.gov/youth-topics/youth-mental-health/how-mental-health-disorders-affect-youth.

resources to address, treat, and cope with mental and behavioral health diagnoses is a benefit to the entire school community because it ensures youth can bring their best selves to the learning environment.

School-based behavioral health services will also benefit the well-being of children outside of school. Being mentally healthy during childhood means reaching developmental and emotional milestones and learning healthy social skills and how to cope when there are problems.[4] Across the country, as many as one in six children (17.4%) are diagnosed with psychological, emotional, or developmental disorders in early childhood. When children live in poverty, they experience even higher rates of these disorders (22%).[5] However, only one-fifth of children with mental, emotional, or behavioral health problems receive care from a specialized provider.[6]

This unmet need for mental health services is more severe for Black children and children of color than for white children, and for the children in the District of Columbia.[7] Twenty-three percent of D.C. children had an emotional, behavioral, or developmental condition in the 2019-2020 school year (up from 21 percent in the 2018-2019 school year).[8] Nearly 15% of D.C. high school students attempted suicide in 2019, 5% higher than the national rate.[9] Children that have

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[4] What Is Children's Mental Health?, Centers for Disease Control and Prevention, 20 Mar. 2019, http://www.cdc.gov/childrensmentalhealth/basics.html. Accessed 31 Mar. 2023.

[5] Bitsko RH, Claussen AH, et. al., *Surveillance of Children's Mental Health – United States, 2013 – 2019*, MMWR, 2022 / 71(Suppl-2);1–42. https://www.cdc.gov/mmwr/volumes/71/su/su7102a1.htm.

[6] Cree RA, Bitsko RH, et. al., *Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2–8 years — United States, 2016*. MMWR, 2018;67(5):1377-1383, available at: https://www.cdc.gov/mmwr/volumes/67/wr/mm6750a1.htm.

[7] Martini R, Hilt R, Marx L, et al.; for the American Academy of Child and Adolescent Psychiatry. *Best principles for integration of child psychiatry into the pediatric health home*, June 2012, available at: https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf.

[8] Office of the State Superintendent of Education, (2019). *District of Columbia Youth Risk Behavior Survey: Mental and Emotional Health.* Retrieved from https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2019%20DC%20YRBS%20Report.pdf.

[9] The Annie E. Casey Foundation, *Children who have one or more emotional, behavioral, or developmental conditions in the United States, 2017-2018, 2018-2019, 2019-2020,* Kids Count Data Center, *available at*: https://datacenter.kidscount.org/data/tables/10668-children-who-have-one-or-more-emotional- behavioral-or-developmental-conditions?loc=1&loct=2#detailed/2/2- 52/false/1769,1696,1648/any/20457,20456.

the skills and resources to cope with their mental health are overall healthier and more equipped to be productive, thriving citizens and contributors to their community.

Finally, providing behavioral health services to children in schools is a direct investment in public safety. When students enter the school building, they carry with them their experiences navigating educational, economic, and social barriers, not to mention the trauma experienced within their families and neighborhoods. These experiences significantly impact their ability to engage and be productive in the school environment. The SBBH program lowers barriers to behavioral health care so youth can receive the support they need right where they spend most of their time (outside of their homes). Our city's approach to public safety should not exclude our youth but instead create focused solutions that will support them and invest in their futures.[10] The successful implementation of the school-based behavioral health program ensures that the District's approach to public safety includes at least one focused solution that will support students and improve the overall health and safety of D.C. communities.

To increase access to behavioral health in D.C. schools, there are several steps that must be strategically implemented by the D.C. Council in FY24. The first step is to attract highly skilled, qualified clinicians by increasing the investment in their salaries. To achieve this, the District must budget for an increase in the salaries for SBBH clinicians. CCE agrees with the recommendations and evaluation of the Strengthening Families Coalition that the starting salaries should be set at $103,000 per clinician to be competitive. Including inflation costs, this will require $5.2 million for the SBBH allotment offered in grants to Community Based Organizations (CBOs) to ensure

[10]The United States Government. (2021, October 19). *Fact sheet: Improving access and care for youth mental. health and substance use conditions*. The White House. Retrieved April 4, 2023, from https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/19/fact-sheet-improving-access-and-care-for-youth-mental-health-and-substance-use-conditions/

that every school can employ at least one CBO clinician. From prevention to intervention to treatment, clinicians can address a variety of student needs. This is a modest but critical investment in the education and future of our children.

Prevention and Intervention - Community Response Team (CRT)

CCE also recommends critical budgetary investments to DBH's CRT, including the Pre-Arrest Diversion (PAD) program. CRT is a multidisciplinary direct service team that expands community based direct service efforts—including homeless outreach, mobile crisis, and pre-arrest diversion. We applaud the increase in funding provided for the CRT in FY23 and urge the Committee to continue to invest in this resource in FY24 by increasing CRT funding by $6.6 million. This increase is reflective of recommendations 1.8 and 2.2 of the District Task Force on Jails & Justice Phase II report.[11] The need for this vital community resource has only become more important as the District emerges from the worst of COVID-19's impacts. The isolation, trauma, and instability of the pandemic all increased the need for behavioral health care generally, and crisis interventions specifically, making financial investments in these services all the more critical.

This additional $6.6 million will allow for enhanced provider and Metropolitan Police Department (MPD) training to properly divert appropriate cases from traditional law enforcement intervention, as well as CRT staff workforce development, and employee recruiting and retention. Even with last year's increase in funding, CRT's current operational capacity does not allow the team to respond in a timely manner to all cases that might be – and should be – eligible for arrest diversion or any other alternative intervention model, or to support the law enforcement trainings and collaborations that are critical to making these programs a success.

[11] District Task Force on Jails and Justice. (2021, February). *Jails & Justice: Our Transformation Starts Today, Phase II Findings and Implementation Plan*. http://www.courtexcellence.org/news-events/district-task-force-on-jails-justice-publishes-phase-ii-report-with-10-year-implementation-plan-to-transform-justice-in-dc

Reaching the majority of eligible PAD cases – a goal shared by CCE, the District Task Force on Jails & Justice, and DBH – would require 1) an expansion of the CRT's capacity, 2) DBH's ability to track high-quality data about the impacts of its interventions, and 3) capacity to develop a successful partnership with MPD. We encourage this Committee to allocate an additional $6.6M to DBH to enable CRT to scale up appropriately in FY24. With that increased capacity, the District – and this Committee – may well be able to see significant community impacts and justice-system cost savings within just a few years.

Community-Based Behavioral Health

Community-based services and responses also play an important role in supporting D.C. residents who are experiencing behavioral health crises. In FY24, CCE recommends an increase of $3.3 million for community-based behavioral health services. This is a modest request to regain the funds lost in FY23 to programs providing community-based services to residents experiencing a behavioral health issue or crisis. Community-based services provide the intervention and prevention that allow D.C. residents to access needed services in their neighborhoods through outpatient services, before more acute interventions are necessary, such as hospitalization or incarceration.

Housing Services for Justice-Involved People with SUDs

Based on our research and recommendations in "*Everything is Scattered… The Intersection of Substance Use Disorders and Incarcerations in the District*,"[12] CCE recommends a $3.7 million investment in targeted housing services for justice-involved people with Substance Use Disorders (SUDs) in FY24. Between 2015 and 2019, almost 48% of people in Department of Corrections (DOC) custody had a documented SUD and of those, people who received SUD

[12] Council for Court Excellence. (2020, August 25). *Everything is Scattered…The Intersection of Substance Use Disorders and Incarcerations in the District.*
http://www.courtexcellence.org/uploads/publications/SUD_Report_82520.pdf

care after their release from DOC custody had a 36% lower chance of being re-arrested or re-incarcerated within 90 days. By providing housing opportunities for these uniquely situated and underserved returning citizens, the District will ultimately save financial resources through lowered recidivism rates and by avoiding the collateral consequences of housing instability for these individuals. The collateral consequences can include difficulty maintaining employment or meeting supervision requirements. CCE recognizes that the District is facing a lean FY24 budget. But by investing in housing services for justice-involved people with SUDs, D.C. can actually save money by embracing a housing-first model, meeting people with the services they need, ultimately reducing the likelihood of re-incarceration, allowing returning citizens to thrive in our community, and increasing public safety.

This investment will restore the District to FY23 funding levels for supportive housing and would allow for a $2 million investment to expand the use of the housing-first model among reentry housing providers, as recommended by the District Task Force on Jails & Justice. This investment would fund new housing and case management services for 55 more returning citizens in FY24 at a cost of $36,000 per person per year. We urge Council to allocate this funding to support vulnerable D.C. residents with basic stability and safety.

Thank you for the opportunity to provide this testimony for the record. We are always available to answer questions that any members of this Committee or the Council may have.

Council of the District of Columbia

Committee on Health

Councilmember Christina Henderson, Chairperson

Budget Hearing on:

Department of Behavioral Health

March 30, 2023

Testimony of:

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Introduction

Hello, my name is Micaela Deming and I am the Policy Director for the DC Coalition Against Domestic Violence (DCCADV). DCCADV is the federally-recognized statewide coalition of domestic violence service providers in the District of Columbia and includes domestic violence specific housing providers, counseling and case management services, legal services, and culturally specific organizations serving: African; Latinx; Asian and Pacific Islander; Immigrant; and LGBTQ survivors of domestic violence. Our members also serve teens and youth, and survivors who are Deaf and Deaf/Blind. Intimate partner violence continues to be a significant public safety and public health concern for DC residents of all ages. These dedicated service providers work tirelessly to address the epidemic of domestic violence across all eight wards of the District. I am here today to inform the Committee on Health about survivors of domestic violence, the providers who serve them, and how that work relates to the Department of Behavioral Health.

One in three women and one in four men have experienced domestic violence in their lifetime[1], which leads to disastrous effects for the victims, their families, and their communities. We also know that 39% of women and 25.5% of men living in DC have experienced sexual violence, physical violence, stalking, or a combination thereof perpetrated by an intimate partner.[2] Taking a closer look at domestic violence fatalities in DC, in 2020, there were 18 domestic violence homicides. In 67% of these domestic violence homicides, the victim died by gunshot. Between 2016-2020, there were 68 domestic violence homicides. 51% of these fatalities involved shootings. According to the Domestic Violence Fatality Review Board 2022 Annual Report, addressing domestic violence homicides that were committed during calendar year 2021, 20 people over the age of 15 were killed in domestic violence fatalities. One child was killed, bringing the total domestic violence fatalities identified to 21.

[1] M.C. Black et al., Ctrs. for Disease Control & Prevention, *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* 2 (2011), https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

[2] S.G. Smith, et al., *The National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report* 144 (2017), https://www.cdc.gov/violenceprevention/pdf/nisvs-statereportbook.pdf.

Department of Behavioral Health Partnership

On September 13, 2018, DCCADV joined six District Councilmembers—Councilmembers Allen, Grey, Grosso, McDuffie, Nadeau, and Silverman—asking that 22 District agencies and the DC Council complete a survey on how their agency responds to domestic violence regarding staff who experience domestic violence and survivors who seek services from their agencies. Unfortunately, DCCADV found that DBH did not have a domestic violence policy, nor did the agency indicate that it has any collaboration with local domestic violence service providers.[3] DCCADV recommended that DBH build relationships with the local domestic violence service provider community so that a positive referral process could be put in place when the need for domestic violence-specific services are identified within the agency's client base. It was also recommended that DBH receive domestic violence training in order to meaningfully engage with clients who are in abusive relationships. In response to this work, the Mayor implemented a DV Policy within two months of our report card release that addressed how each DC government agency should respond when an employee self-identifies as a survivor. DCCADV helped in the development of this policy impacting all DC government employees.

Future Funding

It is unfortunate that DBH has not engaged more with DCCADV and the broader Domestic Violence Service Provider Community since then, considering that experiencing domestic violence is a main driver of mental health and substance use issues for DC residents, as well as homicides. Having already noted that experiencing domestic violence is commonplace in the District, evidence also shows that experience with domestic violence trauma has a detrimental impact on psychological health: compared to District women who have never had an abusive partner, those who survive violence experience higher rates of suicidality,

[3] DC Coalition Against Domestic Violence. (2019). (rep.). *SURVIVING DC: A Domestic Violence Report* (p. 11). Washington, District of Columbia.

depression, post-traumatic stress symptoms, and greater use of drugs or alcohol.[4] National research has suggested that efforts to prevent domestic violence related homicides should include suicide prevention; specifically, efforts to screen and treat depression and substance use in abusive partners, because roughly 20-75% of murder-suicide perpetrators nationally were found to be depressed prior to the deaths.[5]

DCCADV and our member programs wish to support the DBH in their efforts to provide coordinated care to those experiencing mental illness and substance use issues, especially because domestic violence services are free of charge for individuals accessing care and do not require insurance. As organizations funded to provide free services, DV Service Providers in DC are a natural entry point and ally for residents experiencing behavioral health issues, yet are not being supported by DBH or the Mayor's proposed budget in these efforts. Domestic violence survivors seeking mental health support receive services uniquely tailored to meet their needs with our member programs. Mental health services provided by domestic violence programs focus on safety, center best practices to support the trauma caused by domestic violence, and ensure culturally specific and linguistically accessible services that are not dependent on health insurance coverage that is too often linked to or interrupted by an abuser.

The True Cost of Survivor Safety includes the toll experiencing trauma takes on District residents, families, and communities. In order for survivors to heal and rebuild their lives, and in order to prevent those who choose to harm in their relationships from esclalating to lethal violence, vital behavioral health services must be available to both victims and perpetrators. Unfortunately, this reality is not being fully addressed by the DC government and it is not being addressed at all within the DBH budget. We continue to see months long waiting lists for domestic violence specific mental health and other services. As it pertains to DBH's work, domestic violence is a massive contributor to mental health and substance use issues in the District. With more

[4] Bonomi, A.E., Thompson, R. S., Anderson, M., Reid, R.J., Carrell, D., Dimer, J. A., & Rivara, F.P. "Intimate Partner Violence and Women's Physical, Mental, and Social Functioning. American Journal of Preventive Medicine 30 (2006): 458-466; Stockl, H., Devries, K., Rotstein, A., Abrahams, N., Campbell, J., Watts, C., & Moreno, C.G. "The Global Prevalence of Intimate Partner Homicide: A Systematic Review." The Lancet 382, (2013): 859-865.

[5] Salari, Sonia & Sillito, Carrie. (2015). Intimate partner homicide suicide: Perpetrator primary intent across young, middle, and elder adult age categories. Aggression and Violent Behavior. 26. 10.1016/j.avb.2015.11.004.

than 1 in 3 District residents experiencing the trauma of DV and the majority of them will experience behavioral health related impacts. The cost of this is extremely high: The National Center for Injury Prevention and Control (Injury Center) estimated that the mean cost of mental health care for those who sought treatment after a physical assault by an intimate partner was $1,017 per incident [$1874 in 2022 dollars], the mean per incident cost of treatment for intimate partner victims of rape was $978 for mental health care [$1,802, in 2022 dollars], and that the mental health costs for intimate partner violence stalking victims seeking treatment was $690 [$1,271 in 2022 dollars]. In addition, they found that there is an additional $11,042 in lifetime increased medical costs *per child* exposed to DV.[6]

Currently, no DBH funding is directed to domestic violence service providers offering services within the context of wrap-around services. While the DCCADV notes the overall 2.2% increase to the DBH budget, a reallocation of an additional $1.2 million toward serving the mental health needs of survivors of domestic violence within domestic violence survivor service providers will ensure more timely counseling services are available to survivors regardless of their ability to safely access medical insurance. The current need greatly exceeds the available resources: some programs have months-long waiting lists and others not able to accept new clients. It is the clients who are already most marginalized who lack the most access to therapy and mental health supports. The longer we avoid prioritizing these populations, the more their trauma compounds and the more it costs us in the longrun. It is time for DC Council to acknowledge the link between domestic violence and Behavioral Health by dedicating $1.2 million toward mental health care for domestic violence survivors.

Conclusion

We greatly appreciate the Council's commitment to addressing the needs of survivors of domestic violence and the organizations working with them. We hope that through this budget process and in the coming months we can develop a stronger working relationship with DBH to provide domestic violence

[6] IWPR, citing National Center for Injury Prevention and Control, 2003

survivors more comprehensive, coordinated, and timely services. I am happy to discuss any questions you may have. Thank you, Chairperson Henderson, for the opportunity to testify.

Comments on the
Department of Behavioral Health FY24 Budget Oversight
For the Committee on Health
March 30, 2023

On behalf of the Coalition for Nonprofit Equity, a coalition of approximately 1,000 DC nonprofits advocating for full funding and implementation of the Nonprofit Fair Compensation Act of 2020, I submit the following comments on the Mayor's proposed FY24 budget for the Department of Behavioral Health as the Coalition Consultant. Members of the Coalition share a common goal of ensuring all DC residents have access to the vital community-based services and supports they need to not only survive, but thrive, and that community-based providers are treated fairly for their services. This law is an important step in right-sizing and adequately compensating nonprofit partners for their "actual costs" of doing business in DC.

FY24 Proposed Budget

The Mayor proposes a 2.2% increase to the overall budget of DBH for FY24, from $377 million to $385 million. However, as a coalition advancing equity, proposed reductions such as a $7.5 million decrease to the Behavioral Health Block Grant Program, and additional reductions to SUD Prevention and Treatment (while spending millions on a second "sobering" center) and early childhood services, concern the Coalition as we continue to advocate for full implementation and funding of the Nonprofit Fair Compensation Act of 2020.

The Mayor's proposed FY24 budget not only suggests steep cuts in social service contract and grant programs, but fails to be transparent about the continued lack of funding for nonprofits' costs in administering their government contracts and grants. Fiscal Year 2024 is the third year of implementation for the Nonprofit Fair Compensation Act of 2020, and should attach to all contracts and grants to eligible nonprofit awardees for contracts and grants valued up to $10 million. With the steep proposed reductions to the District's many social services office and agency budgets, effectively compensating nonprofits for their actual costs may come at the unfortunate expense of even *fewer* services, which is the antithesis of the intent of the law. This is certainly not what District residents, still recovering from the effects of three years of the COVID pandemic, need.

Notwithstanding DBH's proposed budget increase, budget reductions in important programs within the agency and across the government concern the Coalition, and we share with the Committee that the Executive noted to the Coalition that some agencies and offices may have more budget flexibility than others, and if so, they could reprogram/reallocate funding to meet nonprofits' true indirect costs (until all agencies are properly funded). We urge Councilmembers to adjust agency budgets as able to allow for adequate funding to nonprofit partners in FY24. Further, during the FY24 budget hearing process, it is important to ask agencies and offices **to be**

transparent about whether and how they pay fully for indirect costs and how are they training and implementing the law in their own contract and grant processes currently.

District Government Commitments on Law's Implementation

The District government provided certain acknowledgements and commitments to the Coalition for Nonprofit Equity with respect to assessing the costs of fully implementing the law in meetings in 2022-2023. These acknowledgements and commitments include:

- Acknowledging the initial cost analysis missteps when the law was being considered that caused "significant delay" in the law's implementation;
- Scheduling Listening Sessions in March and April 2023 to hear from nonprofits about their experiences working with the government, and asking for Coalition assistance;
- Building out a database of contract awards to nonprofits across agencies and offices and tracking what indirect cost rates they already have to understand costs and gaps. However, as creation may take into summer 2023, the government noted it will not be prepared to assess the costs of the law in time for proper budgeting for FY24 based on this tool; and
- Creation and distribution of a survey to understand additional "complicating factors" such as stipulations on federal pass-through funds.

Nonprofit Funding Proposal

What the government has *not* promised, however, was ensuring *funding* for the law. DC's nonprofits have subsidized the District government for too long, and the Nonprofit Fair Compensation Act of 2020 passed to finally and fully compensate nonprofit service providers for their work providing District residents DC-government services. Unfortunately, the Mayor's proposed FY24 budget fails to ensure that the law's requirement that grants valued at up to $10 million in FY24 will include additional funding for nonprofit service providers. To right this financial inequity, we propose funding two pots at $10 million ($20 million, total) to directly fund indirect costs on FY24 contract and grants and for nonprofit providers. The Coalition understands the financial challenges in the magnitude of the ask, but notes the proposal is based on similar work in New York City by their Human Services Council.

This proposal would work in tandem while the District is developing its database and assessing contracts and grant costs. Some nonprofits already receive some, if not *all*, of their allowable indirect costs in their DC contracts and grants, while others have gaps to be addressed with ongoing negotiations and fund-adjustments. Two general pots for indirect costs could help assess the magnitude *in concert with* the more detailed work the Executive is doing, *while also ensuring* that nonprofits can receive at least *some* indirect cost funding for contracts and grants in FY24;

as we know, the Mayor has not specifically provided additional funding for those costs in accordance with the law this fiscal year or proposed in FY24.

In the first year of NYC's program, they allocated $40 million, which was a significant underinvestment. The following year the allocation increased to $190 million. The District's nonprofit contract and grant sector is smaller than NYC's, and as discussed, some nonprofits already receive some or all of their indirect rate, so the proposed pots of funds are meant to address the lingering inequity for those nonprofits who have remained under resourced, even as they provided essential and critical services to District residents throughout three years of a pandemic, let alone in the years that preceded COVID.

In NYC, funding was allocated to their Deputy Mayor for Human Services as well as the Deputy Mayor for Contracts, who jointly administered the indirect cost funds. Here, while outside of the purview of this Committee, the Coalition notes the District could site grant funding with the Mayor's Office of Community Affairs, and contract funding within the Office of Contracting and Procurement, or similarly to NYC, within the Deputy Mayors.

Coalition Recommendations for Law's Implementation

Irrespective of development and funding of the proposed indirect cost funds pots advocated for above, the Coalition requests the Department of Behavioral Health work with the Executive Office of the Mayor (EOM) and the Office of Contracting and Procurement to ensure that grant officers and contract administrations throughout the agency are trained on the Nonprofit Fair Compensation Act of 2020 and urges DBH to participate with their cost survey and database under development.

While outside of the realm of DBH specifically, the Coalition also notes that the Executive and Council should consider annual adjustment to nonprofit service provider contracts and grants to account for inflation and cost-of-living increases. We also suggest the Council consider introducing legislation establishing an ombudsperson for nonprofits to assist with the implementation of the Nonprofit Fair Compensation Act of 2020. Having a dedicated advocate for nonprofits, large and small, could increase awareness and consistency of application of the law within the government and throughout the nonprofit sector.

Thanks for the opportunity to provide these comments.

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1350 Pennsylvania Avenue
Washington, D.C. 20004

April 7, 2023

Submitted to the DC Council Committee on Health
Department of Behavioral Health FY 2024 Budget Oversight Hearing on March 29, 2023

Testimony of Scout Cheeks, Policy and Project Management Analyst at the DC Appleseed Center for Law and Justice

Thank you for the opportunity to testify regarding the Fiscal Year ("FY") 2024 proposed budget for the District's Department of Behavioral Health ("DBH"). My name is Scout Cheeks and I am the Policy and Project Management Analyst at DC Appleseed Center for Law and Justice ("DC Appleseed"). DC Appleseed is a non-profit, non-partisan organization that aims to make the District a better place to live and work for all through litigation, teamwork, and advocacy. Throughout our history, we have taken on some of the District's toughest problems, developed proposed solutions to those problems, and then worked to get our proposed solutions adopted and implemented. DC Appleseed has worked closely with the DC government to address the HIV epidemic in DC, including fighting against Congressional intervention into local funding for syringe services programs ("SSPs"). DC Appleseed also works to address the needs of children in DC, with an emphasis on special education and students with disabilities.

I am testifying today to urge the City Council to support health equity in the District by: (1) ensuring appropriate, expedient, and transparent funding of the Opioid Litigation Proceeds Act; (2) ensuring local dollars are allocated to SSPs; and (3) fully-funding DC's School-Based Behavioral Health Program.

<u>Opioid Litigation Proceeds Act</u>

DC Appleseed encourages the DC Council's Committee on Health to seek clarification regarding DC's existing Opioid Abatement Fund, as it is not obviously located within DBH's FY 2024 budget. In recent years, the opioid epidemic inflicted immense damage on communities across the country. DC's Office of the Attorney General worked in collaboration with other states to hold the opioid industry accountable through litigation. Through several settlement agreements, the District may receive more than $49 million over the next eighteen years.

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To ensure settlement funds are spent appropriately, the DC Council passed Law 24-315001, the Opioid Litigation Proceeds Act. This legislation was signed by Mayor Muriel Bowser on January 17, 2023, and the Congressional Review period for the Act ended on March 10, 2023. The Opioid Litigation Proceeds Act requires the establishment of an Office of Opioid Abatement, which will support an Opioid Abatement Advisory Commission. The Advisory Commission will serve a variety of functions, not the least of which is determining how DC should spend the proceeds received in multistate opioid litigations, known as the Opioid Abatement Fund. Pursuant to the Opioid Abatement Act, the Opioid Abatement Fund should be housed at DBH. We understand that some reprogramming of funds is required to move existing Opioid Abatement Funds from the Department of Health ("DOH") to DBH. Unfortunately, we cannot find any mention of the Opioid Abatement Fund, the Opioid Abatement Advisory Commission, or the Office of Opioid Abatement in the Mayor's 2024 budgets for either DBH or DOH.

DC Appleseed urges the DC Council, DBH, and the Office of the Chief Financial Officer to clarify the current status and balance of the Opioid Abatement Fund and to ensure these funds are clearly depicted in FY 2024 and subsequent budgets. Additionally, to the extent feasible, DC Appleseed recommends that the Opioid Abatement Fund, Office, and Commission be assigned a unique budgetary code (similar to the Office of the Chief Clinical Officer or the Office of System Transformation within DBH's budget.) Using a distinct code for Opioid Abatement Funds will promote public involvement, increase transparency, and ensure accountability in the expenditure of the settlement funds. A unique budget code would additionally help ensure the Opioid Litigation Proceeds Act is being used to create *new* programs (as opposed to contributing to *existing* initiatives) and streamline the annual reporting by the Mayor and DC's CFO which is required by this law.

Sustained Funding for Syringe Service Programs

DC Appleseed urges the DC Council to ensure local funds are allocated to support DC's SSPs. Opioid addiction has disrupted the lives of many District residents, many of whom are marginalized people of color. DC now has one of the highest opioid death rates in the country, and it loses hundreds of residents each year to opioid fatalities. DBH and other local healthcare providers work to reduce the impact of opioid abuse disorders on DC's community by implementing harm reduction initiatives, including SSPs. Comprehensive SSPs provide needle exchange and harm reduction services including connecting patients to care for substance use disorders, giving them access to sterile syringes and other injection supplies, and disposing of them. SSPs may use federal dollars for some components of programming, such as personnel, educational materials, and syringe disposal services. However, they cannot use those federal funds for sterile injectable supplies (i.e., hypodermic syringes or needles, alcohol swabs, and other necessary equipment). Thus, DC must allocate local DC funds in addition to federal funds to support SSPs.

Prior to 2023, SSP funding came from the HIV/AIDS, Hepatitis, STD and Tuberculosis Administration (HAHSTA), which is housed in DOH. During calendar year 2023, a transition in funding sources occurred, and DC Appleseed understands that SSP funding is now housed in DBH. Publicly released budget documents for DOH and DBH do not clearly reflect the amount of funds allocated to SSP providers in FY 2024 nor the source of those funds. For this reason, DC Appleseed recommends that the Committee on Health verify that DC allocated sufficient local and federal funds to keep DC's SSPs providing these critical harm reduction services.

Fully-Funding the School-Based Behavioral Health Program

Finally, **DC Appleseed urges the DC Council to allocate at least $5.7 million in FY 2024 to the District's School-Based Behavioral Health ("SBBH") Expansion Program to guarantee stable wages for collaborating community-based organizations ("CBOs").** DBH administers a school-based program in public and public charter schools that provides adolescents and their families with preventive, early

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intervention, and clinical care services. The SBBH initiative has the potential to be a national leader in providing access to high-quality, reliable, and culturally sensitive behavioral healthcare to District students where they spend the majority of their waking hours. However, the Program requires additional investment to support CBO clinicians in DC schools and ensure competitive compensation to draw and retain skilled behavioral health specialists.

Stable compensation for collaborating behavioral health CBOs is essential to the present and future success of the SBBH program due to the shortage of behavioral healthcare providers in the District and across the country. Given the District's rising cost of living, staffing behavioral healthcare roles has become even more difficult. With many clinicians experiencing burnout and receiving competing offers with higher pay, better benefits, and more flexibility to work remotely and set their own schedules, DBH recently increased the CBO grant to $99,371 per clinician in order to ensure that CBOs can successfully recruit and retain clinicians.

Now, in order to account for inflation in FY 2024, the DC Council must make sufficient program investments. With an investment of at least $5.7 million, DBH could offer a grant of approximately $103,000 per clinician—the whole of what CBOs presently receive plus inflation. Allocating less than $5.7 million for this program will reverse existing progress and hamper the program's long-term potential.

Thank you for your time and consideration. I would be happy to answer any questions you may have regarding these important health equity matters in DC, and I can be reached at the contact information below.

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Testimony of Rachel White

Senior Youth Policy Analyst, DC Action

DC Council Committee on Health

Budget Hearing for Department of Behavioral Health

March 30, 2023

Good afternoon Committee Chair Henderson and members of the Committee on Health. Thank you for the opportunity to address the Council today by providing testimony regarding the budget of the Department of Behavioral Health. My name is Rachel White and I am DC Action's Senior Youth Policy Analyst. At DC Action, we use research, data, and a racial equity lens to break down barriers that stand in the way of all kids reaching their full potential. Our collaborative advocacy initiatives bring the power of young people and all residents to raise their voices to create change.

Through our Youth Economic Justice and Housing Coalition, we advocate with youth and youth-serving organizations in the District of Columbia for policies, funding, and programs that expand access to comprehensive support and services that disconnected youth and youth experiencing homelessness need to successfully transition into stable and productive adulthood. We are also the home of DC KIDS COUNT, an online resource that tracks key indicators of child and youth well-being.

One of our priorities is dismantling the pipeline from youth homelessness to chronic adult homelessness, which can only be done through intentional investments into positive youth development systems throughout the District. By investing early and helping young people find stability, we are cutting off a primary contributor to chronic adult and family homelessness. For every day a young person waits for housing, they are 2% more likely to re-experience homelessness later in life. This is a cumulative statistic. Two days of waiting is equal to 4% more likely to re-experience homelessness as an adult. One way to disrupt the youth to adult homelessness trajectory is by making it easier for youth in the District to access mental health support.

People living with impaired mental health and disorders are more susceptible to three key factors that can lead to homelessness: poverty, disaffiliation, and personal vulnerability. Behavioral issues may lead them to withdraw from friends, family and other people, creating a vacuum of support and fewer coping resources in times of trouble. Mental illness can also impair a person's ability to be resilient and resourceful; it can

cloud thinking and impair judgment. For all these reasons, people with mental illness are at greater risk of experiencing homelessness, which is why it is imperative that they can access support.

We are pleased to report that in the past year we have held quarterly meetings with the Department of Behavioral Health, resulting in DBH representatives meeting with youth homelessness providers to educate them about how District youth experiencing homelessness can access mental health support. These conversations highlighted the existing gaps in service access for youth experiencing homelessness and DBH committed to working to close these gaps *if* allocated the appropriate funding. Existing behavioral health supports are missing the mark and not meeting the mental health needs of youth experiencing homelessness. According to youth experiencing homelessness and their service providers, there is a lack of accessible, youth-friendly, and culturally competent mental health services throughout the District. This gap acts as a major barrier to youth achieving long-term stability.

According to the 2019 DC Youth Count survey, 1300+ unaccompanied youth reported experiencing homelessness. Keep in mind that was before the pandemic. Service access data received from DBH highlights that only 288 transition aged youth (16-24) experiencing homelessness received mental health services from DBH. It is unknown whether this data is disaggregated by accompanied versus unaccompanied youth. Youth experiencing homelessness and youth homelessness service providers are expressing serious challenges accessing mental health services and data from DBH supports a widespread unmet need.

To improve access to mental health support for youth experiencing homelessness, we are requesting the Council to allocate **$1.7 million** in funding to establish a traveling mental health unit to meet youth where they physically congregate.

An allocation of **$1.7 million dollars** will allow DBH to hire 10 provisionally licensed social workers, 2 independently licensed social workers to supervise, and 1 consulting psychiatrist to prescribe and monitor medication on an as needed basis. [1]

Accessing services would help transition youth into DBH community services for long-term support and address youth trauma, substance abuse, and medication

[1] 10 provisionally licensed social workers with a caseload of 18-20 youth at a base salary of $75K, 2 independently licensed social worker to supervise clinicians at a base salary of $90K , 1 psychiatrists to administer medication as needed and provide medication management at a cost of $150K and $1.48 million in administrative costs to support the employment of all employees of the unit. Administrative costs will cover retirement, health insurance, and other fringe benefits.

management, all of which will decrease the likelihood of sustained or future homelessness. Recognizing that the children, youth, and families served by the public behavioral health care system in the District are primarily individuals of color, improving our system is a matter of equity. Improved access to behavioral health services is proven to be transformative for children and families and can boost the long-term overall health and productivity of communities, as evidenced by workforce outcomes and reduced crime rates.

Thank you for your time and consideration. I would be happy to answer any questions.

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Testimony of the District of Columbia Behavioral Health Association
Department of Behavioral Health FY '24 Budget Oversight

To the District of Columbia Council Committee on Health
March 30, 2023

Chairperson Henderson and Members of the Council,

Thank you for the opportunity to testify today. My name is Mark LeVota. I am the Executive Director of the District of Columbia Behavioral Health Association and a Ward 2 homeowner. The District of Columbia Behavioral Health Association works to advance high-quality, whole-person care for all District residents with mental illness or substance use disorders, including the 30,000 District residents our 31 member organizations serve annually. The Mayor's proposed budget for fiscal year 2024 for the Department of Behavioral Health reflects awareness of the significant behavioral health needs faced by District residents but omits information needed for the Council or the public to understand how the agency will operate in a year scheduled to include significant changes. The Council needs to scrutinize with care whether the proposed budget provides adequate support for the transition of Department of Behavioral Health services to managed care and the extent of support for school behavioral health or residential services for people with behavioral health conditions. The Council also needs to understand how the agency proposes to meet other resident behavioral health needs despite reductions in funding and agency staffing for several important programs, including many of DBH's services for children and adolescents.

In a particularly challenging budget environment, topline growth in the Department of Behavioral Health operating budget and funding to support a new stabilization and sobering center in the capital budget appears to reflect overall concern from the administration to meet the needs of District residents with behavioral health conditions. Review of the proposed operating budget by activity provides a more meaningful understanding of what led to topline growth. A substantial $17.8M increase in Medicaid matching payments, with additional increases in information technology, financial management, and residential services spending, is balanced against $14.3M in cuts in six of the Department's divisions.

As the District prepares to move DBH-certified provider services into managed care on October 1, 2023, the Department of Behavioral Health budget needs to be understood jointly with the Department of Health Care Finance Budget. Unfortunately, as I have confirmed with staff members from both agencies, there is not yet an integrated document that shows how spending from both agencies combines. The

projected number of beneficiaries who will receive care, the projected utilization of specific services, and the projected payment rates for services are not presented in the budget books and are not yet available from either agency, but might be sometime soon. For enrollment, the Department of Behavioral Health's Fiscal Year 2022 MHEASURES report shows DBH-certified provider organizations served 3,115 more people in FY '22 than in FY '21 – and over 10,000 more people than in 2018.[1] For utilization, the same report shows that expenditures were $65.8M more in FY '22 than in FY '21 – and $168.1M more than in FY '18. For payment rates, as we testified during agency performance oversight, provider organization payment rates are 17.5% less than what would have been needed to keep pace with inflation since the last rate setting work done based on 2016 costs. If we presume that people sick enough to need rehabilitative behavioral health services will not lose their eligibility for Medicaid or the DC Healthcare Alliance, the Mayor's proposed FY '24 budget understandably requires substantially more funding just to meet higher enrollment and utilization. It remains unclear whether there is also room in the proposed budget to adjust provider payment rates to close the gap from inflation. A structured Alternative Payment Methodology (APM) for DBH-certified providers including annual inflationary adjustments supported by audited cost reporting and periodic rebasing would help to smooth the trajectory of Medicaid and Alliance spending for behavioral health services.

The Council needs to take a careful look at what the budget chapter does not show about school behavioral health services. This year, the Department of Behavioral Health issued total grant awards to community-based organizations of $99,371 per clinician per school. Community-based organizations were told that approximately $29,000 of those awards was from one-time funding, with base awards of $70,334. The Council approved funding for FY '23 to increase recurring spending to $80K per school, so the base award description is inconsistent. Either way, the proposed FY '24 budget appears level with the approved FY '23 budget, and there are no indications of available one-time funds in some other line item to keep FY '24 total grant award amounts the same size as FY '23 total grant award amounts. Despite the line item increase of $113,000, the total funding instead appears set to lead to a reduction from FY '23 grant award amounts of between $19,000 and $29,000 per school for school behavioral health expansion grants. The Council should ask the Department of Behavioral Health what total grant award amounts it has budgeted per clinician per school, and the Council then appears to face the hard choice of finding additional funding to keep total grant awards level or to risk that community based organizations will determine they are no longer willing or able to participate in the program or only at a fewer number of schools. Given continuing inflation, we join the Strengthening Families Coalition and the Fair Budget Coalition in calling for level funding from FY '23 to FY '24 with an inflationary adjustment that sets total grant amounts of $103,000 per clinician per school for each public and public charter school.

[1] MHEASURES Annual Report Fiscal Year 2022 (Oct 1, 2021-Sept 30, 2022). District of Columbia Department of Behavioral Health. Available online 3/29/2023. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/MHEASURES%20Report%20January%202023.pdf

The Council should also take time to assess the funding added to residential services spending. As we testified during performance oversight, Mental Health Community Residential Facility operators, like the treatment provider network, have gone years without an inflationary adjustment to operator contract payment amounts. Unlike many District contracts, operators are not provided an opportunity to bid for contracts with their own price proposals and instead face a binary choice to accept the contract rates proposed by DBH or to forfeit payment entirely. In this case, the entire chapter of regulations governing these services has been substantially amended, and operators have not even received payment adjustments to help match updated regulatory expectations. We estimate that $3.3M would be needed to increase operator payment rates commensurate with inflation since those rates were last updated, likely more to correspond with changed regulatory performance expectations. The Council should ask the Department of Behavioral Health how much of the $1.2M increase in housing support services goes toward increasing operator payment rates and look for funding to close any gap. The Council should also encourage the Department of Behavioral Health to develop a process for making annual inflationary adjustments to Community Residential Facility operator payment rates supported by audited cost reporting and periodic rebasing, including exploring with the Department of Health Care Finance whether the services component of the contract – distinct from the room and board component – could be converted to Medicaid reimbursable services to help subsidize operations.

Reductions in funding and FTEs for other Department of Behavioral Health units are more obvious in the budget chapter but still deserve assessment. Is this the right time for the District to reduce its planned staffing compared with FY ’23 for both adult and children’s crisis services? What impact does the Department of Behavioral Health expect from reductions to children’s substance use prevention and treatment or court assessment services? Does the $655K reduction in early childhood services claw back the deployment of Healthy Futures, or only delay its expansion to additional child development centers?

Thank you again for the opportunity to testify today. I look forward to answering any questions that you might have.

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Testimony Before the District of Columbia Council
Committee on Health
March 30, 2023

Public Hearing:
FY2024 Budget Oversight
Department of Behavioral Health
Supplemental Testimony

Amber Rieke
A Path Forward, Project Lead
Children's Law Center

Introduction

Hello, Chairperson Henderson, and members of the Committee. My name is Amber Rieke. I am A Path Forward[1] Project Lead at Children's Law Center. 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.

I am submitting written supplemental testimony regarding the proposed FY24 budget for the Department of Behavioral Health (DBH).[2] First, I would like to thank this Committee and its staff for their diligent and thorough work in creating greater transparency around the budget. We appreciate the Committee raising questions that help create clarity on the proposed budget and, in turn, sharing these responses with the community. Based on the responses to DBH's pre-hearing questions, we are providing supplemental testimony regarding Healthy Futures and the School Based Behavioral Health Expansion Program.

There is No Cut to Healthy Futures Funding; Therefore, We Ask this Committee to Ensure the Funding in the FY24 Budget is Maintained

On March 30, 2023, we testified to an apparent cut to Healthy Futures funding in the proposed FY24 budget.[3] However, we are glad to learn that this funding has not been cut. The reduction shown in the budget is the result of a technical error, which, we understand, will be corrected.[4] The consistent level of funding between FY23 and FY24 will allow Healthy Futures to continue to hire and expand services into the projected 182 child development centers and home childcare providers.[5] This increase will bring the District closer to having Healthy Futures in 300 child development centers and home providers as envisioned in the Birth-to-Three for All DC Amendment Act of 2018.[6] We ask this Committee to ensure the error showing a cut to Healthy Futures is corrected in the budget and that the program maintains stable funding in the FY24 budget.

We urge the Council to Invest at Least $3.45 Million More in SBBH to Ensure Stable and Sufficient Compensation for CBOs in FY24

We are pleased to be able to share some updated numbers regarding the community-based organization grant funding for the School Based Behavioral Health Expansion Program (SBBH). In our earlier testimony, we thanked DBH for responding to hiring difficulties by increasing CBO grants which allowed for hiring or retention incentives for clinicians at a time when many are experiencing burnout and receiving competitive offers elsewhere.[7] The amount reported by DBH to Coordinating Council

members as recently as February 2023 was $99,371 per clinician to recruit and retain staff.[8] Based on this number, we and Coalition members requested the Committee add $5.7 million to the budget to maintain grant amounts – plus inflation – for a total of $103,000 per clinician.[9] We based this enhancement ask on predictions that DBH would only allocate $80,000 per clinician, as had been signaled in meetings. However, DBH budget documents provided after the March 30 hearing state that the amount per clinician in the proposed FY24 budget is $89,366.[10] While this is more than we originally guessed, it still represents a $10,005 per clinician cut between the current FY23 funding and the proposed FY24 funding, and provides no inflationary increase.

We are continuing to ask the Council to ensure that CBO compensation is stable and sufficient in FY24, at a funding level of $103,000 per clinician. Meeting this goal requires $3,449,402 to make up the difference in 253 schools. As we struggle to hire clinicians in the face of an unprecedented shortage of professionals, we must maintain the CBO's ability to offer competitive pay, incentives, and professional support for these essential roles. Failing to do so will result in losing clinicians and puts the whole program at risk.

Long-Term Considerations for Program Vision, Implementation, and Oversight

We also feel that a few other key things regarding the SBBH program budget are pertinent to this testimony. First, the current increase proposed in FY24 to $89,366 relies on American Rescue Plan Act (ARPA) funds that are time limited.[11] Therefore, as we

look ahead, there will likely be another reduction in the SBBH program when those funds expire, reverting the program to the original level of $80,200 per clinician. To meaningfully ensure investment in the SBBH, we ask this Committee to look ahead and ensure this additional funding is not lost in the FY25 budget and beyond.

Second, we would like to note that the total budget for the SBBH program includes investments in program evaluation and data collection, as well as the Community of Practice, which brings together providers, staff, and school leaders in a collaborative learning environment to share best practices, support, and participate in learning activities.

Finally, Committee members have asked smart questions through the hearing process about how to bring the program to its full potential. Along with the Committee, we are looking forward to the overdue rate study and evaluations to provide a better understanding of the costs and opportunities of the program. Finally, we believe further inquiries about this program would be well-served by a dedicated hearing on SBBH following the release of the cost study.[12]

Conclusion

We appreciate the opportunity to share these updated asks and remain available to answer any questions regarding the investments needed to sustain essential programs in the DBH portfolio.

[1] Children's Law Center co-authored a 2021 report called A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia, which detailed 94 recommendations to better meet the needs of DC children and families. As the Project Lead for A Path Forward, my work is focused on driving forward the recommendations contained in our report.

[2] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 30, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf.

[3] *Id.*

[4] Budget line 6620 inadvertently includes $655,000 that was meant for Healthy Futures. See FY2024 DBH Budget Oversight Pre-Hearing Responses, response to Q8 and Q20, *available at*: https://www.dropbox.com/sh/8fmlfns6bd8b39j/AAAXaSvmR4xqGrw1xpBo53JGa/FY%2024%20Budget%20Questions.%20DBH%20Response?dl=0&subfolder_nav_tracking=1.

[5] DBH, FY2022 Performance Oversight Responses, response to Q41, p. 38, available at: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1.

[6] D.C. Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[7] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 30, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf.

[8] Coordinating Council on School Based Behavioral Health, February Meeting, on file with the Children's Law Center.

[9] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 30, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf.

[10] FY2024 DBH Budget Oversight Pre-Hearing Responses, response to Q20, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAGUOnsdH57hHf7WvWf4D55a/FY%202024%20Budget/DBH/Agency%20Responses/FY%2024%20Budget%20Questions.%20DBH%20Response?dl=0&preview=FY+24+Budget+Question+20.docx&subfolder_nav_tracking=1.

[11] *Id.*

[12] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health (February 1, 2023), available at: https://childrenslawcenter.org/wp-content/uploads/2023/02/AmberRieke_CLC_Performance-Oversight-Testimony_DBH_February-1-2023_SBBH_final-1.pdf.

Good Afternoon Chairperson Henderson,

I am a Public Witness. I was a poly victim of Domestic Violence (DV), Intimate Partner Violence (IPV), and Sexual Assault perpetrated by various people I held dearly. I want you to increase USD 1.2 million for DV mental health providers in Washington DC so they can deliver adequate needs of the victims. The physical, emotional, financial, and sexual abuse stop for a while because I changed my status into asylum seeker. However, one of my abusers from my country of origin still stalks me through multiple people. As the consequences, I had unaccountable amount of mental health crises ever since early adulthood. I have been volunteering with the DCCADV as a survivor advisory board member and we ask for you council member to listen because any type of abuses is detrimental for the many, especially girls and women's wellbeing and their development. The COVID-19 pandemic is still going on and DV cases around the world has spiked, DC is not the exception!

I want you, the DC Department of Behavioral Health, to increase budget for survivors' direct services because the pandemic has disrupted many people's life. The suicidal thoughts and gestures I grapple with interfere both my professional and personal life. Even though I received free talk therapy and counseling from Ayuda, DVRP, and The Women's Center, I lost my professional work October last year and have not been able to find one like that ever since. When you granted our request, DCCADV's members will be able to care for at least 485 additional clients.

According to the API GBV research (2002), Gender Based Violence (GBV) such as DV/Teen Dating Violence/Sexual Assault/Human Trafficking possibly impact individuals over their lifespans in many ways. Even though the previous threats were no longer there, residual effects of trauma on mental health can be present/happening over the course of women, girls, and other minority groups. Resiliency is needed for survivors to build their life back! However, if the behavioral health services provided cannot met the needs of survivors and is not continuum, it would be impossible for us to bounce back. All survivors have the right to access behavioral health regardless of their ability to pay and their insurance status, because health is human rights!

I'd like to see this change reflected on the fiscal year 2024 budget. Remember, survivors are also the future of our society. Adequate and fast response to GBV is needed so that we can heal from our past trauma and can ultimately contribute back to our communities.

Thank you for your time and attention.

DC CHARTER SCHOOL ALLIANCE

Testimony Before the Council of the District of Columbia
Committee on Health

at the Budget Oversight Hearing on the
Department of Health

By Rachel Johnston
Senior Director of Operations and School Support, DC Charter School Alliance
April 10, 2023

Good morning Chairperson Henderson and members of the Committee. My name is Rachel Johnston, and I'm the Senior Director of Operations and School Support at the DC Charter School Alliance, the local non-profit that advocates on behalf of public charter schools to ensure that every student can choose high-quality public schools that prepare them for lifelong success.

My testimony today will focus on three investments we believe DC Health can make to better support charter schools and the nearly half of the public school students they serve: (1) investing in full-time coverage in the School Nursing Program, (2) improving the No Shots, No School data systems to ensure they run efficiently and provide accurate data, and (3) expanding the Administration of Medication (AOM) Training to make it more accessible to schools.

Investing in Full-Time Coverage in the School Nursing Program

As we've previously testified, we have a severe shortage of nurses in charter schools that's impacting the health and well being of students and school communities. We need full-time nursing coverage in every charter school to ensure they can provide basic health services. Despite the 2017 law[1] requiring a nurse to be assigned to each public charter school for 40 hours a week, the vast majority lack full-time coverage from the School Nursing Program, and many have no coverage. Many schools have had to hire or contract nurses with funds from their budgets to fill the gaps.

We understand that one of the lasting impacts of the pandemic is a dire shortage of nurses, not just in the District but nationwide. To immediately address this shortage, we strongly recommend the District join the Nurse Licensure Compact (NLC), which will expand the pool of nurses immediately available for hire.[2] Currently, 39 jurisdictions, including neighboring states Virginia and Maryland, are part of the NLC. Nine additional states have legislation pending to facilitate joining the national compact. DC is an outlier.

Additionally, we appreciate the School Nursing Program's ongoing work toward creative solutions to staffing problems. We hope the result of this is consistent coverage and continuity of care because having the same nurse serving the same school every day allows them to build relationships with students and families. It is also critical that these nurses receive explicit trauma-informed care training on working with adolescent students.

Investing in DOCIIS 2.0 Fixes To Resolve Inconsistent and Unreliable Data

Similar to helping students meet their basic health needs, charter schools remain committed to supporting student compliance with No Shots, No School. But as we've repeatedly testified over the last year, the multiple, unreliable data systems DC Health asks schools to use make this

[1] D.C. Law 22-61. Public School Health Services Amendment Act of 2017.
[2] Nurse Licensure Compact. www.nursecompact.com.

already heavy lift more challenging. Schools reported glitches and accuracy issues with DC Health's District of Columbia Immunization Information System (DOCIIS) 2.0, making it difficult to trust its validity. We also learned that systems used by some primary care physicians to track immunizations are not properly feeding DOCIIS 2.0. Ultimately, LEAs had to navigate several data systems, including a Salesforce reporting tool, as they worked to ensure compliance with No Shots, No School. None of these systems had complete or totally accurate information, which OSSE and DC Health recognize, because they are not designed to reflect compliance rates that align with the guidance the city has issued.

We strongly urge DC Health and partner agencies to invest in updating these systems now so that they report accurate compliance rates aligned with the city's laws and guidance. School staff and nurses need to have accurate tools to determine vaccine compliance rates, and addressing these weaknesses now can help prevent similar struggles from happening next school year.

Given the shortage of nursing staff and challenges in fully implementing No Shots, No School, we also urge OSSE to continue funding Patient Care Technicians (PCTs) for next school year. PCTs provide schools with the technical support they need to ensure students receive all their vaccines and that paperwork is logged, which helps keep students healthy and in school.

Investing in the Efficiency and Expansion of Administration of Medication Training

Third and lastly, we appreciate the steps taken in recent years to streamline the Administration of Medication (AOM) Training for schools, including moving a significant portion of the training online to make it more accessible. This training is critical in making sure school staff are adequately trained to administer life-saving medications to students. As DC Health continues to further refine the program, we want to make sure it can train even more staff. That's why we encourage the Council to support new investments that improve the AOM Training program's efficiency, while expanding the training frequency, so that more school staff can participate.

Moving Forward

Charter schools value the health and well-being of their students first and foremost. It is because of this that we advocate for these investments. As always, the DC Charter School Alliance welcomes the opportunity to collaborate to make sure every student has their health needs met so that they can actively and safely engage in learning.

Thank you for your time and attention, and I welcome your questions.

Testimony of Dr. Rebecca Durbahn, PhD, LCSW, Wanda Alston Foundation

March 30, 2023

Chairperson Christina Henderson
Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue
Washington, D.C. 20004
The Committee on Health 2024 Department of Behavioral Health Budget Oversight Hearing

Councilmember Henderson and members of the Committee on Health:

Thank you for the opportunity to testify before the DC Council today. My name is Dr. Rebecca Durbahn, my pronouns are she/her/hers, and I am the Clinical Director of the Wanda Alston Foundation. The Wanda Alston Foundation's mission is to eradicate homelessness and poverty experienced by LGBTQIA2S+ youth and to provide services to LGBTQIA2S+ individuals impacted by intimate partner violence or sexual assault. We provide our services through our shelters, case management, therapy, life skills development, and support with educational and employment opportunities.

I am here today to speak about a proposed solution to help mitigate the impact of youth homelessness and will be highlighting the need for the 2024 budget to include funding for a mobile mental health unit to work with the homeless youth population of DC. I will also be speaking about the importance of funding a harm reduction model that is both holistic, and also provides safety and security for those impacted by not only homelessness, but also by mental health and substance abuse issues.

With respect to a traveling mental health unit for youth experiencing homelessness, this ask was not funded in the budget released earlier in March. In fact the Mayor completely eliminated previous funding for DBH to conduct outreach for those experiencing homelessness in addition to cutting their mobile crisis unit. This decision can and will have a significant impact on youth homelessness, the DC community, and society at large. This Council has the opportunity to correct this failure by the Mayor and push for the funding of the mobile mental health unit.

In 2017, the District of Columbia, published a data driven plan to make youth homelessness rare, brief, and nonrecurring experience. As stated in the strategic plan, “The plan called for a comprehensive system that can help prevent youth homelessness, or significantly reduce the duration over which youth experience homelessness by creating stable housing for youth with adequate supports necessary for improving the social and emotional wellbeing of the youth, enable meaningful access to education, training, and a livelihood, and create an environment so youth can make permanent connections to their

communities" (DC Policy Center, 2023). Unfortunately, the system continues to have numerous gaps related to providing adequate support essential for improving the social and emotional wellbeing of the youth. These gaps are largely due to a lack of sufficient funding that interferes with providers' ability to effectively help mitigate the impact of youth homelessness. Not only are we seeing staggering numbers of individuals entering into homelessness, we are also seeing an increased comorbidity with mental health, substance abuse, and exposure to adverse childhood experiences. All of which have detrimental outcomes at the individual, societal and economic levels.

Youth enter into homelessness for a plethora of reasons. Youth become homeless in large numbers because home was not seen as a safe place for them. Factors that create this lack of safety are often related to abuse, neglect, domestic violence, adult substance abuse, poverty, adult relational instability and other adverse experiences. Equally as important as the risk factors that correlate with homelessness, is prioritizing best practices, services, and quality care to support youth to successfully transition out of homelessness. Simply put, traditional models of care, such as outpatient therapy, are just not enough for these individuals.There are nearly 180 youth in transitional and extended transitional housing programs throughout DC. All of these youth are provided the opportunity to engage with wrap-around style case management services; and although this often aims to support youth mental health, the level of acuity and needs of the youth indicate the importance of developing an alternative solution to more effectively meet the behavioral, emotional and mental health needs of the youth. One creative solution is to fund a mobile mental health unit that is specifically devoted to serving youth in Transitional and Extended Transitional Housing programs and homeless youth who attend drop-in centers.

This year, we advocate for the Department of Behavioral Services to partner with the DHS to fund a mental health or behavioral health mobile unit program. This unit would consist of culturally competent providers who regularly visit programs and shelters that house individuals experiencing homelessness. They would build trusting and credible relationships with youth, provide in-person therapeutic support, and also help to support consistent medication management.

Several factors have been identified in the literature that hinder and act as barriers to engaging homeless youth in services. Homeless youth are often reluctant to engage in services with unknown providers, and are significantly less likely to follow through with attending services that include scheduling appointments and accessing transportation. Some other key factors include rigid agency policies, substance use, misperception of service providers, youth lacking knowledge and ability to access services, and insufficient quality services for the youth. As the literature informs us, the best practices for working with homeless youth is the "Housing First " model as well as providing trusting relationships with caring adults that travel to the youth.. To effectively implement a culturally competent and LGBTQIA2S+ inclusive housing first model, funding must be allocated to support the physical space, to support multiple points of entry, medical services, mental and behavioral health services, and services that help clients who

are struggling with substance abuse problems while doing this through an accessible model that the mobile mental health unit would provide.

A mobile mental health unit removes these barriers by providing consistent access to services in the youth's preferred environments, and also provides strength based, culturally appropriate and trauma informed care that meet the youth where they are at. This integrated model of care, although similar to services provided by the Department of Behavioral Services, is unique in that it aims to be proactive, consistent, and to reduce the number of behavioral and mental health crises' and the utilization of crisis services, the emergency room, and of the police department.

People who use drugs, people who struggle with substance use disorder, people with co-occurring issues, low-income folks, queer and trans people, Black people, families, and whole communities are impacted by homelessness. And as the current system is operating, the mental health support and behavioral health support for homeless youth simply is not meeting the needs of this population. When a youth in the Wanda Alston Foundation needs support, it can take weeks to get that client linked to a provider in the community. Often in that timeframe, the youth deteriorates emotionally and behaviorally which in turn impacts their motivation to follow through with getting help, and impacts the likelihood of transporting themselves to an outpatient provider. This ripple effect increases the need to rely on the police and emergency services rather than trained mental health professionals. Unfortunately, oftentimes when the Community Response Team is called for support, their response to us has been that they are too backlogged and their system is too busy to support our clients. Our clients are literally and figuratively falling through the cracks of the system, and funding for the mobile mental health unit would be one step toward mending the system.

The 1.7 million dollar proposed budget would go toward the funding of 1 psychiatrist, 2 Licensed Independent Social Workers to perform the function of supervisors, and 10 master level social workers to provide services. This comprehensive integrated model would provide services to the approximately 180 youth who reside in Extended Transition Housing and who access services at Drop In centers throughout the city.

In addition to supporting and advocating for the mobile mental health unit; I am also here to talk about the importance of funding a harm reduction model that is both holistic, and also provides safety and security for those impacted by not only homelessness, but also by mental health and substance abuse issues. The Wanda Alston Foundation, like many other Transitional Housing and Extended Transitional Housing programs, is funded in part by Federal dollars, which necessitates that the programs be substance and alcohol free. We recognize and support the importance of this philosophy from a safety perspective. However, as with many youth with co-occuring mental health, trauma, poverty, and maladaptive ways of coping; many of the youth who enter into these programs also experience substance abuse issues. Due to this significant overlap in need, it is imperative that funds be allocated for a harm reduction model in DC.

Evidence shows that harm reduction centers increase participation in other health and addiction services, and significantly reduce overdose risk. These outcomes directly correlate with the intended outcomes of TH and ETH programs, and align with the strategic plan published by the DC Policy Center. This strategic plan focuses on the analysis of costs in the various programs that serve youth that are experiencing homelessness in the District of Columbia. More specifically, it is an analysis of the cost drivers and pressures for organizations serving youth that are experiencing homelessness, including the funding gaps and bottleneck. The mental health needs of homeless youth, and the co-occurrence with substance abuse, is one of the areas with significant funding gaps that lead to adverse outcomes. The expectation of sobriety or that homeless youth are immediately ready for treatment is an assumption that is detrimental and misaligned with the reality of the lived experiences of these youth. These youth need services that align with where they are in their journey of recovery, and that is both trauma informed and holistic in nature.

This Council has the opportunity to correct the failure by the Mayor and push for the funding of the mobile mental health unit and of the 24 hour Harm Reduction Unit, and we implore the council to consider both of these requests.

Thank you for your time and consideration,

Dr. Rebecca Durbahn , PhD, LCSW
Clinical Director
Wanda Alston Foundation
rdurbahn@wandaalstonfoundation.org

Council of the District of Columbia
Committee on Health
Fiscal Year 2024 Budget Oversight Hearing
Thursday, March 30, 2023

Dear Chair Henderson, Members of the Committee,

The Sports Betting Alliance (SBA) submits the enclosed testimony for the Committee's record in reference to Title VII, Subtitle C, Section 7022 of B25-0202, the "Fiscal Year 2024 Budget Support Act of 2023."

SBA is comprised of members that offer safe and legal online and retail sports betting to customers with critical safeguards in place to keep minors from betting. Our member companies operate only in approximately the 25 states and additional jurisdictions where online sports betting is legal and the 35 states and additional jurisdictions where retail sports betting is legal, including the District of Columbia.

SBA supports the District's dedicated source of funding for problem gaming treatment and prevention. Across the country and in DC, SBA member companies have supported efforts to fund publicly-administered problem gaming programs through revenue generated by sports betting.

Legal and regulated sports betting operators provide tools and resources to help players manage their gaming habits and prevent problem gaming, including self-limits on the amount of time spent on the platform, caps on account deposit and betting amounts, and exclusion all together from the app. In addition, legal and regulated sports betting operators have dedicated Player Protection teams to support the monitoring of user accounts for potential problem gaming behavior and language. All of our members' employees receive responsible gaming training when they are onboarded and periodically thereafter. And above all, consumers are provided substantial responsible gaming resources and messaging directly through the app. These internal protections are most effective when complemented by a publicly-administered problem gaming treatment and prevention program.

Thank you for the opportunity to submit the enclosed testimony. If you have any questions, please do not hesitate to contact me.

Jeremy Kudon
President
Sports Betting Alliance

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March 30, 2023

Chairperson Christina Henderson
Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue
Washington, D.C. 20004

The Committee on Health 2024 Department of Behavioral Health Budget Hearing

Greetings, my name is Danny Rodas, Deputy Director at the Wanda Alston Foundation. My pronouns are he/him/his. As you have heard from various people so far, there is a large ask for support of safe drug consumption sites and to prioritize the health and safety of our queer community by funding a mobile mental health unit. The Mayor's FY24 budget does not align with the current need for increased mental health support to those experiencing homelessness in DC, which I hope the Council will change so that the Department of Behavioral Health (DBH) can receive the appropriate amount of funding to make the intentional impact that it can have in reducing homelessness in DC.

I would like to highlight that providers who work with youth experiencing homelessness in extended transitional housing programs have shared with the Department of Human Services (DHS) that there has been an increase in mental health related issues in our programs. DHS has done a good job in including DBH in meetings to provide guidance and assistance to case managers who are doing the groundwork with clients. Unfortunately, youth experiencing homelessness are reverting back to behaviors that ensured their survival, which prevents them from progressing in their stabilization.

It was very disheartening to have learned that the Mayor's budget eliminated critical funding for DBH to conduct outreach for those experiencing homelessness, which will result in a reversal of all the progress that has been made thus far. Those experiencing homelessness need to stay connected to services and support that DBH provides. It is even more disheartening to have learned that the Mayor ignored all of the data that is out there that discusses the need for mental health support to those experiencing homelessness, but more specifically, those experiencing homelessness who identify as queer.

One of the Mayor's policy priorities last year was to end homelessness. Ending homelessness is not a one year's priority. Ending homelessness takes time and it takes dedication. The dedication that I, along with others, want to see is for the Mayor to fund a mobile mental health unit to keep clients safe and continue to encourage a healthy relationship with mental health services.

We know that queer youth experiencing homelessness have high levels of trauma and need access to quality and culturally competent behavioral health and mental health services. 100% of the youth in our program need mental health services, but struggle to access them. When our program has contacted DBH for support, they have encouraged us to contact the police department instead because all of the staff working to support those who are experiencing a mental health-related crisis are busy and it would take a long time to have a team assist us. Several times staff should have called CPEP, but they didn't because the staff knew there would be no response, which speaks to the high demand for the support that DBH provides.

To summarize last year; we called the Comprehensive Psychiatric Emergency Program - CPEP at least 9 times in the last 12 months, and CPEP has come 0 times to our program. We have never had an actual CPEP team come to our programs. At least four other times, staff should have called CPEP, but they didn't because the staff knew there would be no response. When we have called for CPEP, we sometimes have a Crisis Intervention Officer (CIO) respond or EMTs. CIO teams intimidate the youth and do not build the trust needed for mental health care and support to be initiated in a crisis. For example, when one of our youth had a suicide attempt, we called CPEP, and a CIO team arrived and took our youth in handcuffs to the hospital. The youth was so traumatized that he refused to stay in the hospital for treatment and only stayed for the watch period. The youth had made other suicide attempts following that but would deny them when CIO or EMT came, so he was never connected to appropriate services in his crisis. Again, CPEP did not come for those attempts. In a different incident of self-harm, a youth was taken to the hospital rather than assessed by CPEP. They resisted; they didn't want to go to the hospital, so they were injected with a medication that caused an allergic reaction, requiring multiple trips to the ER. Further, it is difficult linking to CSA: At least four youth linked to CSAs had to wait over a month for intake appointments, and when they are linked, there is no connection to build trust, so our youth misses out on much-needed support, and services.

We hope that the Council invests in 24-hour harm reduction centers to address the overdose crisis in DC. DBH is the city's leader in combating the overdose crisis, but DBH needs an increase in funding to prevent any more lives from being lost due to overdose.

Thanks,

Danny Rodas
Deputy Director at the Wanda Alston Foundation

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Fiscal Year 2024 Budget Oversight Hearing

Testimony of
Barbara J. Bazron, Ph.D.
Director

Before the
Committee on Health
Council of the District of Columbia
The Honorable Christina Henderson, Chairperson

April 6, 2023
12 Noon

Good Afternoon, Chairperson Henderson, Councilmembers, and Council staff.

I am Dr. Barbara J. Bazron, Director of the Department of Behavioral Health (DBH). I am pleased to testify before you today on Mayor Muriel Bowser's proposed Fiscal Year 2024 Fair Shot Budget that makes the necessary investments to promote and sustain the District's comeback including increased investments in behavioral healthcare.

With me today is Adran Reid, Agency Fiscal Officer; Michael Neff, Chief Operating Officer, and Mark Chastang, Chief Executive Officer at Saint Elizabeths Hospital.

Under the leadership of Mayor Bowser and the guidance of Deputy Mayor Wayne Turnage, DBH supports healthier and stronger communities by working to prevent the onset of mental and substance use disorders and providing a range of community-based treatment services and recovery supports. DBH also provides crisis services, operates adult and child urgent care clinics, and manages Saint Elizabeths Hospital for psychiatric inpatient care.

Mental health is health. A person's mental health can change over time, depending on many factors and changing circumstances such as the pandemic. Gun violence and safety concerns place additional stress for too many in our communities. When demands placed on a person exceed their resources and coping abilities, their mental health could be affected. Losing a job, caring for a relative, or experiencing sustained trauma can lead to poor mental health. Mental illness and poor mental health are not the same thing. A person diagnosed with a mental illness can have periods of mental well-being and a person can experience poor mental health and not have a diagnosed mental illness.

More than 41,000 residents of all ages receive treatment and recovery support through DBH. During the pandemic, with increased investments supported by the Council, DBH met the increased demand with enhanced or new services. In FY 22, more than 41,560 people received mental health treatment through DBH, a 24 percent increase from FY 20 during the height of the pandemic, driven in part by greater use of telehealth. There also was a six percent increase in the number of people who received substance use disorder services compared to FY 21.

Mayor Bowser's proposed budget for DBH keeps pace with the increased need and ensures that residents can get connected to the care they need—by phone, at home, in school or in the community. In addition, the proposed FY 24 budget continues supports started during the pandemic to meet the needs of residents with moderate or mild depression and anxiety. A 24 hour Mental Health Hotline to talk with a mental health specialist is free to any resident. A Wellness Wednesday virtual forum supports parents and caregivers, and a Healthy Teachers, DC virtual forum supports educator wellness. In addition, the FY 24 budget continues support for expanded crisis services including the 988 Suicide and Crisis Lifeline. Since the launch of the new three digit number in July 2022, calls have increased by 18 percent.

The proposed FY 24 budget supports the transformation work underway with our partners to provide residents with a high quality, more equitable, culturally sensitive public health system and to address the mental health needs of all residents.

This transformation supports our work with the Department of Healthcare Finance (DHCF) to prepare the provider network to operate in a managed care environment. Bringing behavioral health services into the Medicaid managed care program supports better care coordination and case management essential to whole person care to achieve optimal health. The promise of integrated care is healthier people living longer, more fulfilling lives.

As a state authority, DBH will establish standards and policies for behavioral health care delivery, monitor quality of care, promote behavioral health education and disease prevention, and measure population health outcomes.

I will now present an overview of the proposed FY 2024 budget for DBH. We provided responses to the Committee's detailed pre-hearing questions, and we appreciated the collaboration with Committee staff.

FY 24 Budget Overview

DBH's FY 24 budget formulation is driven by several factors—the integration of behavioral health and primary health care into managed care; additional reimbursable services; rate adjustments, and provider training and technical support. Other key drivers of budget formulation were to maintain essential services such as our school-based behavioral health, early childhood and substance use disorder services. The Mayor's proposed budget for DBH reflects these priority areas.

The proposed FY 24 gross operating budget is $385,143,814 which is a 2.2 percent increase over the FY 23 approved budget. The increase is primary due to an $8.6 million dollar increase in local funds.

The proposed FY 24 capital budget is $12.1 million,$2.6 million for Saint Elizabeths Hospital facilities projects and $9.5 million to support the opening of a second Stabilization and Sobering Center.

I will share a few budget highlights and provide more detail in our discussion.

- $72 million for mental health services which will match $164 million in federal dollars
- $28.4 million to maintain supported housing for 1,700 residents
- $52.6. million for substance use disorder services
- $18.3 million for crisis services
- $50.4 million to support children, youth and families that includes $7.3 million for prevention and early identification services, and
- $103 million to support Saint Elizabeths Hospital

I would now like to discuss the Mayor Bowser's enhancments to the proposed budget:

- $24.5 million in behavioral health services to match Medicaid funding for increased utilization of services and the anticipated rate adjustment.

- $1.7 million to support residents with housing subsidies in partnership with the Department of Human Services.

As the District government has succeeded in moving more people from homelessness into their own homes, there are some residents whose behavior consistently is disruptive to the well-being of their neighbors and suggests that behavioral health support is needed. I am deeply appreciative of neighbors who have shown compassion and sought help for them, and I also recognize that is unfair for them to live in such conditions. The Community Response Team and frequently MPD respond, often daily, to calls for help but involuntary treatment is typically not an option. Further, short-term emergency care is not the solution. The $1.7 million will support ongoing engagement and the provision of individualized support to assist them in living successfully within the community.

- $9.5 million in the capital budget to open a second Sobering and Stabilization Center

The FY 24 capital budget includes $9.5 million to open a second Sobering and Stabilization Center to support individuals under the influence of alcohol or drugs who require stabilization services and support but do not need to be transported to a hospital emergency department. The FY 24 budget includes $2.2 million in operating costs to support the first center expected to open this summer.

- $1.1 million to fund the rising cost of medication and food at Saint Elizabeths Hospital

The proposed budget includes $1.1 million to support the inflationary costs of medication and food. I take every opportunity to say publicly that I am extremely proud of the team at Saint Elizabeths Hospital who worked onsite throughout the pandemic to maintain care.

Support for Children and Families

The proposed FY 24 budget continues support for children and families at home, in school, and as needed during crises. Children and young people have been particularly impacted by the pandemic as disruptions in routines and relationships have led to increased social isolation, anxiety, and learning loss. Studies show that use of social media also has created anxiety and depression as it presents a warped view of reality and challenges body image and self-esteem.

The school-based program was set up to make it easy for children and their families to get treatment where kids spend most of their day and where the eyes of many adults are on them. Cities around the country are making mental health support available in public schools. Washington, DC is a national leader as the proposed FY 24 budget of $37.6 million funds at least one licensed clinician in every public school through multi-year investments by Mayor Bowser and the Council. I have attached a breakdown of the proposed FY 24 budget to my testimony submitted to the Committee.

The DBH clinician and CBO clinician are part of the school's behavioral health team that could include the school social worker, a lead teacher, a school nurse, and a parent and is led by the School Behavioral Health Coordinator.

Behavioral health clinicians from DBH or contracted community-based organizations (or CBOs) are now in 159 or 63 percent of public schools and we continue to expand in partnership with the DC Public Schools and the DC Public Charter School Board. School-based clinicians are expected to provide prevention, early intervention, and treatment services funded with a combination of local dollars and billing through Medicaid and private insurance. To guarantee the delivery of prevention and early intervention services that are not eligible for Medicaid reimbursement, DBH provides $63,153 per clinician for salaries. The total budget support for CBOs is a little more than $23 million dollars and includes $89,366.00 per clinician for salaries, personal development, and supervisory support.

In our performance oversight hearing, we talked about the challenges of hiring and retaining nearly 300 licensed social workers. The proposed FY 24 budget maintains funding to support our workforce development initiatives. In addition, DBH will participate in the new workforce development fund proposed in the Mayor's budget to support our recruitment.

We continue to work with our partners to examine the model to make sure we are using our significant resources in the most effective way and are reaching the students and families who need support.

I want to take this opportunity to address the funding for Healthy Futures. The Mayor's proposed budget maintains current funding to support Healthy Futures in 182 child development centers. There is no reduction. Healthy Futures funds inadvertently were placed in another program area. The total amount in the proposed budget is $4,124,412.

Update on LiveLongDC Plan

The proposed FY 24 budget includes $28.2 million in federal funds to support evidence-based prevention, harm reduction, treatment, and recovery strategies in our LiveLongDC plan to fight the opioid epidemic. Opioid overdose deaths driven by fentanyl continue to climb though at a slower rate. The Chief Medical Examiner reports the deadly synthetic opioid was in 96 percent of overdose deaths. 448 of our neighbors died last year, most in their own homes or the homes of family and friends.

We are doubling down on the distribution of Naloxone with a push to reach people facing opioid addiction and their families and friends. Last year, more than 2,600 overdoses were reversed. In the four years since we started our LiveLongDC campaign, more than 130 government and community partners distributed 156,000 naloxone kits. Along with naloxone, we are distributing fentanyl test strips to check for the presence of fentanyl. Last year we distributed more than 14,000 test strips.

We are making more treatment options available and last fiscal year, there was a small increase in the number of people in medication assisted treatment.

Support for Consumer Leadership and Peers

I want to end my testimony by recognizing the budget's continued support for consumer leadership and peer integration throughout our system of care. This year, we resumed in person peer certification training. Peer specialists now work in the provider network with treatment teams, in community hospital emergency departments, our emergency care facility, and at Saint Elizabeths Hospital. Consumers conduct the annual consumer satisfaction survey. In addition, DBH funds four peer operated centers.

In conclusion, Mayor Bowser's proposed FY 24 budget for DBH provides ongoing and new investments that support the opportunity for residents with behavioral health needs to live longer, healthier lives.

Madam Chair, we appreciate our partnership and the work of the Committee and look forward to our continued work together. I am ready with my team to answer any questions. Thank you.

ATTACHMENT
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COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
PUBLIC HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH
ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Department of Health Care Finance

AND

Office of the Deputy Mayor for Health and Human Services

ON

Wednesday April 5, 2023, 9:00 a.m.
Virtual Meeting via Zoom Video Conference Broadcast
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

Department of Health Care Finance

1. Catherine Crosland, Director of Homeless Outreach Development, Unity Health Care
2. Makeda Vanderpuije, Executive Director, LeadingAge DC
3. Mark LeVota, Executive Director, District of Columbia Behavioral Health Association
4. Ian Paregol, Executive Director, DC Coalition of Disability Service Providers
5. Corinne Cannon, Executive Director, Greater DC Diaper Bank
6. Sally White, Outreach and Community Relations, Edenbridge PACE at Skyland

7. Leah Castelaz, Policy Attorney, Children's Law Center
8. Justin Palmer, Vice President, Public Policy & External Affairs, DC Hospital Association
9. Sal Selvaggio, Chairman, Iona Senior Services Citizen Advisory Group
10. Deja Williams, Health Equity Organizer, SPACEs In Action
11. TJ James, Organizer, SPACEs In Action
12. Fari Ghamnia Tumpe, Senior Community Builder, SPACEs In Action
13. Luisa Furstenberg-Beckman, Produce Rx Program Manager, DC Greens
14. Tiffany Bukoffsky, Government Affairs Manager, Mid-Atlantic Region, The National Service Office for Nurse-Family Partnership & Child First
15. Patricia Quinn, Vice President of Policy and Partnerships, DC Primary Care Association
16. Kurt Newman, President & CEO, Children's National Hospital
17. Aldwin Lindsay, EVP & Chief Financial Officer, Children's National Hospital
18. Tonya Kinlow, Vice President Community Engagement, Advocacy & Government Affairs Children's National Hospital
19. Nisa Hussain, Program Manager, Early Childhood, DC Action
20. Jibran Eubanks, Political Organizer, 1199SEIU
21. Marie Morilus-Black, CEO, MBI Health Services, LLC
22. Claudia Schlosberg, Castle Hill Consulting, LLC
23. Dean Brenner, Alzheimer's Association

Office of the Deputy Mayor for Health and Human Services

1. Fernanda Ruiz, Home Visiting Director, Mary's Center
2. Felix Hernandez, Advocacy and Fatherhood Program Manager, Mary's Center
3. Reginald Black, Public Witness
4. Amy Robins, Director of Advocacy, PHI

5. Jesse Rabinowitz, Miriam's Kitchen
6. Danica Hawkins, Public Witness
7. Newton Lennon, CFO, Newlen Early Childhood School Readiness Center
8. Hilary Kacser, Public Witness
9. Emily Carnevale, DC Avodah Service Corps Member, Jews United for Justice
10. Clay Gregory, Mettle Works Behavioral Health
11. Karla Reid-Witt, Co-founder, Decoding Dyslexia DC

Government Witness

1. Turnage, Deputy Mayor for Health and Human Services and Director of the Department of Health Care Finance

Testimony of Claudia Schlosberg, J.D.
Interim Convener
DC Coalition on Long Term Care
Chair, Workforce Development Subcommittee

Before the
Committee on Health
Mayor Bowser's Proposed FY'24 Budget

for the Department of Health Care Finance

April 5, 2023

Chairperson Henderson and Members of the Committee on Health, thank you for the opportunity to testify today regarding Mayor Bowser's proposed FY 24 Budget for the Department of Health Care Finance. The DC Coalition on Long Term Care brings together consumers, advocates, providers and provider associations and organized labor to improve access to high quality care for District seniors and people with disabilities.

The Department of Health Care Finance has seen significant enrollment growth in Medicaid and the DC Health Care Alliance program during the Covid 19 Pandemic. Today, DHCF is responsible for funding the health care costs of nearly half (48%) of the District's population. Notably, in the Medicaid population, the fastest growing segments of the population are the elderly. According to DHCF between FY 2011 and FY 2022, while the overall Medicaid enrollment growth was 43%, the growth rate for beneficiaries between the ages of 60 – 85 was 111%, while the oldest old, those over age 81, grew by 28%. While aged and disabled individuals only account for about 20% of Medicaid enrollment, they are more costly, representing 56% of total Medicaid spending.

In reviewing the proposed budget against this backdrop of a growing population of older adults with high-cost needs, several issues of concern come to the forefront:

1. Provider payment rates: For the past three years, several classes of providers received enhanced rates to address increased costs during the pandemic. We are pleased that DHCF has agreed to maintain these enhanced rates for assisted living providers until a new rate methodology can be developed that reflects their true costs. However, other provider types including ICF/IDD, nursing facilities and home health and personal care assistance providers with see their rates revert to pre-pandemic levels. As noted in the chart below, the timetable for these rate reductions varies depending on the authority that was used to authorize them. However, when they hit, they will have significant impact on the ability of these providers to meet current operating costs including labor costs.

Provider/Service Type	Enhanced Rate/Flexibility	Expiration Date
ICF/IID	15% reimbursement increase to the Direct Service cost center	July 11, 2023
Nursing Facility Reimbursement	20% reimbursement increase to all Facility Rate Component	July 11, 2023
Home Health and PCA	Reimbursement for overtime rates, quarantine rates and staffing agency rates for skilled nursing, private duty nursing and personal care assistance	November 11, 2023

2. The Direct Care Workforce Crisis - The proposed budget reflects that DHCF is implementing the Direct Support Professional Payment Rate Act of 2022, which Counsel passed last year. DHCF is using a small portion of ARPA funds to incrementally raise the *average* wage of direct care workers to 117.6% of the Living Wage by January 2025. As a result of this initiative, last month, Medicaid funded home and community-based service providers received a supplemental payment and with that, are directed to maintain an *average* wage rate of $18.15/hour for their workers, effective January 1, 2023.

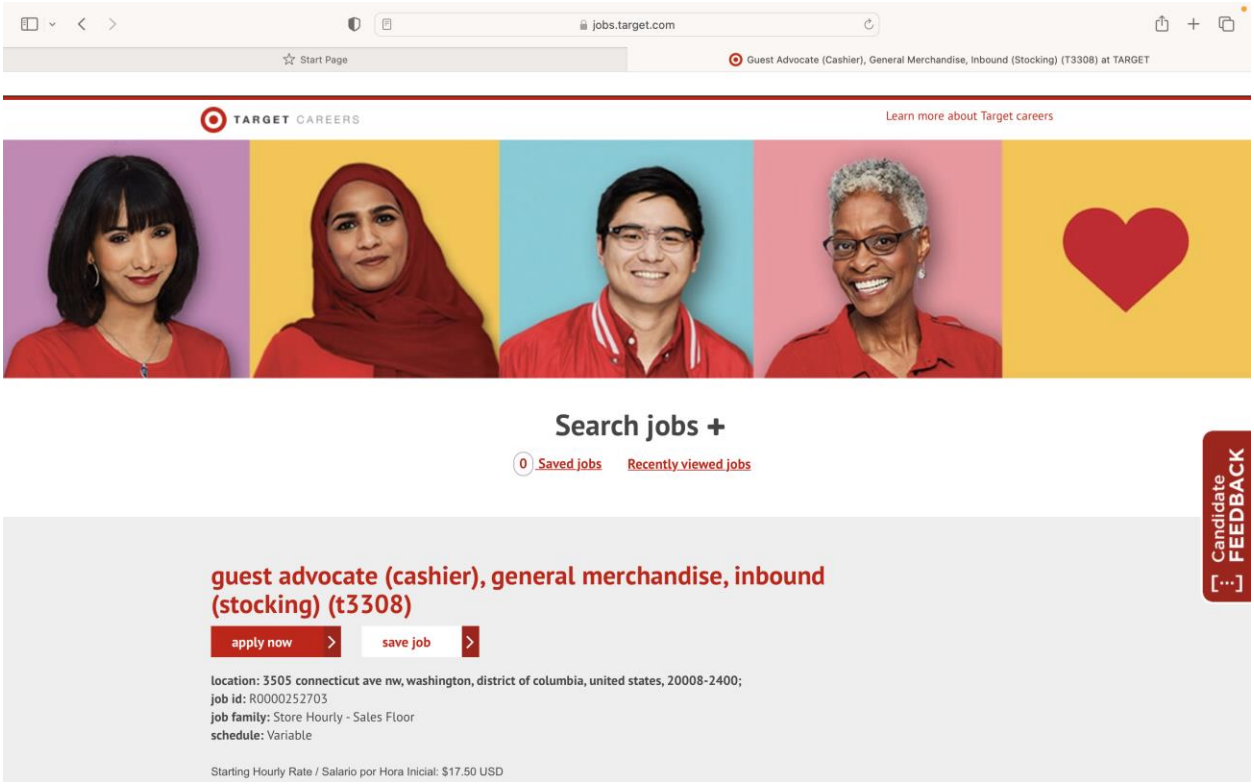
   Critically important to understand is that this *average* wage is only 10% above the current minimum wage and only $.65 an hour above the advertised *starting* salary of a Target cashier. See Screen Shot attached. Our Coalition has consistently and persistently stated that such small incremental increases in the average wage of the direct care workforce are insufficient to attract and retain the number of workers needed to meet the growing demand and need for direct care workers across the spectrum of our health care system.

   As PHI International's researchers have concluded, DC's wage rates for direct care workers fall significantly short of the medium wage for all other occupations with similar or even lower entry level requirements *by over $5.00/hour*. DHCF's response, which was shared in the agency's budget briefing, is that DC pays direct care workers more than Maryland and Virginia. However, while this is true, the wage differential between DC and the surrounding jurisdictions, is not driving more job seekers to become direct care workers or to come to DC for work. In fact, Maryland and Virginia also are facing a severe shortage of direct care workers. This is because, like DC, the wage rates for these workers are too low. Like workers in the District, Marylanders and Virginians can make more money in other jobs that are less demanding, less stressful and require less skill and training.

As we have stated previously in testimony, raising the average wage to 110% of the minimum wage this year and to 117.6% of the minimum wage next year does not adequately compensate direct care workers for the difficult and essential job that they do and is insufficient to attract thousands of needed new workers into the field. Further, when coupled with provider rate reductions of 15% and 20% and that eliminate reimbursement for overtime and staffing agencies, we anticipate that many more seniors and people with disabilities will be going without needed care.

3. Personal Needs Allowance – During the Oversight hearings, I and others testified about the need to raise the Personal Needs Allowance (PNA) for older adults and people with disabilities in community-based residential care settings. The current allowance of $100 (which was established in the 1980s) is insufficient to cover the personal needs of those living in assisted living and other community-based residential programs in 2023. Notably, the Mayor has budgeted $ 744,600 for an increase in the PNA, but this funding, which was found in the budget of the Department on Disability Services, raises the PNA to $150/month only for individuals with developmental disabilities. We are unclear why this amount was chosen (as it does not equate to the recent COLA increase) or why seniors who live in assisted living and other residential care settings are excluded. We believe the PNA needs to be raised but it should be raised equitably for all who are eligible to receive it.

In closing, the DC Coalition on Long Term Care is deeply concerned about pending provider rate cuts and the failure of the Mayor to provide for a meaningful increase in the wages of direct care workers. These workers are essential to the functioning of our health care system and to the health and safety of thousands of seniors across the District. We urge the Council to find the funding to raise wages to $24/hour in FY 24 and to address other needed reforms to stimulate recruitment and ensure retention of these essential workers.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job family: Store Hourly - Sales Floor
schedule: Variable
Starting Hourly Rate / Salario por Hora Inicial: $17.50 USD

Healthier You. Healthier Communities.

TESTIMONY OF

Dr. Catherine Crosland
Director for Homeless Outreach Development, Health Care for the Homeless
UNITY HEALTH CARE

Council of the District of Columbia
Committee on Health
Christina Henderson, Chair

Budget Oversight Hearing
Deputy Mayor for Health and Human Services
Department of Health Care Finance

April 5, 2023

Good morning, Chairperson Henderson and Members of the Committee on Health. My name is Catherine Crosland. I am a DC resident, a physician with Unity Health Care ("Unity") who has been caring for people experiencing homelessness in Washington DC for the past fourteen years, and a member of DC's Interagency Council on Homelessness (ICH). Currently, I serve as the Director for Homeless Outreach Development for Unity's Health Care for the Homeless program. Since 2020, I have worked in collaboration with DC's Department of Human Services (DHS) on the COVID-19 pandemic response to meet the needs of people experiencing homelessness in DC. I am pleased to have this opportunity to present testimony as part of the Fiscal Year 2024 Budget process.

I want to thank you for holding today's hearing. In addition, I would like to thank Mayor Bowser, Deputy Mayor Turnage, and their dedicated staffs for their work in assembling the proposed Fiscal Year 2024 budget. To be sure, balancing the many demands of our complex city is not easy.

In February, I was delighted to testify before this Committee's Performance Oversight Hearing on these very agencies. During that hearing, I expressed my gratitude at the District's swift and effective action to meet the needs of people experiencing homelessness during the COVID-19 pandemic, including the establishment of Isolation and Quarantine hotel shelters (ISAQ) and the Pandemic Emergency Program for Vulnerable individuals (PEP-V), among other proactive measures to meet the needs of people most likely to experience complications or death from COVID-19.

I am here today to urge the District to consider building on its incredible work and the lessons learned during the pandemic on issues related to medical respite services. Undoubtedly, housing is healthcare, especially for someone experiencing homelessness and, simultaneously, recuperating from an illness. For these individuals, who are too sick to be in the shelter or on the street – but not sick enough to be in the hospital, medical respite care is an indispensable bridge to wellness.

Given the recent downward projections in the District's revenue, now is the time to be investing in medical respite. Simply put, medical respite saves lives and money!

People experiencing homelessness are nearly 5 times more likely to be hospitalized than housed individuals.[1] In addition, the average hospital stay for a homeless patient is double that of a non-homeless patient. Homelessness, therefore, represents a major factor in hospital utilization. Studies confirm, however, that the availability of medical respite care significantly reduces future hospitalizations for individuals experiencing homelessness. In fact, by some estimates, they experience 50% fewer hospital readmissions within 90 days of being discharged compared to people experiencing homelessness discharged to the street or a shelter.[2]

In addition, medical respite care is an effective way to avoid unnecessary and costly inpatient hospital stays for this population. The financial savings associated with providing respite care, when compared to the cost of inpatient hospitalization, are enormous.[3] According to a March 2011 study that examined the subject in Salt Lake City, inpatient hospital care is 10 times more expensive, on average, than medical respite care: $1,359 per day versus $135 per day.[4] Over the span of a year, the study confirmed that Salt Lake City hospitals saved $5.5 million, by partnering with medical respite care centers.[5] Similarly, a Los Angeles-focused study also concluded that inpatient hospital care is approximately 10 times more expensive than medical respite care: $2,279 per day versus $175 to $200 per day.[6] The utilization of respite care,

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[1] "Shelter for convalescence: Hospitals link with respite programs to aid homeless patients through recovery," Modern Health Care, (March 22, 2014) ("Homeless patients use hospitals at a much higher rate than housed patients, studies have found. A 2010 study found about 23 hospitalizations for every 100 homeless people in a year, comparted with five hospitalizations for every 100 people in the general population."). Retrieved from https://www.modernhealthcare.com/article/20140322/MAGAZINE/303229937

[2] National Health Care for the Homeless Council. (March 2011). National Health Care for the Homeless Council Survey of Medical Respite Program. Retrieved from National Health Care for the Homeless Council: https://www.nhchc.org/wp-content/uploads/2011/09/RespiteCostFinal.pdf

[3] "Study Shows that Medical Respite Care for Patients Experiencing Homelessness is Cost-effective for Hospitals," *Association of American Universities,* (May 22, 2108) ("Each day spent in a hospital is about 10 times as expensive as a day spent in medical respite.").

[4] National Health Care for the Homeless Council. (March 2011). *National Health Care for the Homeless Council Survey of Medical Respite Program.* Retrieved from National Health Care for the Homeless Council: https://www.nhchc.org/wp-content/uploads/2011/09/RespiteCostFinal.pdf

[5] Hanks, M. Fourth Street Respite Care. *National Health Care for the Homeless Council (Personal Communication, March 18, 2011)*.

[6] Gregerson, P. JWCH Institute, Inc. *National Health Care for the Homeless Council (Personal Communication, April 8, 2011).*

according to the study, resulted in millions of dollars in reduced health care expenditures in Los Angeles and Orange County.[7]

Unsurprisingly, reductions in health care expenditures for people experiencing homelessness translate into savings for publicly funded health care programs, specifically Medicaid. In 2013, Yale New Haven Hospital (YNHH) launched a 12-bed medical respite care facility for homeless people in partnership with Columbia House, complete with case management. A 2017 study conducted by YHNN estimated that the program saved Medicaid between $12,000 to $25,000 *per patient* in the year following participation in the respite program.[8] As part of the study, YHNN found that "the 30-day readmission rate for respite patients dropped from the 2012 level of 50% to 16.7% by 2016," and included a reduction in the average length of stay from 8.6 days in 2014 to 7 days in 2016.[9]

Furthermore, medical respite permits a more efficient use of shelter resources. When there is someone in the shelter who is too sick to be there, they either cycle in and out of the hospital, as mentioned earlier, or cause a significant drain on the shelter resources and staff who are not equipped to manage their needs. By having enough medical respite beds for those with higher medical needs, the shelters would be able to operate more effectively to meet the needs of the rest of the population.

As the evidence confirms, there are many tangible benefits associated with medical respite care. At present, the District has a limited supply of medical respite care providers: Joseph's House (8 beds); Christ House (33 beds); Hope has a Home Medical Respite Program (16 beds); and the Patricia Handy Place for Women (12 beds). All are excellent programs! The reality is, however, that we need more beds to serve an increasingly older and more medically complex

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[7] "Shelter for convalescence: Hospitals link with respite programs to aid homeless patients through recovery," Modern Health Care, (March 22, 2014). (Treating 1,500 homeless patients in Recuperative Care Centers in Los Angeles and Orange County saved hospitals approximately $12 million, or roughly $8,000 per homeless patent.). Retrieved from https://www.modernhealthcare.com/article/20140322/MAGAZINE/303229937

[8] Crombie, Paula, Director of Social Work, Yale New Haven Health & Cunningham, Alison, CEO of Columbus House, "Medical Respite Care: Reducing Readmissions, LOS, and ED Visits of People Experiencing Homelessness," Connecticut Coalition to End Homelessness. Retrieved from http://cceh.org/wp-content/uploads/2017/02/Medical-Respite-Celebration-v19.pdf

[9] "Yale New Haven Hospital medical respite program puts homeless patients on path to better health," (January 31, 2018). Retrieved from https://www.aha.org/news/insights-and-analysis/2018-01-31-yale-new-haven-hospital-medical-respite-program-puts-homeless.

population experiencing homelessness. We also need more "low barrier" medical respite beds – beds that are not tied to a specific insurance plan, as well as medical respite beds that do not require sobriety. Last year, Unity conducted a survey of hospital care coordinators as well as shelter staff and outreach workers. Based on this informal needs-assessment, Unity estimates the need to be approximately 150 beds. If we subtract the currently operational medical respite beds listed above, there remains a need of approximately 80 additional beds.

Determining precisely how the District should fund these life-saving and cost-effective medical respite beds will require a thoughtful approach. To this end, we urge the District to revisit the work that was initiated as part of the Fiscal Year 2020 budget related to creating a Medicaid funding source for medical respite care services for homeless individuals. Specifically, Subtitle H, Section 5071(a) required the Department of Health Care Finance to submit a report to the Council by September 30, 2022, outlining its

> "(i) Recommendations for the establishment of medical respite care services for homeless individuals, through either: (I) An amendment to the District of Columbia's State Plan; or (II) A waiver pursuant to section 1115 of the Social Security Act, …, for home and community-based services
>
> (ii) The types of services that may be offered to homeless individuals through a medical respite care program; and
>
> (iii) An identification of any potential restrictions on the provision of services identified pursuant to sub-subparagraph (ii) of this paragraph, including the use of prior authorization."

For reasons, which we all fully appreciate, the Department of Health Care Finance was unable to meet this requirement while confronting the COVID-19 pandemic. It is our hope that we can now return our attention to this important task, which will now be informed by our recent pandemic experiences on the matter.

Accordingly, we urge the Committee to incorporate the above language into the FY2024 Budget Support Act and request the report be submitted to the Council by January 1, 2024. In addition, we recommend that the report include an analysis on the appropriate reimbursement rates to sustain these services.

Chairperson Henderson, thank you for the opportunity to testify. I am happy to answer any questions that you or Members of the Committee might have.

Before the

District of Columbia Council

Committee on Health

Testimony of

Dean R. Brenner

5044 Macomb Street, NW

Washington DC 20016

Budget Hearing

Department of Health Care Finance

Wednesday, April 5, 2023

Chairman Henderson and Committee Members, my name is Dean Brenner, and I live in Ward 3. I'm testifying today on behalf of the 10,000 DC residents living with Alzheimer's and the over 14,000 family members struggling to take care of them. For reasons that scientists cannot explain, Alzheimer's disproportionately affects women, African Americans, and Hispanics, and the monetary cost of Alzheimer's is astronomical-- $126 million in DC Medicaid costs alone in 2020.

In many cases, DC residents who are unpaid family caregivers for a relative with Alzheimer's disease or another form of dementia rely upon home health care aides, who are paid under the District's Home & Community-Based Services waiver in the Medicaid program. The home health care aides perform essential services, often on a 24/7 basis, in one of the most difficult jobs imaginable. It's not surprising that we have a shortage of home health aides, given how hard the job is, but even worse, these aides are woefully underpaid. The Alzheimer's Association estimates that we will need a 25% increase in home health care aides by 2030 to keep up with the needs of so many DC residents.

That's why, in 2021, the Council passed the Direct Support Professional Payment Rate Act of 2021, a law that promised, on average, to pay them the greater of either 117.6% of the District minimum wage pursuant to the Minimum Wage Act, or 117.6% of the District living wage pursuant to the Living Wage Act.

In last year's budget, the Council did not spend any local funds to implement the 2021 law. Instead, in the financial plan, DHCF stated that, while not required by law, it would ensure that by FY 2025, the provisions of the 2021 law would be fully implemented via a three-year phased in plan. Under the plan, in FY 23, the DHCF would solely spend ARPA federal funds; in

FY 24, 50% would come from ARPA funds and 50% from local funds; and, in FY 25, when the 2021 law would fully be implemented, the final costs would come entirely from local funds.

The FY 24 budget and the supporting materials are silent on whether DHCF will use ARPA and local funds to increase pay for direct care workers, consistent with last year's financial plan and the FY 23 financial plan. It is absolutely essential that the funds promised in the FY 23 financial plan-- $14 million from ARPA and $14 million from local funds—be included in the FY 24 budget to raise pay for our direct care workers. I realize how many needs compete for every budget dollar, but in a budget of over $19 billion, it would be unconscionable to turn our backs on these important workers, who have been promised a raise by our Council since 2021.

Thank you very much for hearing the concerns of the DC Alzheimer's community on this important issue.

TESTIMONY
Mary Procter
Committee on Health
Budget Oversight for Department of Health Care Finance
April 5, 2023

Good morning, Chairperson Henderson, and members of the Committee, my name is Mary Procter and I am a member of the Capitol Hill Village Advocacy Team. CHV has a membership of more than 400 members, with an average age in their late 70's. We have joined the Capitol Hill Village with a goal of still living in our own homes or at least in our community when we need help as we age. Many of my fellow members have Parkinson's disease, or have disabilities from a stroke, or mobility problems, and already need a home health aide.

I am here to testify in favor of a substantial increase in the DC Living Wage for Direct Care Health Workers—to $24 an hour by 2024. These include Certified Nurse Assistants, Home Health Aides, and Direct Support Professionals who care for disabled adults

CHV has been a member of the Coalition on Long Term Care Workforce Development for three years. The Coalition has surveyed the employers of Direct Care Workers five times since May 2020. The most recent survey in January 2023 of hospitals, assisted living facilities, adult day health centers, agencies serving disabled adults, and home care agencies **reports that shortages of Direct Care Workers are no better and in many cases increasingly worse.** This burden on the remaining staff induces more losses of the existing staff.

Claudia Schlosberg, the leader of the Long Term Care Workforce Development Coalition has made the case for $24 per hour by 2024, from research about how Direct Care Worker pay compares to similar jobs they compete with. In December

2022, the widely respected PHI health research center published a report on Direct Care Worker issues. In DC, the average wage gap between Direct Care Workers and jobs with similar skills and responsibility was reported as **5$, larger than in any of the 50 states.**

The DC Department of Health Care Finance (DHCF) has heard the shortage issues and has taken some steps to increase the wages of Direct Care workers in a cumbersome increase of the *average Direct Care Worker wage to 117.6% of the living wage* or $19.04 an hour, which is still well behind competing jobs. Tracking averages rather than minimum wages is a burdensome, weekly chore for the agencies that employ Direct Care workers.

Moreover, low wages to Direct Care Workers discourage investments in apprenticeships or in other forms of good training. You will hear from Patricia Brantley, the CEO of Friendship Public Charter School that Friendship had a program to train Certified Nurse Assistants but gave it up in 2012 because Friendship PCS did not want to train students for jobs that would not lift them out of poverty.

I urge the Committee, to avoid a nightmare for older adults, their families and all health facilities, to pay Direct Care Workers reimbursed by Medicaid enough to be eligible hold attractive jobs.

I urge the Committee also to fund job training that will give young people a head start on responsible careers in healthcare.

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COUNCIL OF THE DISTRICT OF COLUMBIA
Committee on Health
Christina Henderson

FY 2024 Budget Hearing
Department of Healthcare Finance (DHCF)

April 5, 2023

Testimony of Veronica Sharpe
President
District of Columbia Health Care Association

My name is Veronica Sharpe. I am the President of the District of Columbia Health Care Association (DCHCA), representing all the licensed nursing facilities and several assisted living communities in the District.

On behalf of the DCHCA facility members and the over three thousand District residents who rely on them for essential care and services, I must say that we are somewhat disappointed in the DHCF budget.

Long term care providers across all provider types are facing an unprecedented workforce crisis. Nursing homes and residential care facilities lost over 234,000 employees during the pandemic and in some facilities in DC the employee loss is in the high teens.

Before the supply of PPE was available and before there was a vaccine, the intimate work of a CNA put them and their families at risk. It is still a difficult job even with the protections. The workers that perform these jobs for the vulnerable in our population deserve and should be paid a true living wage of $24.00/hour. Surely the work they perform is as important as being a bank teller or an Amazon driver. The District has been a leader in providing access to healthcare for all of it's citizens. I urge the District to be a leader in preserving that access to healthcare for seniors and the disabled by supporting the workforce that cares for them. I have

at least two providers who are not accepting admission or are temporarily closing beds because of the lack of CNA and Nurse staffing. Limited workforce decreases access.

The proposed FY ’24 DHCF budget shows a decrease in spending in the Long Term Care Administration. Although provider rates are not being cut I know that the current rates without the 20% add-on payment that providers have received throughout the PHE will not be sufficient to sustain the increased costs that providers are facing. There are increased staffing costs, insurance costs, food costs and others. Just as household budgets have been affected by inflation so have providers costs.

The 20% and 15% add-ons for nursing home and assisted living providers have been critical in keeping providers able to continue their quality care throughout the pandemic but before they are rolled back DHCF should evaluate current costs and make corrections if necessary. Included in that evaluation must be the ability for providers to pay their CNA’s a true living wage of $24.00 per hour and to be able to establish career ladders for CNA’s that take advanced training including becoming a certified medication aide.

The long-term care industry is in a staffing crisis and the resolve to remedy the situation must start now. We ask the Committee to repurpose funds toward that goal.

The proposed budget also shows a significant cut to the Alliance program. I don’t know the rationale behind the decrease in funding but I do know that the Alliance program offers very minimal long term care services and supports (LTCC) benefits to Alliance beneficiaries. Access to these services are limited by the fact that other than the 90 day window under the MCO contracts there are no long term care benefits. This is problematic because under the 6-108 law a facility would have to keep the beneficiary and would not be paid for the care they were required to

provide. This of course lengthens the hospital stay for the Alliance beneficiary and costs Medicaid more than the nursing home or assisted living stay. My ask today is that we evaluate the need for long term care services and supports for Alliance beneficiaries and budget in the 2025 proposal.

Thank you for the opportunity to submit testimony.

Children's National

111 Michigan Ave NW
Washington, DC 20010-2916
ChildrensNational.org

Council of the District of Columbia

Committee on Health

FY 2024 Budget Oversight Hearing: Department of Healthcare Finance

Testimony of Kurt Newman, MD
President & CEO
Children's National Hospital
Wednesday, April 5, 2023

Good afternoon, Chairperson Henderson and members of the Committee on Health. My name is Kurt Newman, and I am President & CEO and of Children's National Hospital. As you know, Children's National has served the nation's children for more than 150 years and is an innovator in pediatric health around the world. I am joined here today by Tonya Kinlow, Vice President of Community Engagement, Advocacy, and Government Affairs and Aldwin Lindsay, Chief Financial Officer. We thank you for the opportunity to present testimony at the Department of Health Care Finance's Fiscal Year 2024 budget oversight hearing.

As you know, Children's National has long understood the importance of making high quality health care accessible in all 8 Wards. We are very excited to be a partner at the new Cedar Hill Regional Medical Center, and are finalizing the details of our partnership with GW Hospital to operate the neonatal care unit and the pediatric emergency medicine department. We look forward to continuing to provide the highest level of health care excellence to the families of Ward 7 and 8 just as we have done at our ED at United Medical Center and in our primary care centers at Children's Health Center Anacostia and Children's Health Center at THEARC.

Children's National is a vital safety net for all children in the D.C. metropolitan region, treating all children with all levels of health care needs.

Children's National plays an integral role in the District's Medicaid program. In FY 2022, nearly 43,000 DC Medicaid beneficiaries received care from Children's National. Of the 43,000, 20% were enrolled under fee-for-service (FFS) Medicaid and 80% were with a Medicaid managed care organization (MCO) plan.

We are testifying today because we are very concerned about a proposed policy change to inpatient and outpatient rates for Medicaid Managed Care Organizations that will negatively impact Children's National. This Budget Support Act provision would cap outpatient and inpatient MCO rates. We believe this policy will trickle down and force cuts in the reimbursement that MCOs pay hospitals. While the proposed change is projected to save the District of Columbia $11.3 million local funds, the District would lose an estimated $26 million in federal funds due to a cut to the Medicaid program. Based on our analysis, Children's National would lose $17 million annually if this policy was adopted. As the health care safety net for District children, insufficient reimbursement rates would significantly harm our ability to sustain the comprehensive system of pediatric health care that we have created.

Unlike our adult counterparts, children's hospitals depend heavily on Medicaid. Children's National encounters unique hurdles compared to other hospitals because providing hospital-level of care to children, including those

children with medically complex conditions, creates challenges that are not experienced when treating the adult population. Our care team model includes specialists, allied health professionals, and technology for children not found in other hospitals. Specialized equipment and supplies required for small children also represent an extensive cost incurred by Children's National.

While most children are healthy, children with medical complexity account for more than 30% of total pediatric healthcare costs.[1] These costs are rapidly rising as this patient population have the highest medical needs that drive them in and out of inpatient and outpatient settings. The unique needs of children with medically complex conditions require intensive care and are often dependent on medical technologies.

In addition to treating a child's illness, it also important to recognize that we care for child's psychosocial and emotional state. Our child life specialists help children, adolescents, and families cope with illness, injury, trauma, disability, loss and bereavement. Although, they do not provide medical care, it is an important service that make children feel more comfortable in a medical setting. Currently, there is no reimbursement to support services such as Child Life. The widening

[1] Cohen, E, Berry JG, Camacho X, Anderson,G, Wodchis W, Guttman A. Patterns and costs of healthcare use of children with medical complexity. Pediatrics. 2012; 130 (6). Available at: www.pediatrics.org/cgi/content/full/130/6/e1463

gap between cost of caring for children and reimbursement, makes it hard to expand services and find sources to cover those costs.

We recognize that we are in challenging financial environments and difficult decisions must be made. Trust me, our hospital is facing similar challenges with escalating operating costs and diminishing revenues. It is for this reason that we urge you to reject DHCF's proposal. We believe it will have a disproportionate impact on Children's National. If adopted, we will be forced to make hard choices about the future financial health on other necessary growth initiatives that further the hospital's mission. We urge the Council to oppose the Budget Support Act Subtitle Medical Hospital Reimbursement Act of 2023.

Thank you for allowing me to testify today, and I am happy to answer any questions you may have.

Testimony of Claudia Schlosberg, J.D.
Interim Convener
DC Coalition on Long Term Care
Chair, Workforce Development Subcommittee

Before the
Committee on Health
Mayor Bowser's Proposed FY'24 Budget

for the Department of Health Care Finance

April 5, 2023

Chairperson Henderson and Members of the Committee on Health, thank you for the opportunity to testify today regarding Mayor Bowser's proposed FY 24 Budget for the Department of Health Care Finance. The DC Coalition on Long Term Care brings together consumers, advocates, providers and provider associations and organized labor to improve access to high quality care for District seniors and people with disabilities.

The Department of Health Care Finance has seen significant enrollment growth in Medicaid and the DC Health Care Alliance program during the Covid 19 Pandemic. Today, DHCF is responsible for funding the health care costs of nearly half (48%) of the District's population. Notably, in the Medicaid population, the fastest growing segments of the population are among the elderly. According to DHCF between FY 2011 and FY 2022, while the overall Medicaid enrollment growth was 43%, the growth rate for beneficiaries between the ages of 60 – 85 was 111%, while the oldest old, those over age 81, grew by 28%. While aged and disabled individuals only account for about 20% of Medicaid enrollment, they are more costly, representing 56% of total Medicaid spending.

In reviewing the proposed budget against this backdrop of a growing population of older adults with high-cost needs, several issues of concern come to the forefront:

1. Provider payment rates: For the past three years, several classes of providers received enhanced rates to address increased costs during the pandemic. We are pleased that DHCF has agreed to maintain these enhanced rates for assisted living providers until a new rate methodology can be developed that reflects their true costs. However, other provider types including ICF/IDD, nursing facilities and home health and personal care assistance providers with see their rates revert to pre-pandemic levels. As noted in the chart below, the timetable for these rate reductions varies depending on the authority that was used to authorize them. However, when they hit, they will have significant impact on the ability of these providers to meet current operating costs including labor costs.

Provider/Service Type	Enhanced Rate/Flexibility	Expiration Date
ICF/IID	15% reimbursement increase to the Direct Service cost center	July 11, 2023
Nursing Facility Reimbursement	20% reimbursement increase to all Facility Rate Component	July 11, 2023
Home Health and PCA	Reimbursement for overtime rates, quarantine rates and staffing agency rates for skilled nursing, private duty nursing and personal care assistance	November 11, 2023

2. The Direct Care Workforce Crisis - The proposed budget reflects that DHCF is implementing the Direct Support Professional Payment Rate Act of 2022, which Counsel passed last year. DHCF is using a small portion of ARPA funds to incrementally raise the *average* wage of direct care workers to 117.6% of the Living Wage by January 2025. As a result of this initiative, last month, Medicaid funded home and community-based service providers received a supplemental payment and with that, are directed to maintain an *average* wage rate of $18.15/hour for their workers, effective January 1, 2023.

   Critically important to understand is that this *average* wage is only 10% above the current minimum wage and only $.65 an hour above the advertised *starting* salary of a Target cashier. See Screen Shot attached. Our Coalition has consistently and persistently stated that such small incremental increases in the average wage of the direct care workforce are insufficient to attract and retain the number of workers needed to meet the growing demand and need for direct care workers across the spectrum of our health care system.

   As PHI International's researchers have concluded, DC's wage rates for direct care workers fall significantly short of the medium wage for all other occupations with similar or even lower entry level requirements *by over $5.00/hour*. DHCF's response, which was shared in the agency's budget briefing, is that DC pays direct care workers more than Maryland and Virginia. However, while this is true, the wage differential between DC and the surrounding jurisdictions, is not driving more job seekers to become direct care workers or to come to DC for work. In fact, Maryland and Virginia also are facing a severe shortage of direct care workers. This is because, like DC, the wage rates for these workers are too low. Like workers in the District, Marylanders and Virginians can make more money in other jobs that are less demanding, less stressful and require less skill and training.

As we have stated previously in testimony, raising the average wage to 110% of the minimum wage this year and to 117.6% of the minimum wage next year does not adequately compensate direct care workers for the difficult and essential job that they do and is insufficient to attract thousands of needed new workers into the field. Further, when coupled with provider rate reductions of 15% and 20% and that eliminate reimbursement for overtime and staffing agencies, we anticipate that many more seniors and people with disabilities will be going without needed care.

3. Personal Needs Allowance – During the Oversight hearings, I and others testified about the need to raise the Personal Needs Allowance (PNA) for older adults and people with disabilities in community-based residential care settings. The current allowance of $100 (which was established in the 1980s) is insufficient to cover the personal needs of those living in assisted living and other community-based residential programs in 2023. Notably, the Mayor has budgeted $ 744,600 for an increase in the PNA, but this funding, which was found in the budget of the Department on Disability Services, raises the PNA to $150/month only for individuals with developmental disabilities. We are unclear why this amount was chosen (as it does not equate to the recent COLA increase) or why seniors who live in assisted living and other residential care settings are excluded. We believe the PNA needs to be raised but it should be raised equitably for all who are eligible to receive it.

In closing, the DC Coalition on Long Term Care is deeply concerned about pending provider rate cuts and the failure of the Mayor to provide for a meaningful increase in the wages of direct care workers. These workers are essential to the functioning of our health care system and to the health and safety of thousands of seniors across the District. We urge the Council to find the funding to raise wages to $24/hour in FY 24 and to address other needed reforms to stimulate recruitment and ensure retain of these essential workers.

Testimony of MBI Health Services, LLC

Department of Health Care Finance FY23 Budget Oversight Hearing

To the District of Columbia Council Committee on Health

By Marie Morilus-Black, CEO – MBI Health Services, LLC

Mblack@mbihs.com

April 5, 2023

Chairperson Henderson, Members of the Council

Thank you for the opportunity to testify at the Department of Health Care Finance Budget Oversight Hearing. My name is Marie Morilus-Black, I am the CEO of MBI Health Services, LLC. We are a large Medicaid provider in the District serving District residents in our Home Health Agency, intellectual or Developmental Disability programs (IDD), Homeless Prevention and Permanent Supportive Housing, and supportive employment, we opened the First Urgent Care Clinic East of the River, operating from 7 am to midnight, and we are the largest behavioral health agency in the District serving over 6000 adults and children and families in its behavioral health programs in the District. MBI connects with just about every Human Service Agency in the District providing services to approximately 10,000 District residents in all its programs and employing over 1000 staff. We are committed to serving residents of the District by providing excellent customer service, and high-quality care, and achieving positive outcomes and results which empower them to live their best lives.

I want to thank Deputy Mayor Turnage for his leadership of all the Human Services Agencies and all of the Leaders of these Agencies, Director Bazron, Director Zeilenger Director Byrd, and Director Reese for their leadership throughout the pandemic with their weekly meetings. A special thank you to Director Byrd and her staff for her ongoing participation at the DBH Thursday meetings throughout the pandemic. The weekly Thursday meetings were extremely informative and kept the provider network informed with real-time information from Mayor Bowser, DC Health, and other decisions impacting the work, so we were able to quickly pivot to meet the need of our consumers, families, and children.

I know we are moving on from the pandemic, but I wanted to take this opportunity to say thank you to Director Byrd, Dr. Bazron, Deputy Mayor Turnage, Mayor Bowser, and Past Director Nesbitt for helping us survive the last three years. And now that we are moving beyond COVID, those weekly meetings have been moved to monthly. I want them to know that I find the meetings useful and informational, keeping us informed on shared issues and opportunities from DHCF and DBH. I hope they will keep them going.

MBI remained fully operational throughout the pandemic, but it was not without a cost. Many of our staff resigned, opting for fully virtual positions or less risky positions, and we are still grappling with and recovering from the workforce shortage not uncommon for many of my colleagues. I want to thank

Deputy Mayor Turnage and Director Byrd for supporting the retention of many of our direct staff and supporting a living wage for many of our personal care aides (PCAs) and direct support professionals serving the DDS programs. I am asking that DHCF provides an automatic cost of living adjustment for all the Medicaid rates, including Behavioral Health to help providers like MBI keep up with the increased cost of salaries and inflation.

The last rate study for DBH for example was completed in 2016; I am grateful for a little over 6% cost of living adjustment that DHCF provided the DBH network this past year, however, it has not kept up with inflation, and the cost of living, leaving us with about 17% inflation rate gap. The salaries for clinicians alone have gone up 25%, and we obviously need them to do the work and to supervise quality services. I recommend that the rate study takes into consideration all of these factors and right-size the provider rates to enable us to provide quality services and that the new rates take effect in the next 90 days if at all possible.

The DBH provider network is being transitioned to the MCOs by October of 2023. We are only 6 months away and there are still many unanswered questions. I am asking that DHCF, with active support from the Bowser administration and the council, ensure that providers know affirmatively what services the MCOs are retaining, and providers are reimbursed timely for those services rendered, at a maximum within 14 days of claims submission; although, we would prefer it remains the same as it is now, **weekly.** We are a fee-for-service system, currently paid weekly. It would be challenging to move from weekly to monthly or even 45 to 60 days for some claims. It would negatively disrupt the provider's network and create fiscal constraints which would adversely impact the provider network. I ask that you consider mandating payments be paid within 7 to 14 days for claims submitted to the MCOs as part of the MCOs contracts.

As a member of the DC Advisory Committee and Chair of the Subcommittee, Health System Redesign, I want to thank you for the opportunity to serve the Districts residents and bring the community provider voice to the table. I want to commend Director Byrd and Deputy Mayor Turnage on the work they are doing with other District Agencies to improve our system of care and services for the Districts residents. Thank you for adding Wraparound/Intensive Care Coordination and Crisis Services to Medicaid, saving the District money by leveraging federal funding for our system. I recommend that those local savings are re-invested in Human Services programming to meet gaps in services.

Finally, thank you for working with DBH to move ACT from 15 min unit-based service to a Per Member Per Month, facilitating fidelity and best practices. Although the details need to be worked out, I want to thank you for those wins.

MBI is committed to providing excellent services to District Residents and we stand ready to continue our work with you and the MCOs to deliver timely and quality care to the Districts resident.

Thank you very much Chair Henderson for your work with the Health Committee and for the opportunity to share MBI's testimony, I am open to any questions that you may have for me.

dcgreens

April 5, 2023

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Councilmember Christina Henderson
Chairperson, Committee on Health
1350 Pennsylvania Avenue, Suite 402
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Re: Committee on Health Budget Oversight Hearing for DHCF

Good Morning Councilmember Henderson, members of the Committee, and council staff. My name is Luisa Furstenberg-Beckman, and I am the Produce Prescription Program Manager at DC Greens, a non-profit that advances health equity by building a just and resilient food system in the District.

Our organization administers a produce prescription program that provides qualifying adults and children who are Medicaid recipients with $80/month to purchase fresh and frozen fruits and vegetables. Produce prescriptions benefit patients by helping to prevent diet-related illnesses and reducing healthcare costs; they also benefit DC's economy by reinvesting produce prescription funds into the local stores. Currently, our program serves over 1,300 adults and 900 children throughout the District.

Access to produce prescriptions through Medicaid has grown substantially over the past two years thanks to the support and investment from DC Health Care Finance (DHCF) and their produce prescription grant programs. In 2022, with financial support from DHCF, DC Greens was able to expand our program to three additional clinics, allowing patients to access produce prescriptions at a total of 17 clinic locations across all three managed care organizations (MCOs)) in DC. We were also able to increase the number of Giant locations, our current redemption site, to five locations.

This year, with support from DHCF's produce prescription grant, we will expanding the program even further to include other major grocers like Safeway and Walmart as we switch to a more scalable program model.

When Mayor Bowser's budget proposal was released on March 22, DC Greens was ecstatic to see that she recommended allocating $500,000 of local funds to support DHCF's produce prescription grant program in FY24. We're happy the Mayor sees the value of

produce prescriptions and we urge the Council to as well.

Research shows that participation in produce prescription programs has led to:

- Improved HbA1c levels in individuals with diabetes[1], improved BMI scores[2], and lowered blood pressure;[3]
- Increased fruit and vegetable consumption;[4]
- Lower depression scores;[5]
- And decreased hospitalization and emergency room utilization.[6]

Recently, DC Greens also conducted a local evaluation of our program. Results illustrated that of those who participated in the study, receiving money to purchase fruits and vegetables for their health:

- 39% experienced a reduction in their HbA1c levels;
- 35% saw a reduction in BMI;
- 34% saw a reduction in blood pressure; and
- 75% reported an increase in their fruit and vegetable consumption.[7]

In addition to these encouraging health outcomes, the program fed $250,000 back into the local economy through fruit and vegetable purchases in FY22.

DHCF's produce prescription grant continues to provide critical funding to operationalize produce prescriptions in the District and the $500,000 will surely help thousands of Medicaid beneficiaries who are navigating chronic conditions while food insecure. Yet, we urge the council to recognize that current access to produce prescriptions remains quite small relative to the need in our city.

[1] Susan Veldheer et al., Impact of a Prescription Produce Program on Diabetes and Cardiovascular Risk Outcomes, 53 J. Nutr. Educ. Behav. 1008 (2017), https://doi.org/10.1016/j.jneb.2021.07.005;; Richard Bryce et al., A Pilot Randomized Controlled Trial of a Fruit and Vegetable Prescription Program at a Federally Qualified Health Center in Low-Income Uncontrolled Diabetics, 23 Prev. Med. Rep. (2021), https://doi.org/10.1016/j.pmedr.2021.101410.

[2] Michelle Cavanagh et al., Veggie Rx: An Outcome Evaluation of a Healthy Food Incentive Program, 20 Pub. Health Nutr. 2636 (2017), .doi:10.1017/ S1368980016002081.

[3] Jasmine-Yasmine A. Omar et al., Fresh Prescription Program: A Program to Improve Access to Fresh Products Among Underserved Patients in Downtown Detroit, 31 J. Gen. Internal Med. S879 (2016); Benjamin York et al., Farming for Life: Pilot Assessment of the Impact of Medical Prescriptions for Vegetables on Health and Food Security Among Latino Adults with Type 2 Diabetes, 26 Nutr. Health 9 (2020), https://doi.org/10.1177/026010601989899.5.

[4] Ronit A. Ridberg et al., Fruit and Vegetable Vouchers in Pregnancy: Preliminary Impact on Diet & Food Security, 16 J. of Hunger & Env't Nutr. 149 (2021), https://doi.org/10.1080/19320248.2020.1778593;; Seth A. Berkowitz et al., Health Center–Based Community-Supported Agriculture: An RCT, 57 Am. J. Preventive Med. S55 (2019), https://doi.org/10.1016/j.amepre.2019.07.015; ;Gus Schumacher Nutrition Incentive Program Training, Technical Assistance, Evaluation, and Information Center (GusNIP NTAE): Impact Findings, Nutrition Incentive Hub (2021), https://www.nutritionincentivehub.org/media/fjohmr2n/gusnip-ntae-impact-findings-year-2.pdf.

[5] Kate Cheyne et al., Food Bank-Based Diabetes Prevention Intervention to Address Food Security, Dietary Intake, and Physical Activity in a Food-Insecure Cohort at High Risk for Diabetes, 17 Prev. Chronic Dis. E04 (2020), http://dx.doi.org/10.5888/pcd17.190210; Benjamin Emmert-Aronson et al., Group Medical Visits 2.0: The Open Source Wellness Behavioral Pharmacy Model, 25 J. Alternative & Complementary Med. 1026 (2019), doi: 10.1089/ acm.2019.0079. [6]

Julian Xie et al., The Impact of a Produce Prescription Programme on Healthy Food Purchasing and Diabetes-Related Health Outcomes, 24 Public Health Nutr. 3945 (2021), doi: 10.1017/S1368980021001828; Benjamin Emmert-Aronson et al., Group Medical Visits 2.0: The Open Source Wellness Behavioral Pharmacy Model, 25 J. Alternative & Complementary Med. 1026 (2019), doi: 10.1089/ acm.2019.0079.

[7] Socially Determined. Preliminary Findings for Produce Rx Evaluation. (On file with author).

A survey by the Capital Area Food Bank found that 36% of District residents experienced some level of food insecurity in 2021, but that food insecurity wasn't evenly distributed across the city.[8] Food insecurity rates for those who identified as Hispanic was 55%, and 50% among those who identified as Black. By contrast, the prevalence of food insecurity was only 13% among respondents who identified as white. We see this disparity even more sharply in health outcomes – there is currently a 17-year difference in life expectancy between residents of Ward 8 and residents of Ward 3[9]. This is due almost entirely to diet related chronic illnesses such as diabetes and hypertension – two of the 10 leading causes of death in our city.[10]

Food is Medicine programming, spanning medically tailored meals, medically supportive groceries, and produce prescriptions should be fully integrated into our health care system in DC. These programs are essential medical interventions that our residents need badly. By making these programs reimbursable services, we will create sustainable funding streams for Food is Medicine providers, improve health, and decrease health care costs.

At DC Greens, we envision a day where access to nutritious food is part of the overall health care system in our city and we know that DHCF shares that dream. We urge the council to support the Mayor's budget recommendation while also considering the future needs of Food is Medicine programming in the District.

Thank you for your time and consideration of this testimony. Please email Luisa@dcgreens.org with any questions.

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Testimony Before the District of Columbia Council
Committee of Health

Public Hearing:
FY2024 Budget Oversight
Department of Health Care Finance

Leah Castelaz
Policy Attorney
Children's Law Center

Introduction

Good morning, Chairperson Henderson, and members of the Committee. My name is Leah Castelaz. I am a 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.

I appreciate the opportunity to testify today regarding the Mayor's proposed budget for the Department of Health Care Finance (DHCF) and its potential impact on children and families. Over the past few years, DHCF has initiated several major changes to the District's Medicaid program that will impact the behavioral health system. First, DC's Section 1115 Medicaid Behavioral Health Transformation Demonstration became effective in 2020, which allows the District's Medicaid program to cover more behavioral health services.[1] Second, DHCF is moving toward a fully managed Medicaid program– a process that will be completed by 2024.[2] Third, DHCF is integrating behavioral health services into the District's managed Medicaid program

beginning October 1, 2023.[3] Finally, a new behavioral health service rate study is being conducted by Public Consulting Group (PCG).[4]

In light of these changes, my testimony will focus on three ways in which DHCF's FY2024 budget can improve access to behavioral health services to children and families as well as pregnant and postpartum people:

- Leverage federal Medicaid dollars to sustain home visiting in the District
- Incorporate HealthySteps into DHCF's ongoing rate study
- Support the continued work of the Perinatal Mental Health Task Force

My testimony will also address how we can invest in our current behavioral health workforce so that it meets the behavioral health needs of District children and families.

DHCF'S FY2024 Budget Must Prioritize Increasing Access to Behavioral Health Supports During Pregnancy and Early Childhood

One of the best ways to strengthen families is by providing supports early on in pregnancy and throughout the beginning years of a child's life. New parents must navigate many new challenges and obstacles that can cause stress. Repeated, prolonged stress, often referred to as toxic stress, can have a long-term negative impact on both the overall well-being of both parent and child as well as the parent-child relationship.[5] Additionally, it is reported that anxiety and/or depression can affect a significant amount of people during pregnancy or the first year following birth.[6] Undiagnosed and untreated behavioral health disorders are the number one complication of pregnancy and childbirth and when continuously ignored they can result in death.[7] Suicide and overdose combined

are the leading cause of death in the first year following pregnancy.[8] Identifying and funding programs and resources that provide the supports that prevent and mitigate the stressors of pregnancy and postpartum are lifesaving.

The District Should Leverage Federal Medicaid Dollars to Sustain Evidence-Based Home Visiting Programs in the District

Home visiting programs connect families with a trained professional who is equipped to provide supports and resources that improve outcomes for both children and families in their homes or another comfortable setting.[9] Home visitors can play an important role in identifying and addressing parents' needs from screening for maternal depression, to providing education about parent-child interaction, to connecting parents to community-based supports that address challenges that might impact their parenting.[10] Home visiting has been shown to result in increases in access to maternal and child healthcare, decreases in child abuse and neglect, improvements in school readiness and achievement, and advancement of family economic self-sufficiency.[11] In FY2022, home visiting participants reported they were very satisfied and received high quality services with the programs they were participating in through DC Health.[12]

Despite the desire for and satisfaction with home visiting, this program continues to be under-resourced due to unsustainable funding. The grants for home visiting have not been adjusted for inflation since 2019.[13] We must work to create a funding structure that meets the needs of this program. Currently, the District is leaving a potential source of significant funding on the table by not leveraging federal Medicaid dollars to support

evidence-based home visiting. There are currently 37 jurisdictions that have or are in the process (pending Center for Medicaid and Medicare Services approval) of having a Medicaid billing pathway for home visiting.[14] The utilization of Medicaid dollars will not only provide a more sustainable form of funding but will also free up local dollars which can be used to increase access to more evidence-based home visiting programs and other services.

DHCF should, therefore, establish the coverage and reimbursement of evidence-based home visiting under Medicaid. The process of establishing Medicaid coverage for evidence-based home visiting programs must be done with stakeholder involvement including home visitors, participants, national experts, and agency representatives. The goal would be to devise a plan that would establish the processes for billing and reimbursement, identify key performance metrics and ongoing evaluation, and apply for any necessary amendments to the District's Medicaid State Plan.

After the establishment process, DHCF will need adequate financing to draw the federal match from Medicaid. The federal match is 70 percent.[15] We are, therefore, asking this Committee for up to $450,000 to be invested into DHCF's budget to support Medicaid funding of evidenced-based home visiting once it is established for coverage and reimbursement through Medicaid.[16]

Incorporation of HealthySteps in DHCF's Ongoing Rate Study Promotes Sustainability of the Program

In 2018, this Council passed a significant piece of legislation, the Birth-to-Three for All Act of 2018 (Birth-to-Three), which lays out a blueprint for structural change and key investments in programs to build a system that works for DC's youngest residents and their families.[17] Through Birth-to-Three, the District has locally funded five (soon to be six) HealthySteps sites, surpassing the original goal laid out in the law.[18] HealthySteps is an evidence-based national program model that provides infants and toddlers with social-emotional and development support by integrating child development specialists into pediatric primary care.[19] HealthySteps strengthens the parent-child relationship by reducing several risk factors commonly associated with child abuse and neglect, such as caregiver substance abuse, caregiver mental illness, and exposure to violence.[20] The expansion of HealthySteps means that more children, ages 0-3, and their families can access appropriate health screenings, system navigation support, and connection to resources in one central place, thus lessening the burden on families.

Although HealthySteps provides critical supports for children and families in the District, its current funding structure is unsustainable. At this time, all HealthySteps in the District, a total that is soon to reach 10 sites, must rely on local or philanthropic funds for its operations.[21] These funding streams are often time-limited or insufficient to cover the true cost of services rendered. Therefore, the District must develop a comprehensive

funding model for HealthySteps that expands the sources of funding and ensures we leverage all available dollars to this program.

Therefore, we ask that HealthySteps be included in DHCF's ongoing rate study to allow for the possibility that HealthySteps (all components clinical, non-clinical, and care coordination) be a Medicaid billable program. The inclusion of HealthySteps in the rate study will identify: (1) existing billing codes for HealthySteps; (2) enhanced rates for currently covered codes; and (3) Medicaid codes that could cover other aspects of the program.[22] Additionally, the rate study may identify that HealthySteps could be covered through other coverage options such as the Early Periodic Screening Diagnostic and Treatment benefit. The inclusion of HealthySteps in the rate study would be a significant step forward in ensuring that HealthySteps is billable through Medicaid and the District is best leveraging federal dollars to support children and families in the District. Sustaining HealthySteps through Medicaid billing and reimbursement frees up local dollars to support other early childhood and family-serving programs.

Extension of the Perinatal Mental Health Task Force Will Provide More Time that is Necessary to Develop a Comprehensive, Informed Report

Last budget season, this Council created and financed the Perinatal Mental Health Task Force (PMHTF, Task Force), a group of government agencies, council representatives, and community stakeholders that are working to devise comprehensive policy recommendations for improving perinatal mental health in the District.[23] Beginning in October 2022, DHCF worked to diligently stand up the Task Force and held

the first official meeting in January 2023.[24] We recognize it is not an easy to build something from the ground up, so we appreciate the time and care that has gone into building a strong foundation for this work.

Parent's and children's needs are unique, and we must provide the appropriate array of services, supports, and resources to improve maternal health outcomes in the District. Unfortunately, the District lacks some key data and landscaping to understand the strengths and gaps in perinatal mental health. The Task Force is a step in the right direction to ensure pregnant and postpartum people and their families have adequate, high-quality, affirming, and sustainable support for their mental health during the perinatal period and beyond.

We appreciate that the deadline was already extended from August 31, 2023, to October 1, 2023.[25] However, as we testified to in performance oversight, the timeframe may be too limited to complete a thorough and useful public report that will inform recommendations to resolve inequities in perinatal mental health care access, coverage, and coordination.[26] These concerns are shared by other Task Force members and leadership.[27]

We, therefore, ask this Committee to amend the Task Force Establishment legislation to extend the deadline for submission of the final publicly available report from October 1, 2023, to December 31, 2023.[28] Three additional months will create the necessary time to engage with the community and have important conversations while

ensuring the Task Force works expeditiously and diligently to provide a public report to inform needed change and improvements to the systems that support perinatal mental health.

The District Must Offer Competitive Reimbursement Rates to Create a Health System that Supports District Families from Pregnancy Onward

A consistent theme of the work to improve mental health is the imperative to create more places and professionals for behavioral health care. This is done, in part, through sufficient pay for providers in public programs. Just as programs like SBBH, HealthySteps, and home visiting need sufficient grant funds, providers must be sufficiently paid for services in hospitals, health centers, primary care, and private practice offices, if they are to participate in Medicaid. A 2019 report from the National Bureau of Economic Research demonstrates that more competitive Medicaid reimbursement rates are tied to better access to care and outcomes for children.[29]

At Children's Law Center, nearly all of our clients are Medicaid beneficiaries. We know the importance of having a public health insurance system that can meet the diverse health needs of District residents. The major changes underway in DC's Medicaid structures could potentially improve access to behavioral health services, especially for children.[30] In our recent performance oversight testimony, we described how current networks are functionally inadequate, with people waiting too long for evaluations and

appointments and clients frequently losing therapists to turn-over.[31] We cannot meet the demands posed by the mental health crisis without dramatic improvements.

DBH and DHCF share the responsibility to ensure there are enough providers in MCO networks to meet the needs of beneficiaries, as is required by Medicaid rules.[32] Yet through last year's budget, DBH's reimbursement rates for behavioral health care for people enrolled in Medicaid (Behavioral Health Rehabilitation Services) and for those disqualified from Medicaid (Mental Health Rehabilitation Services) had not been adjusted beyond 2016 rates.[33] The effect is that providers are being paid 17.5% less than if rates had increased with the Medicare Economic Index, minus 6.2%, DBH and DHCF added over 2022.[34]

Therefore, we are heartened to see significant increases in some of the lines for provider payments in both agencies' budgets. Specifically, the proposed FY2024 budget increases the line for Behavioral Health Rehabilitation Services (Local Match) by $17,760,000 for a total of $61 million.[35] We need an increase of at least $7.5 million in the reimbursement levels to achieve the 17.5% inflationary increase, and we hope that this is included in the enhancement. We want to better understand the line, and whether the additional $10 million reflects further increases to rates (i.e., higher payments) and/or an anticipated increase in volume of services (i.e., more patients).[36] In light of this enhancement, it is unclear why the line in the budget for Mental Health Rehabilitation Services (Local Only) – services for people ineligible for Medicaid – has not increased a

single dollar.[37] We believe providers for these services should also have an increase to payments of 17.5%, or about $1.9 million enhancement.

We recognize that DBH and DHCF are basing future provider payment rates on the ongoing behavioral health reimbursement rate study, which is intended to improve rates and rate-setting methodologies. We noted at oversight hearings that it is important that this rate study prioritizes reimbursement of children's behavioral health services.[38] We expect the forthcoming rate study to reflect the realities of the workforce landscape, such as adjustments for high turnover and retention costs, and national salary data.[39] In the meantime, we wish to better understand the changes that have been made, and how they will work to improve the service network in FY2024.

Conclusion

We urge the Committee to consider our recommendations with respect to the proposed FY2024 budget for both DHCF and across all of DC's health agencies. Building a behavioral health system that meets the needs of DC's children and families requires strong collaboration and communication across multiple agencies. For example, although the home visiting program is implemented by DC Health, DHCF would be responsible for leveraging federal dollars through Medicaid to sustain the program. Inclusion of these recommendations in the FY2024 budget process will help sustain and grow effective programs in the District and develop new ones that will support children and families in

achieving optimal health outcomes regardless of where they live, work, or play. Thank you for the opportunity to testify today. I welcome any questions.

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[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, DC Behavioral Health Transformation, (January 6, 2021), p. 1, available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DHCF%20Demonstration%20STCs%20with%20Evaluation%20Design%20and%20Monitoring%20Protocol%20010621.pdf.

[2]DHCF, DHCF Announce Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts, (September 11, 2019), *available at*: https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reformsand-intent-re-procure-managed-care-contracts.

[3] Government of the District of Columbia Department of Health Care Finance, Letter RE: Behavioral Health Transformation: Updated Timeline, Office of the Senior Deputy Director/State Medicaid Director. (December 2, 2021), p. 2, *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MDL%2021-06%20BH%20Transformation%20Update%20Timeline%2020211202-signed.pdf.

[4] FY2024 DHCF Budget Oversight Pre-Hearing Questions, response to Q13, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAU5LcrnEwp5OEVnT7SQ_bNa/FY%202024%20Budget/DHCF/Agency%20Responses?dl=0&preview=FINAL+DHCF+Pre-Hearing+Questions_3.31.23.pdf&subfolder_nav_tracking=1.

[5] Pamela Li, *Effects of Stress on Child Development*, Parenting for Brain, February 23, 2023, *available at*: https://www.parentingforbrain.com/types-of-stress/; Franke HA. Toxic Stress: Effects, Prevention and Treatment. Children (Basel). 2014 Nov 3;1(3):390-402. doi: 10.3390/children1030390. PMID: 27417486; PMCID: PMC4928741; Center for Disease Control and Prevention, Violence Prevention, *What are adverse childhood experiences, available at*: https://www.cdc.gov/violenceprevention/aces/fastfact.html; Andrew Garner and Michael Yogman, *Preventing Childhood Toxic Stress: Partnering with Families and Communities to Promote Relational Health,* American Academy of Pediatrics, August 1, 2021, *available at*: https://publications.aap.org/pediatrics/article/148/2/e2021052582/179805/Preventing-Childhood-Toxic-Stress-Partnering-With?autologincheck=redirected.

[6] Masters GA, Li N, Lapane KL, Liu SH, Person SD, Byatt N. Utilization of Health Care Among Perinatal Women in the United States: The Role of Depression. J Womens Health (Larchmt). 2020 Jul;29(7):944-951. doi: 10.1089/jwh.2019.7903. Epub 2020 Feb 20. PMID: 32077784; PMCID: PMC7371545; Rhitu Chatterjee, *A Lifeline for Doctors Helps Them Treat Postpartum Depression,* NPR, January 15, 2020, *available at*: https://www.npr.org/sections/health-shots/2020/01/15/794943944/a-lifeline-for-doctors-helps-them-treat-postpartum-depression; DHCF, Perinatal Mental Health Task Force, February 2023 Presentation,

February 28, 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20February%20Presentation.pdf; Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR), *Weekly*/May 15, 2020/ 60(19);575-581, *available at*: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919a2.htm; U.S. Department of Health & Human Services, *The Surgeon General's Call to Action to Improve Maternal Health,* December 2020, p. 22, *available at*: https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf.

[7] National Partnership for Women & Families, *The Maternal Mental Health Crisis Undermines Moms' and Babies' Health,* June 2021, *available at*: https://www.nationalpartnership.org/our-work/health/moms-and-babies/the-maternal-mental-health-crisis-undermines-moms-and-babies-health.html; Schubert KO, Air T, Clark SR, Grzeskowiak LE, Miller E, Dekker GA, et al. (2017) Trajectories of anxiety and health related quality of life during pregnancy. PLoS ONE 12(7): e0181149. https://doi.org/10.1371/journal.pone.0181149; DHCF, Perinatal Mental Health Task Force, February 2023 Presentation, February 28, 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20February%20Presentation.pdf; U.S. Department of Health & Human Services, *The Surgeon General's Call to Action to Improve Maternal Health,* December 2020, p. 22, *available at*: https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf.

[8] Centers for Disease Control and Prevention, *Four in 5 pregnancy-related deaths in the U.S. are preventable,* September 19, 2022, *available at*: https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html; Chin K, Wendt A, Bennett IM, Bhat A. Suicide and Maternal Mortality. Curr Psychiatry Rep. 2022 Apr;24(4):239-275. doi: 10.1007/s11920-022-01334-3. Epub 2022 Apr 2. PMID: 35366195; PMCID: PMC8976222.

[9]DC Action, *DC Home Visiting Council, available at*: https://www.wearedcaction.org/our-initiatives/home-visiting#:~:text=Home%20visiting%20helps%20parents%20deepen,to%20meet%20their%20child's%20needs.

[10] Center for the Study of Social Policy, Strengthening Families, available at: https://cssp.org/our-work/project/strengthening-families/; Center for the Study of Social Policy, *Strengthening Families Through Home Visiting*, available at: https://cssp.org/resource/sf-through-home-visiting/; DC Action, *DC Home Visiting Council, available at*: https://www.wearedcaction.org/our-initiatives/home-visiting#:~:text=Home%20visiting%20helps%20parents%20deepen,to%20meet%20their%20child's%20needs.

[11] *Id.*

[12] FY22 DC Health Performance Oversight Responses, response to Q43, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAD3F2Mir6VFnyRlo3Tca3bma/COH%20Performance%20Oversight/DC%20Health/Agency%20Responses?dl=0&subfolder_nav_tracking=1.

[13] We are also asking minimally for an additional $700,000 to DC Health and an additional $300,000 to CFSA to help address the immediate need to close gaps in home visiting funding in the District. *See* Leah Castelaz, Testimony before the District of Columbia Council Committee on Health, (April 10, 2023), *available at*: https://childrenslawcenter.org/audience/policy-testimony/; Sharra E. Greer, Testimony before the District of Columbia Council Committee on Facilities and Family Services, (April 11, 2023), *available at*: https://childrenslawcenter.org/audience/policy-testimony/.

[14] Presentation from Mary's Center, available on file with the Children's Law Center.

[15] FY2024 DHCF Budget Oversight Pre-Hearing Questions, response to Q13, available at: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAU5LcrnEwp5OEVnT7SQ_bNa/FY%202024%20Budget/DHCF/Agency%20Responses?dl=0&preview=FINAL+DHCF+Pre-Hearing+Questions_3.31.23.pdf&subfolder_nav_tracking=1.

[16] $450,000 is the cost of operating a full team of eight nurses in the evidence-based home visiting program, Nurse Family Partnership, for one full year. It is unlikely we would need to full amount in the first year given the necessary planning process. However, in subsequent years we will need to meet locally the full operating costs of evidence-based home visiting in the District to properly leverage federal Medicaid dollars.

[17] D.C. Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[18] The Request for Application for the 6th locally funded site is on file with the Children's Law Center.

[19] 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/. HealthySteps in the District embeds Family Services Coordinators (FSCs) and HealthySteps Specialists (HSSs) within the primary care setting to engage with families at each routine pediatric visit from birth to three years of age. Family Service Coordinators provide dedicated case management and care coordination for families through the support of DC residents with lived experience navigating systems. Early Childhood Innovation Network, *Innovation Spotlight: HealthySteps DC*, May 2019, ECIN Newsletter, available at: https://www.ecin.org/newsletter-may-2019. HealthySteps Specialists can deliver clinic-based mental health visits with families to address critical needs in areas such as maternal depression, grief and loss, and child behavior management. Specialists can also answer questions about behavioral health as well as facilitate the development of attachment, self-regulation skills, and family resiliency. *Id.*

[20] HealthySteps, *Risk Factors for Child Abuse and Neglect*, *available at*: https://www.healthysteps.org/our-impact/the-evidence-base/risk-factors-for-abuse-neglect/; HealthySteps, *HealthySteps Specialist Competencies*, 2022, *available at:* https://www.healthysteps.org/wp-content/uploads/2022/02/HS_SpecialistCompentencies.pdf.

[21] The current five locally funded cites include Unity Health Care, Inc.-Minnesota Avenue Health Center, Unity Health Care, Inc.-East of the River Health Center, Unity Health Care, Inc.-Parkside, Unity Health Care, Inc.-Unity Healthcare Anacostia, Children's National Medical Center-Anacostia. FY22 DC Health Performance Oversight Responses, response to Q45, available at: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAD3F2Mir6VFnyRlo3Tca3bma/COH%20Performance%20Oversight/DC%20Health/Agency%20Responses?dl=0&subfolder_nav_tracking=1. The four privately funded sites include MedStar Georgetown – MGUH Pediatrics/Kids Mobile Medical Clinic, MedStar Georgetown – MedStar Medical Group at Fort Lincoln, Children's National – Children's Health Center at THEARC, and Children's National – Children's Health Center at Columbia Heights. *See* HealthySteps, Find a HealthySteps Site Near You, available at: https://www.healthysteps.org/who-we-are/the-healthystepsnetwork/healthysteps-practice-directory/?location=Washington+DC.

[22] FY2024 DHCF Budget Oversight Pre-Hearing Questions, response to Q13, available at: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAU5LcrnEwp5OEVnT7SQ_bNa/FY%202024%20Budget/DHCF/Agency%20Responses?dl=0&preview=FINAL+DHCF+Pre-Hearing+Questions_3.31.23.pdf&subfolder_nav_tracking=1.

[23] § 7–1234.02(Perm). Perinatal Mental Health Task Force.

[24] DHCF, Perinatal Mental Health Task Force, *available at:* https://dhcf.dc.gov/publication/perinatal-mental-health-task-force.

[25] B24-0964, *Perinatal Mental Task Force Temporary Amendment Act of 2022*.

[26] Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (February 16, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/Leah-Castelaz_Testimony-Performance-Oversight_DHCF_FINAL.pdf.
[27] DHCF, Perinatal Mental Health Task Force, Monthly Meeting, March 28, 2023, *available at*: https://dhcf.dc.gov/publication/perinatal-mental-health-task-force.
[28] Currently, the Task Force is set to end on October 1, 2023. *See* B24-0964, *Perinatal Mental Task Force Temporary Amendment Act of 2022*. As of March 2023, DHCF has not delineated any of the funds appropriated to the Task Force in the FY2023 budget. *See* DHCF, Perinatal Mental Health Task Force, Monthly Meeting, March 28, 2023, *available at*: https://dhcf.dc.gov/publication/perinatal-mental-health-task-force. We do not believe an extension of three months will require additional funds. One thing to note is the Task Force is very interested in including community members with lived experience in the perinatal mental health space. We feel it is important that we compensate members for their time. We understand there are certain procedures that must happen internally at DHCF to allow for this process but would like to voice support to ensure adequate funds to pay those with lived experience for their time. Therefore, we would minimally advocate that there be sufficient funding to ensure this level of compensation. We ask this Committee to work with DHCF to understand and fund the total needed is to extend the Task Force and compensation community members with lived experienced for their time appropriately.
[29] Robin McKnight, *Increased Medicaid Reimbursement Rates Expand Access to Care*, National Bureau of Economic Research, October 2019, *available at*: https://www.nber.org/bh/increased-medicaid-reimbursement-rates-expand-access-care.
[30] Over the past few years, DHCF has initiated several major changes to the District's behavioral health system that will expand what care Medicaid will cover as it also moves toward a fully managed Medicaid program by 2024. Beginning October 1, 2023, behavioral health services will be integrated into the District's managed care contracts.
[31] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 16, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/Amber-Rieke_DHCF-Performance-Oversight_FINAL-2.16-and-2.17.pdf; Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 1, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/Amber-Rieke_CLC_Performance-Oversight-Testimony_DBH_February-1-2023_SBBH_final-1.pdf.
[32] Andy Schneider & Alexandra Corcoran, Standards for Provider Network Adequacy in Medicaid and the Marketplaces, Georgetown University Health Policy Institute Center for Children & Families (May 16, 2022), available at: https://ccf.georgetown.edu/2022/05/16/standards-for-provider-network-adequacy-inmedicaid-and-the-marketplaces/; Contract CW83148: Managed Care Organization (MCO) – MedStar Family Choice, Base Period 10/1/2020 - 9/30/2021, C.3.2, C.5.28.10.2, C.5.29.12.1, p. 11–12, 92, 120 (September 3, 2020), available at: https://contracts.ocp.dc.gov/contracts/attachments/Q1c4MzE0OMKmQmFzZSBQZXJpb2TCpns4RDQ5R%20UVEMS1FRDhFLTRBQkMtODg4RC03RDk5QzM4QkY5NjN9; 842 C.F.R. § 438.68 – Network Adequacy Standards.
[33] Centers for Medicare and Medicaid Services. Market Basket Data. Online. Available 4/4/2023: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.
[34] A 6.2 percent increase to rates was temporarily added over 2022 due to the Families First Coronavirus Response Act (FFCRA). *See* FY2022 DHCF Performance Oversight Responses, response to Q37, *available*

at:https://www.dropbox.com/sh/z6g48dc4tq8528u/AACOn8Enbisk7hSKkH1NjzFga/COH%20Performance%20Oversight/DHCF/Agency%20Responses?dl=0&subfolder_nav_tracking=1.

[35] *See* Mayor's Proposed FY 2024 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Behavioral Health, line 6515, (March 22, 2023), *available at*: https://app.box.com/s/kabhvjznbplwq1tkwd2gv66187aw37ii/file/1170978161849.

[36] Both DBH and DHCF Budget Oversight Pre-Hearing Responses begin to scratch the surface but do not provide the depth needed to understand the true impact of this increase and its impact on increasing provider rates. FY024 DHCF Budget Oversight Pre-Hearing Questions, response to Q14, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAU5LcrnEwp5OEVnT7SQ_bNa/FY%202024%20Budget/DHCF/Agency%20Responses?dl=0&preview=FINAL+DHCF+Pre-Hearing+Questions_3.31.23.pdf&subfolder_nav_tracking=1; FY024 DBH Budget Oversight Pre-Hearing Questions, response to Q8, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAGUOnsdH57hHf7WvWf4D55a/FY%202024%20Budget/DBH/Agency%20Responses/FY%2024%20Budget%20Questions.%20DBH%20Response?dl=0&preview=FY+24+Budget+Question+8+Increase+to+Local+Match.docx&subfolder_nav_tracking=1.

[37] *See* Mayor's Proposed FY 2024 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Behavioral Health, line 6514, (March 22, 2023), *available at*: https://app.box.com/s/kabhvjznbplwq1tkwd2gv66187aw37ii/file/1170978161849. Noting in DHCF's FY2024 Budget Pre-Hearing Responses they noted that Mental Health Rehabilitation Services were included in the DBH Behavioral Health Rehabilitation Local Match. *See* FY024 DHCF Budget Oversight Pre-Hearing Questions, response to Q14, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAU5LcrnEwp5OEVnT7SQ_bNa/FY%202024%20Budget/DHCF/Agency%20Responses?dl=0&preview=FINAL+DHCF+Pre-Hearing+Questions_3.31.23.pdf&subfolder_nav_tracking=1.

[38] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 16, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/Amber-Rieke_DHCF-Performance-Oversight_FINAL-2.16-and-2.17.pdf.

[39] Presentation shared during the DHCF Public Forum on Integrated Care meeting on November 30, 2022.

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Testimony for DC Department of Healthcare Finance Budget Hearing FY24 – April 5, 2023

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Chairperson Mendelson and members of the Council, thank you for the opportunity to testify today. My name is Corinne Cannon and I am the founder and executive director of Greater DC Diaper Bank. Greater DC Diaper Bank is the first-ever recipient of the $500,000 "DC Diaper Distribution Program" grant from the DC Department of Healthcare Finance specifically intended for the use of purchasing diapers. The grant, which was first introduced in the "Diaper Affordability & Access Act" by DC Councilmember Christina Henderson in March of 2022, is unique in that this is the first time the city is providing direct resources to fund the purchase of diapers for redistribution. **Today I am here to both thank the Council for these funds and what they have allowed our organization to do as well as ask for a continuation of this funding in FY24.**

Greater DC Diaper Bank serves 32,000 babies and 40,000 families in DC, MD, and VA with approximately 11 million annually. Since our founding in 2010, we have distributed nearly 40 million diapers to families in need. We also provide approximately $500,000 worth of other essential products each year through our Baby Pantry (formula, wipes, baby food, period products, incontinence items, breastfeeding supplies, and often-overlooked hygiene and personal care products for babies and adults) and Nursery Project (brand new car seats, cribs, baby carriers, strollers, and diaper bags) each year. Our vision is to provide basic necessities that aren't covered by government programs, such as Food Stamps and WIC.

We are thrilled to be working with the DC Department of Healthcare Finance and so grateful for the support that the DC Diaper Distribution Program provides us. With the FY23 funding received through the grant to date, we have purchased 1,103,800 diapers valued at $441,520. Eventually, with the half a million dollars awarded through the grant, we will be able to purchase over 3 million diapers (valued at $1.2 million). In the first three months of 2023, 29% of our diapers have been distributed to partners located in Ward 8. 21.23% of families in Ward 8 are below the poverty line, the highest of all eight wards, which means the diapers we provide are serving the families most vulnerable to diaper need at the greatest rates.

The model of the DHCF grant funding allows us to distribute the greatest number of diapers possible. Because of our wholesale relationships, we are able to purchase diapers at a highly discounted rate of between 11 and 16 cents per diaper. This makes receiving funds that allow us to purchase diapers wholesale and redistribute them, as this grant does, preferable to receiving donations of diapers or other products in-kind which would be purchased at retail rate.

We strengthen DC families through a partnership model, by leveraging our extensive network to secure diapers from in-kind donations, community drives, individual donations, corporations, and discounted wholesale purchases, which we then provide to our Community Partners for distribution through dozens and dozens of social service programs to District families. In DC, GDCDB works with 31 Community Partners and 6 Diaper Need Hubs, all of which are local social services agencies and government agencies serving District families. Working in deep collaboration with this extensive network of partners we are able to distribute diapers for free to families in all eight Wards.

GREATER DC DIAPER BANK

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Therefore, the grant funding provided by the Department of Healthcare Finance is not only supporting DC families but also strengthening the services of our 31 DC partners. Our partnership model augments the services and ability of our community partners to respond to a family's range of needs. Our partners view diapers as a "gateway resource" and leverage them in a range of ways, including attracting and retaining clients, using them as incentives for families to attend classes and programs, and providing resources that foster trust between clients and partners. Some of our largest DC partners include Martha's Table, Children's National, Centro Nía, Community of Hope, Horton's Kids, Jubilee JumpStart, Latin American Youth Center, and more. By bolstering the work of these organizations that are already serving clients in life-changing ways, we are able to create a stronger community in which organizations and families are able to work together to thrive.

Providing diapers for your baby is not a choice – though we see too many families who are faced every month with the question of buying diapers or other essential basic items. 63% of the families we serve told us that over the past year, they had to make a choice between buying diapers and spending money on other necessities like food, rent, utilities, transportation, and clothing for their families.

The impact of these decisions is felt by everyone in the family. If a family runs short of diapers and cannot change their baby as frequently as they would like, we know that can lead to health issues like diaper rash and urinary tract infections, not to mention that babies who are in wet diapers cry more and can be more irritable, which adds to the stress of being a parent. We asked parents about the impact of diaper need on their own emotional health and they overwhelmingly told us that when they don't have enough diapers they feel stressed, anxious, sad, and like bad parents.

I am very proud of our work in DC and throughout the region to help families parenting in poverty, but the need continues to be great. An adequate supply of diapers costs more than $100 per month for most of our families – about 50 diapers a week or 200 each month. Funding like the grant provided through the DC Diaper Distribution Program allows us to serve a greater number of families in DC while focusing our resources where they are needed most. Each family we serve receives between 50 and 100 diapers each month, which allows us to fill the gap between what parents are able to afford and the total number of diapers their baby needs each month.

In closing, I want to thank the DC Department of Healthcare Finance for their support in FY23. I also ask that you regrant this funding for FY24 so that we can continue to work together to ensure all families have the essentials they need to thrive.

Thank you for your time. I would welcome any questions.

Testimony of Jibran Eubanks, Political Organizer
1199SEIU United Healthcare Workers East
Before the
Committee on Health
Budget Hearing
Department of Health Care Finance
April 5, 2023

Chairperson Henderson and Members of the Committee,

Thank you for the opportunity to testify at this Budget Hearing. My name is Jibran Eubanks, I am the Political Organizer for 1199SEIU. We represent 400,000 workers across the healthcare continuum up and down the east coast, with thousands of healthcare workers in Hospitals, Clinics and Skilled Nursing Facilities in the District of Columbia. I am here today testifying on behalf of our members and of all the District's healthcare workers who are struggling to make ends meet on low wages, and are unable to provide the necessary care for consumers due to severe staffing shortages.

We know that we are facing staffing shortages in many different industries throughout the nation but since the pandemic, shortages in Home Health Aides and Certified Nursing Assistants have caused a crisis in the workforce. These workers who we called essential workers are now feeling even more unappreciated than ever.

According to PHI, a leading advocacy organization advancing policies to transform eldercare and disability services, the District of Columbia is projected to have over 3,000 new job openings for CNAs and 3,000 new job openings for HHAs between 2020 and 2030 to meet the needs of an aging population. As our senior citizen population drastically increases so will the need for qualified direct care workers. When considering the normal rates of worker turnover, there will be over 23,000 job openings for CNAs and HHAs during this decade.

The Department of Healthcare Finance is using the American Rescue Plan Act (ARPA) funding which has increased the average wage of home health aides to 110%, or $18.15/hr, but this is not enough to address the staffing shortage nor is it a Living Wage in the District of Columbia. Everything is going up from rent to gas to even groceries increasing by 11.3% from January 2022 to January 2023, but wages have stayed the same. Simply put, District of Columbia residents cannot afford to do this work and still live here.

When speaking to our members regarding the challenges they face, their concern is always for the patients. They are upset and frustrated that they cannot provide the patients with the quality of care that they deserve because they are responsible for looking after so many patients at once. In the workplace, workers are typically responsible for up to 15 patients but due to the staffing shortage and

high turnover, workers are now caring for 20-25 patients each. They share stories of residents who get bed sores because they have not been flipped due to not having enough nurses to assist with the physical demand of moving the resident. These patients are then sent back to overpopulated hospitals to be treated for new injuries, causing a seemingly never-ending cycle. We hear stories of the mental burden the job has when workers are being constantly called into work on their off day to cover a shift, stripping them of sometimes the only day off that they have to handle their own personal needs. Many providers are also no longer accepting new patients because they do not have enough workers to properly care for them.

When we consider solutions, the District must follow the lead of other jurisdictions and make a greater permanent investment in these jobs. Projections show that the number of adults over 65 in the District will increase by nearly 25% within this decade. Our direct service workers will need additional training and that training and experience should be compensated for. Our members in skilled nursing facilities have experienced changes in their day-to-day due to an increase of residents with higher needs such as dementia care, wound care or residents on ventilators. 1199SEIU strongly supports efforts to ensure workers receive all the training they need to find success in this extremely difficult work environment. We support initiatives that create career ladders for healthcare workers. In addition, ensuring the highest quality of care in our skilled nursing facilities takes more than just the medical staff. Everyone from cooks to housekeepers have crucial responsibilities when it comes to upholding a high standard of care. Our healthcare system is often viewed in silos: Hospitals, Clinics, Nursing Homes, Home and Community Based Services. In fact, these care settings are deeply connected. Hospitals must be confident that they are discharging patients into settings where they will thrive. For too long, long-term care has been an afterthought in our healthcare system.

Last but far from least, this is not just a workforce crisis but also an equity crisis. Over 87% of direct service workers in the region are people of color. Most of the workforce is constituted of Black women. 1 in 5 direct service workers in DC live in poverty and 63% rely on public assistance. As someone who had a family member who battled Alzheimer's for 12 years, I fully understand the importance of home care work. My aunt who was bedridden and could not do anything for herself, needed a home health aide and personal caretaker. Our HHA, Ms. Sylvia became more than just a worker, she became family. The care that she provided to my aunt could not be duplicated by just anyone. You have a have a certain type of character to do this work. When I think of what a superhero is to me, I think about the dedicated people in this workforce that make countless sacrifices to care for the less fortunate. We need to show these people that we have their back and that we truly appreciate the work they do because no one plans to get sick, but we can plan to care. Families like mine depend on us to center the needs of our elderly and disabled residents. Thank you and I am happy to answer any questions.

Testimony of Sally White, MS

Edenbridge PACE

Before the Committee on Health

FY 2023 Oversight Hearing

February 16, 2023

Dear Chairperson Henderson and members of the Committee. My name is Sally White. I am working with the exciting new Edenbridge PACE Program of All-Inclusive Care for the Elderly at Skyland.

As I testified previously, PACE is designed to meet the needs of adults ages 55 and older who would qualify for nursing home care, but who want very much to remain in their own homes, in their own communities, living the best life possible.

As the PACE provider, Edenbridge is responsible for providing all the services that each participant needs, including routine medical care, specialized care, therapies, assistance with activities of daily living, medications, socialization, transportation and even hospital care when needed. It is the job of the interdisciplinary PACE team to seamlessly integrate Medicare and Medicaid benefits and ensure that everyone in their care receives superior medical management and the care and support that allows them to live as well as possible in their own homes while providing respite and other support to often-exhausted family caregivers. For PACE participants who are eligible for both Medicaid and Medicare, there is no charge to the participant or their family members.

We are extremely pleased that the beautiful new Edenbridge PACE Center, located at the Skyland Town Center in Ward 7, opened its doors on March 1st.

I want to thank DHCF leadership and staff for working with Edenbridge PACE and others to improve the timeline for assessments through their vendor, Liberty Health. We are encouraged that the assessment process is moving in the right direction and hope that much needed improvements will be made in all areas of the enrollment process.

I am also here to address one aspect of the workforce issues that are having a huge impact on the availability of Home Health Aides and other critical direct care workers.

We— advocates and members of the DC Coalition on Long Term Care-- continue to advocate for direct care workers to be paid $24 per hour in 2024. Raising the minimum wage of Direct Care Workers across all settings to a minimum of $24 an hour is critical to the survival of many direct care workers and consequentially, to the care of our most needy residents.

DHCF is planning to increase the AVERAGE wage of direct care workers to 117.6% of the Living Wage by the year 2025. The Living Wage recently increased to $17 per hour. At that rate the 117.6% would bring the average, rather than the minimum, up to $19.99 per hour. Unless the living wage changes dramatically, this small percentage increase by 2025 will not result in wages near the $24 per hour needed in the FY24 budget to attract and retain workers. We cannot attract the workforce needed without aggressive action. Where can DC find the $40 Million plus that we estimate will be needed to make this happen? I urge the Council to examine areas of unspent funds this year and last to see where there might be money that could be shifted.

I know that it is daunting to put together a budget that meets the greatest needs in the city when so much federal support is ending; but the knowledge that thousands of older adults and younger adults with disabilities will be alone and neglected without the help they need because DC can't hire and retain the people to care for them is daunting as well.

Thank you so much for the opportunity to speak before you today.

Sally White
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Testimony Submitted to the Committee on Health: Budget Hearing for the Department of Health Care Finance

By

The Office of the District of Columbia Long Term Care Ombudsman

April 5, 2023

Mark C. Miller, District Ombudsman
Office of the D.C. Long-Term Care Ombudsman
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Greetings Chairperson Henderson and members of the Committee. My name is Mark Miller. I am the D.C. Long-Term Care Ombudsman with Legal Counsel for the Elderly (LCE). Thank you for the opportunity to provide testimony on behalf of approximately 9,000 District residents who receive long-term care services in nursing homes, assisted living residences, community residence facilities and in their own homes through the Elderly and Persons with Physical Disabilities (EPD) Medicaid Waiver Program. Our mission is to promote and help ensure the highest quality of life and quality of care for these individuals, who are among District's most vulnerable citizens. The Program's responsibilities are authorized under federal and local statute, and we are a Department of Aging and Community Living's Senior Service Network provider.

In FY 2022, the Ombudsman Program investigated 264 complaints, resolving 86% of those issues to the satisfaction of the care recipients or complainants. This resolution rate is well above the national average of approximately 74%. Most persons we serve are Medicaid recipients.

The Ombudsman Program educates individuals about their rights, empowering them to maintain their decision-making autonomy and to self-advocate when possible. In 2022, the program provided 574 individuals with information and consultation to help them navigate the long-term care system, understand their rights, and to assist them with self-advocacy.

Our Office is one of only 13 Ombudsman programs in the country that serve persons receiving long-term care services in the community, specifically EPD waiver

beneficiaries. As you are aware, the EPD waiver program provides critical care and support to older adults and persons with disabilities that allow them to continue living independently in their own homes. The 67 EPD Waiver complaints investigated by the Ombudsman Program in 2022 included provider response to complaints, quality of care concerns, and staffing-related issues. Approximately, one half of these complaints concerned staffing related issues.

There are two items I want to bring to the Committee's attention today --- the continued lack of staffing for EPD Waiver beneficiaries, and the need for additional affordable assisted living units. I believe both issues are connected to ensuring health equity through access to needed services.

Lack of Staffing to Meet Beneficiaries' Assessed Needs

As I mentioned, staffing is a frequent complaint that my Office receives. Unfortunately, some home health agencies (HHAs) are accepting beneficiaries without the capacity to provide full coverage for their assessed hours of care. A common gap in staffing coverage is evening and weekend hours. We have had several complaints on this issue including a beneficiary who was assessed for 14 hours, but who has not received weekend coverage for months. EPD Waiver beneficiaries have a nursing home level of care and must receive these services to remain safely in the community. Without consistent staffing many of these persons are at risk of institutionalization.

HHAs who accept DC Medicaid funds to provide EPD Waiver services should not be allowed to accept new clients if they cannot adequately staff the clients they are already serving. The Office of the DC Long Term Care Ombudsman recommends that HHAs be required to publicly report data on the total number of EPD Waiver clients they

serve, the number of EPD Waiver clients they are unable to fully serve, and the number of hours they were unable to staff. This is information prospective consumers need to make the best choice for their situation.

The District Needs Affordable Assisted Living

Assisted living represents an important component to a comprehensive long-term care network of services and supports. It provides a valuable service for those who can no longer live independently, but do not need all the services of a nursing home. Unfortunately, the cost for assisted living, which is predominantly private pay, remains out the reach of many individuals. Lack of access to this level of care has disproportionately impacts our communities of color, resulting in nursing homes being the only option available when they can no longer safely live at home. A recent 2021 study reported in *The Journal of Post-Acute and Long-Term Care Medicine* notes that few assisted living homes accept Medicaid, and that most are in high-income, primarily white neighborhoods, resulting in Black individuals representing only 4% of all assisted living facility residents nationally. In addition, for District residents, this may mean having to leave the District for a facility in Maryland. DHCF is currently paying millions of Medicaid dollars for District residents living in Maryland nursing homes.

Fortunately, over the past two years three new assisted living facilities have opened which accept EPD Medicaid Waiver beneficiaries, and one previously private pay facility now accepts Waiver beneficiaries as well. DHCF needs to continue to promote and incentivize the development of additional assisted living residences to accept Medicaid beneficiaries. Utilizing this option will also saves the District the

millions of dollars in the unnecessary higher cost of nursing home care for these individuals.

I want to acknowledge and thank you Councilwoman Henderson for your support and that of your Committee to promote the District's interests and efforts on behalf of older adults, and especially those who are socially and economically disadvantaged. Thank you for the opportunity to testify today, and I welcome any questions from the Committee.

District of Columbia Committee on Health

FY 2024 Budget Hearing

Department of Health Care Finance

Tiffany Bukoffsky, MHA, BSN, RN

The National Service Office for Nurse-Family Partnership and Child First

April 5, 2023

Good morning, Chairperson Henderson, and members of the Committee on Health. My name is Tiffany Bukoffsky, and I am the Government Affairs Manager for the Mid-Atlantic Region of The National Service Office for Nurse-Family Partnership and Child First. Thank you for allowing me to testify on Mayor Bowser's proposed FY 2024 Budget for the Department of Health Care Finance.

For those of you who may not be familiar with Nurse-Family Partnership, I would like to provide a high-level overview of our program. Nurse-Family Partnership, commonly referred to as NFP, is a community health program, with over 40 years of evidence, that pairs registered nurses with low-income, first-time mothers to provide home visits during pregnancy and through the first two years of the child's life. Specially trained NFP nurses provide home visits to help moms set goals to improve their health, their children's health, and their families' economic self-sufficiency.

The first NFP program in the District launched at Mary's Center in July of 2021, with a four nurse home visitor team. To date, the NFP program at Mary's Center has enrolled and served more than 95 families throughout the District and is currently working with Martha's Table to expand NFP access to families in Wards 7 and 8. Successful NFP implementation at Mary's Center was due to both Council grant funding plus philanthropic dollars raised. The Council previously committed $150,000 annually, beginning in FY 2021 and Mary's Center received $1.3 million in private charitable funds, with an additional $967,000 from The National Service Office for Nurse-Family Partnership and Child First Incentive Funds. The Incentive Fund and private philanthropic dollars end between March and August of 2024, therefore leaving the NFP at Mary's Center and Martha's Table without sustainable funding.

The vast majority of families who receive NFP services are enrolled in Medicaid or DC Health Alliance. With this knowledge, I am respectfully asking the Council to leverage Medicaid dollars to support evidence-based home visiting. Using the Medicaid program's federal match will allow Mary' Center to not only sustain its existing NFP program, but will allow a second team of four nurses to serve families in Wards 7 and 8 at a cost of only $187 per month, per family. On an annual basis, the total cost to sustain the current program and expand the program in two additional Wards is less than $450,000.

Funding NFP and other evidence-based home visiting programs through Medicaid is not only cost effective, but the District would see greater cost-savings based on improved health outcomes of moms

and babies. According to a Miller report, "Nationwide, Medicaid will accrue 60% of the government cost savings per family served by NFP. If Medicaid fully funded NFP in the District of Columbia, each level of government would reap Medicaid savings that exceed its share of undiscounted NFP costs when the child was age 6. By the child's 18th birthday, Medicaid would recoup $2.50 per dollar invested."[1] NFP yields an 8.1 to 1 benefit-cost ratio, which means for every $1 invested in NFP, roughly $8.10 in future costs for the highest risk families will be saved. The return on investment for the District includes numerous health benefits, consisting of, but not limited to the following data:

- 33% decrease in pregnancy-induced hypertension.
- 34% decrease in emergency department use for childhood injuries.
- 14% increase in full childhood immunization.
- 15% decrease in pre-term births.
- 48% decrease in infant mortality.
- 12% increase in moms who attempt breastfeeding.

Medicaid dollars are currently being leveraged in 37 states to help fund evidence-based home visiting programs, including NFP. While payment structures and rates vary from state to state, utilizing Medicaid is cost-effective. For example:

- Alabama utilizes a targeted case management state plan amendment, where the Medicaid benefit covers prenatal through baby, age two. Alabama reimburses via a monthly case rate of $765.47, with a minimum of two home visits expected; that amount of course must cover all home visiting provided in that service month.
- Idaho utilizes a targeted case management state plan amendment, where the Medicaid benefit covers prenatal through baby, age two. The payment is $250 per visit, with no limit to the number of visits.
- Maryland utilizes targeted case management through a state plan amendment, where Medicaid covers home visiting services, prenatal through baby, age two. The reimbursement is $188 per visit, with a maximum of one home visit per week.
- Oregon utilizes a targeted case management state plan amendment, where the Medicaid benefit covers prenatal home visiting services through baby, age two. The benefit is based on model and client need at a cost of $460 per visit for the total Federal Medical Assistance Percentage (FMAP), with the federal portion at about $307 per visit.

The National Service Office for Nurse-Family Partnership and Child First would like to see the District of Columbia leverage Medicaid dollars to not only support evidence-based home visiting, but use programs like NFP as an integral part of state strategies to address black maternal health and disparities in perinatal health outcomes.

[1] Miller, T.R. (2015). Projected outcomes of Nurse-Family Partnership home visitation during 1996-2013, USA. *Prevention Science* 16 (6). 765-777. Facts on state-specific return on investment calculator derived by Dr. Miller from published national estimates to project state-specific outcomes and associated return on investment. The calculator is revised periodically to reflect major research updates (latest revision: 12/22/2018).

Evidence-based home visiting benefits the District and provides an opportunity to support moms and babies within our communities. As such, we at The National Service Office for Nurse-Family Partnership and Child First respectfully request your support to leverage Medicaid dollars to support evidence-based home visiting, sustain the current program at Mary's Center and expand the program in two additional Wards.

Thank you for the opportunity to testify.

Testimony before the Committee on Health

Oversight Hearing on the Department of Health Care Finance

Janet A. Phoenix, MD, MPH, MS

Assistant Research Professor

George Washington University Milken Institute of Public Health

Submitted for the Record, April 11, 2023

Chairperson Henderson and members of the Committee of Health. My name is Dr. Janet Phoenix. I am an Assistant Research Professor at the Milken Institute School of Public Health at George Washington University and a physician by training. I also chair the DC Asthma Coalition. I am presenting this testimony regarding budgetary needs for the District of Columbia Department of Health Care Finance.

Because so many children in DC were adversely affected by childhood asthma and lead poisoning, a group of organizations joined together to create the Campaign to Reduce Lead Exposure and Asthma which launched last year. This campaign has met with and will continue to meet with many of you to advocate for improved conditions to reduce the numbers of DC residents exposed to lead and suffering from asthma.

For chronic diseases like asthma, there is a need to provide evidence linking sources of exposure to asthma allergens and irritants to outbreaks of disease. The majority of children with asthma in the District of Columbia are insured through the Medicaid program. The Medicaid program has, in the past, implemented system wide interventions focusing on childhood asthma because it is such a driver of utilization and spending for managed care organizations.

Several years ago, all Medicaid managed care organizations referred children whose asthma was poorly controlled to Children's National. These children received an intensive intervention through IMPACT DC, the specialty asthma clinic housed on the main campus at Children's National. As part of that system

wide asthma initiative a comprehensive evaluation and report was prepared by the Delmarva Foundation.

While this system wide approach was helpful and outcomes improved for children who received referrals, analysis of the data for those children seen at the IMPACT DC clinic was done by Children's National, not by the Department of Health Care Finance.

Although Health Care Finance receives reports from all the managed care entities it oversees, it has not in the past had the ability to analyze the data it receives on asthma (or other health outcomes) across the entire Medicaid system. Part of the issue has been that data systems across MCOs differ, so that work would have to be done by the agency to be able to merge the data sets it receives so that analysis could take place.

I am advocating that additional support be provided to the agency so that it can begin to make better use of the data it receives, merge data for specific high utilizing health outcomes and use that information to inform interventions that can be implemented across the entire Medicaid system. Innovative approaches are undertaken each year by individual MCOs. Some of those approaches could and should be scaled up. The data to support the selection of candidate interventions that should be promoted to system wide approaches is there, but the capacity to use it is limited.

If additional resources were made available to the Department of Health Care Finance, they could more effectively work with their sister agency, DC Health, to identify problematic health outcomes, identify evidence-based approaches, implement those across the Medicaid system and evaluate the impact on health and health care utilization. This has the potential to improve health outcomes for a disproportionately sicker population of DC residents and drive down health costs for the Medicaid program.

Thank you for the opportunity to testify.

DC Council Committee on Health
Budget Oversight Hearing - Department of Health Care Finance
Wednesday, April 5, 2023 - 9:00AM

Good morning, Chairperson Henderson and members of the Health Committee. My name is Ian Paregol, and I serve as the Executive Director of the DC Coalition of Disability Service Providers. The DC Coalition currently represents over 50 provider agencies, supporting over 2,300 persons with intellectual and developmental disabilities and employing over 4,700 staff - most of whom are residents of the District of Columbia. Member organizations provide residential, day, employment, in-home and other home and community-based waiver services as well as Intermediate Care Facility ("ICF") supports to residents of the District with intellectual and developmental disabilities.

On behalf of the DC Coalition and its membership, we support the Mayor's FY 24 budget, but we do urge the Mayor to issue the written findings from the Healthcare Workforce Taskforce which she convened over the summer of 2022. Within the committee member proposed recommendations there were a number of suggested strategies to address the workforce crisis that continues to exist within the healthcare industry. One such recommendation - which was generated within several sub-committees reports - was increasing the benchmark funding threshold for direct support staff to 120% of the Living Wage, replacing the 117.6% factor that was borne of legislation passed in 2019 through this body's DSP Rate Payment Act.

Prior to Covid, the DSP Rate Payment Act remained largely unfunded by the Mayor, and turnover and vacancy rates continued to swell. And then Covid struck, which resulted in a parabolic rise in vacancies from an already dangerously high baseline. As a result, the DC Coalition, as well as numerous other healthcare advocates including long term care leaders, home health service providers, and the SEIU would suggest that recruitment and retention needs will require an even more substantial commitment to funding.

<u>Increased Front-line Staff Funding</u>

While the funding arm of DD supports, the Department of Health Care Finance (DHCF), has offered supplementary funding in FY23 which attains 110% of the DSP Wage Act mandated 117.6% funding, at this point, DD providers are just too far behind with continually mounting turnover and vacancy rates. Vacancy rates are in average 23% with some providers reporting vacancy rates as high as 40%. We would submit that in spite of recent efforts, the 117.6% increase - *which will not be fully funded until January 2025* - will just not be enough to attract and recruit staff for these demanding jobs and will not have an impact on staff vacancy rates.

Unlike other industries, direct care services must be provided. Providers cannot simply choose not to staff someone who requires direct supports. Instead, those supports are covered by already exhausted staff persons working at an overtime rate. Funding does not include any adjustment for overtime within its funding formula, so those overtime hours are only funded at the base living wage rate resulting in substantial unsustainable fiscal losses for service providers.

The anticipated funding increases for FY23 seek an averaged wage of $18.15/hr, but even that calculation remains very close to Minimum Wage, netting a mere $66.00 gross weekly upside on average versus a straight Minimum Wage paycheck. Given the significant training requirements, independent responsibilities and the array of documentation required of DSP staff, the role of the DSP is much more involved than one that pays at or near the DC minimum wage, and in order to protect workers as well as those supported, it cannot be treated as such.

In 2013, hourly wage rates for DSP workers were 162.5% of the Minimum Wage. In fact, the District's wisdom in creating a favorable DSP wage differential yielded results that led the nation for lowest vacancy and turnover rates. We need to return to those successes. At the end of the day, **even at averaged funding of 10% above the Minimum wage, there is no economic reason for a job seeker to choose to become a DSP**. And without a suitable workforce, the District will fail to meet the needs of our most vulnerable residents, while also failing to address the socio-economic equity arguments surrounding this workforce that others have raised.

Further, providers need some accommodation or additional funding to account for the overtime generated from these staff vacancy rates which now result in even higher operational expenses. This is exactly the scenario that we testified about back in 2017 and 2018 and why we needed to address wages five (5) years ago - so we would not find ourselves in this situation now.

Finally, we wish to highlight a few other fiscal considerations that need to be addressed by DHCF.

<u>Wage Compression</u>

As hourly rates for the substantial direct support workforce are projected to increase, we do need to address the wage compression impact that those increases are having upon the mid-level managers and supervisors. In part because of the difficulties in recruiting and retaining front line workers have resulted in significant overtime wages occasioned by the unsustainable vacancy rate among front line workers, those who are providing direct supports are now earning - on an annual basis - more than their supervisory team. Albeit more weekly work hours are required to attain those weekly pay levels, but the consequence has been that mid-level staff and supervisors are vacating their supervisory positions because they can earn more with overtime as a direct care worker. This has left a supervision gap and an inability to recruit mid-level leadership for the IDD provider community. **We are recommending additional fiscal support for these mid-level staff so that providers can maintain appropriate supervision ratios.**

<u>Nursing Shortage</u>

Similarly, funding for our nursing cohort lags behind the wages that these same nurses can earn in more traditional or institutional settings where they have a more clearly defined work schedule and actual hours where they can be "off duty." As a result of severe nursing shortages in

community-based services, IDD nurses are on-call *all day, everyday*, and are not funded at comparable levels to those in more traditional settings even for a 40 hour work week.

We do recognize that there are nursing shortages throughout the region, but we are also asking for **funding so that our IDD providers can pay their nurses at least a competitive rate**.

Post-PHE Implications

Also notably on the horizon, we do fear what will happen when the additional Federal funding occasioned by the Public Health Emergency status is withdrawn in November 2023. Providers are using PHE-abled funds to cover overtime and per diem staff coverage, but our staffing shortfalls will not be remedied by the Fall. In fact, supplementary funding that is keeping the Intermediate Care Facilities afloat will disappear in July. We need to engage in a strategic dialogue now which considers projected vacancy data and post-PHE funding support in order to chart a sustainable future for services that is not reliant on PHE stabilizing assets.

Of course, this has ramifications throughout all of the waiver supported services, but we **recommend convening a team of stakeholders to consider the fiscal implications of the Post-PHE world**.

Reallocation of Remaining ARPA Funds

The DC Coalition has requested that the District **consider the reallocation of remaining ARPA resources** which remain either unspent (or unlikely to be spent) and that those undeveloped funds be braided into a more meaningful wage factor in order to increases wages not only for direct support workers but also for nurses – which remain in short supply in the DD provider world. For example, there remains $5.2M in unspent ARPA funds which were targeted for direct support professional recruitment. The DC Coalition encourages DHCF to convene a meeting which describes the planned use of the remaining ARPA funds and addresses comments from the community on possible reallocations.

Accounting for Overtime

Lastly, the DC Coalition recommends that **any continuing wage enhancements for front-line staff include allocations for expected continued overtime costs resulting from the unsustainable vacancy and turnover rates within the industry**.

On behalf of the DC Coalition of Disability Service Providers, I thank you for the opportunity to provide this testimony at today's Budget Oversight Hearing, and I welcome any questions you may have.

Respectfully submitted,

Ian Paregol
Executive Director, DC Coalition of Disability Service Providers

Testimony before the

Council of the District of Columbia

Committee on Health

FY24 Budget Oversight Hearing

for the

Department of Health Care Finance

* * *

Presented by

Justin Palmer, MPA

VP, Public Policy & External Affairs

April 5, 2023

Greetings Chairperson Henderson and members of the Committee on Health, my name is Justin Palmer, and I am the Vice President for Public Policy and External Affairs for the District of Columbia Hospital Association (DCHA). I appreciate the opportunity to present testimony at the Department of Health Care Finance's FY24 Budget Oversight Hearing.

DCHA is a unifying force advancing hospitals and health systems in the District of Columbia. We are committed to promoting policies and initiatives that strengthen our system of care, preserve access, eliminate disparities and promote better health outcomes for patients and our community. Our driving vision is to achieve an efficient and effective health care

delivery system that supports a healthy, equitable and vibrant community.

Despite the revenue challenges, the Mayor's FY24 budget for the Department of Health Care Finance continues to invest in the health and wellbeing of District residents. It does this while holding provider taxes relatively stable across the board and investing $108 million in local funds to support increases in the managed care programs.

As the Department begins the redetermination process and winds down the PHE it will be incredibly important to monitor the impact on patients and providers. The Department's community engagement plan is very robust, and our members are committed to supporting DHCF in its efforts to ensure eligible beneficiaries maintain coverage without a break.

Just as important is the need to monitor providers as they navigate the ending of the PHE. Several provider types received enhanced reimbursement rates during the PHE which will end soon after the PHE expires. This may present challenges given the increased staffing costs and overall inflation all sectors of the economy are facing. We know the Department is sensitive to these challenges and will be instrumental during this transition period to monitor provider stability.

Important to this budget year will be robust oversight of the District MCO's to ensure that providers are paid in a timely manner, that denials are minimized, and unnecessary prior authorizations are avoided. We are greatly appreciative of the Department's openness to require MCOs to report or make information public provided regarding paid and denied claims as well as prior authorizations. This builds on their MCO

accountability measures in place today. We believe this will be important, especially as behavioral health providers are carved into the MCO program.

Finally, I would like to comment on a BSA subtitle that impacts several of our members regarding negotiated MCO rates. DCHA would prefer that this matter was handled through MCO negotiations with the hospitals and discussions with the Department rather than the BSA. We continue to work with DHCF and our members to identify budget neutral policy options that might address this issue for everyone.

In closing, I want to reiterate that DCHA looks forward to our continued collaboration with the Department in advancing system transformation in the District.

Thank you for allowing me to testify today, and I am happy to answer any questions you may have.

District of Columbia Behavioral Health Association
PO Box 33515
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Testimony of the District of Columbia Behavioral Health Association
Department of Health Care Finance FY '24 Budget Oversight

To the District of Columbia Council Committee on Health
April 5, 2023

Chairperson Henderson and Members of the Council,

Thank you for the opportunity to testify today. My name is Mark LeVota. I am the Executive Director of the District of Columbia Behavioral Health Association and a Ward 2 homeowner. The District of Columbia Behavioral Health Association works to advance high-quality, whole-person care for all District residents with mental illness or substance use disorders, including the 30,000 District residents our 31 member organizations serve annually. The Mayor's proposed budget for fiscal year 2024 for the Department of Health Care Finance reflects substantial projected increases in health care spending, but relies on assumptions that deserve Council scrutiny – both to determine whether adequate funding levels have been budgeted but perhaps more importantly to understand the expected impact on District residents if the assumptions are largely correct.

The Department of Health Care Finance has several major tasks in the rest of FY '23 and over the course of FY '24, especially bringing new managed care contracts online, restarting Medicaid eligibility redeterminations paused by the federal public health emergency, and carrying out the transition of DBH-certified provider services into managed care. Each of these operational tasks has important budget consequences.

With each of the new managed care contracts decided and handoff from CareFirst to Amerigroup completed April 1, DHCF will need to watch closely over the next several months to ensure that beneficiaries are well-informed about open enrollment, that prior authorized care is not needlessly disrupted, and that managed care paneling, credentialing, and payment functions are operating smoothly. Initiation of the new contracts provides important spending safeguards absent from previous managed care contracts through the use of payment risk corridors, and the District should benefit from this important tool for improved fiscal stewardship. While the most challenging of managed care contract award issues likely will be stabilized by October 1, the contract turnover adds additional stress while DHCF is undertaking the other two substantial projects.

Restart of Medicaid eligibility redeterminations is an enormous undertaking. The District has more Medicaid beneficiaries enrolled than any time in recent memory, both in absolute numbers and as a share of the District's overall population. The Council should ask DHCF to explain its assumptions about enrollment, service utilization, and provider payment rates with sufficient detail to have necessary assurance that funding levels budgeted will be adequate. The Council should also weigh how projected disenrollments will play a role in reduced DHCF spending that also imply District residents will need to look elsewhere for healthcare that the District has financed over the past several years. Dramatic dropoffs in DC Healthcare Alliance enrollment since the end of the District's public health emergency and restart of Alliance recertification certainly provide some reassurance that the District is not offering coverage to people who are no longer eligible because they earn more or live elsewhere, but there are also likely large numbers of now-former recent Alliance beneficiaries who simply failed to complete recertification even though they remain technically eligible. DHCF's budget plans and its aspirations are in tension if the budget is built with assumptions that eligible District residents will reduce their participation in healthcare services due to coverage losses. The $10.1M proposed reduction in Alliance Provider Payments reflects that tension and may also be a signal of the path forward for reduced growth in Medicaid spending due to coverage losses for eligible District residents who fail to complete the recertification gauntlet. Greater tolerance for coverage losses eases budgetary pressures, and lower tolerance for coverage losses increases budgetary pressures.

The transition of DBH-certified provider services to managed care is a third substantial undertaking for DHCF over the course of the next twenty-four months. In my DBH budget oversight testimony, I shared the need for DBH and DHCF to provide an integrated account of proposed behavioral health spending and to clarify enrollment, utilization, and payment rate assumptions. The $10.1M proposed cut to overall Alliance spending seems even more stark given DBH and DHCF plans to add for the first time outpatient behavioral health services to the Alliance program. The new benefit is good health policy, and I am grateful to see the investment. The Council must also ask, though, just how many more Alliance beneficiaries does DHCF expect to lose coverage if it is able to add a substantial new program benefit and also substantially reduce spending? As I also said in my DBH budget oversight testimony, "It remains unclear whether there is also room in the proposed budget to adjust provider payment rates to close the gap from inflation. A structured Alternative Payment Methodology (APM) for DBH-certified providers including annual inflationary adjustments supported by audited cost reporting and periodic rebasing would help to smooth the trajectory of Medicaid and Alliance spending for behavioral health services." I hope the Council will encourage DHCF to take up the project to establish an Alternative Payment Methodology for DBH-certified provider services during FY '24, so we can go into the FY '25 budget prepared for the end of the so-called 'bridge period' that DBH and DHCF have promised for the first eighteen months that DBH-certified provider services are in managed care. There's a great deal of incomplete work to prepare for October 1, 2023, and it is also critical to begin to prepare for March 31, 2025.

I will not offer extended commentary on other changes proposed in the DHCF FY '24 budget. I would encourage the Council to discuss with DHCF the mix of District government staff as well as third-party contractors needed to support the process of restarting Medicaid eligibility redetermination. In the face of proposed reductions in grants and contracts for technical assistance services, I would encourage DHCF to continue to look for opportunities for federal grant funding and Medicaid matching funds to support continuing need to develop the capacity and capabilities of the provider network.

Thank you again for the opportunity to testify today. I look forward to answering any questions that you might have.

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

To: The Honorable Christina Henderson, Chair, DC Council Committee on Health
Members of the Committee on Health
From: Patricia Quinn, VP of Policy and Partnerships, DC Primary Care Association
Re: Budget Oversight Hearing for DC Department of Health Care Finance
Date: April 5, 2023

The DC Primary Care Association (DCPCA) works to build a healthier DC by sustaining community health centers, transforming DC care delivery, and advancing racial and health equity. Our collaborators in this work include community health centers, serving almost 1 in 4 District residents in every ward of the city; District government agencies including the Department of Health Care Finance (DHCF), DC Department of Behavioral Health and DC Health; as well as other providers in the DC health ecosystem. Thank you for the opportunity to provide testimony regarding the budget for the District of Columbia Department of Health Care Finance (DHCF.)

DCPCA's greatest concern for community health centers and the patients they serve in 2023 and 2024 is the impact of the end of the Medicaid continuous coverage provisions implemented at the start of the COVID-19 pandemic. Using data from the US Health Resources and Services Administration (HRSA) 2021 Uniform Data System (UDS),[1] the Geiger Gibson Program in Community Health at George Washington University estimates the revenue losses for the District's community health centers as between $12.9M and $24.2M. As a result of the revenue decline, health centers will lose capacity to serve between 6,500 and 12,300 patients. The lower bound estimates account for the fact that some of those who lose Medicaid coverage may gain other insurance.[2]

The projected coverage and revenue losses will have significant impact on the District's drive for health equity. Seventy percent of people served by our members identify as Black; 36% identify as Hispanic or Latino/a, and 67% of our patients have incomes below 100% of the Federal Poverty Level; 87% below 200% FPL. Thirteen percent of health center patients identify as lesbian, gay, or bisexual, and 2% are transgender. Over 11,000 health center patients are homeless. DC's community health centers are the cornerstone to reaching and serving the highest priority populations in the quest to give every District resident a fair shot at a full healthy life.

A second area of fiscal pressure on the District's community health centers is the loss of an enhanced rate for their fee-for-service patients put in place to mitigate pandemic impacts. This rate will revert to a utilization-based rate.

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[1] https://data.hrsa.gov/tools/data-reporting/program-data/state/DC/table?tableName=Full

[2] The Potential Effect of Medicaid Unwinding on Community Health Centers | Geiger Gibson Program in Community Health | Milken Institute School of Public Health | The George Washington University (gwu.edu)

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

DCPCA urges the Committee on Health to support the following actions to mitigate the impact of Medicaid coverage losses and ensure that every District resident eligible for Medicaid retains coverage, and that those no longer eligible find safe harbor through Alliance coverage or affordable commercial insurance:

1. Create direct, fast-track access between health center staff supporting patients through the enrollment/redetermination process and the District staff who can assist them in addressing system issues. This maximizes the human capital we are collectively investing in making sure our residents maintain coverage.
2. Co-locate District employees responsible for managing Alliance and Medicaid redeterminations at community health centers. This was often utilized pre-pandemic to increase efficiency and improve service.
3. Monitor rates of coverage losses, subsequent health center revenue declines, and impacts on health center capacity, and be prepared to put holds on removals from the Alliance and Medicaid rolls if redetermination/enrollment system issues are at fault.

A second area of fiscal pressure on the District's community health centers is the loss of an enhanced rate for their fee-for-service patients put in place to mitigate pandemic impacts. This rate will revert to a utilization-based rate at the end of May.

As we confront the potential loss of significant revenue and the subsequent loss in patient care capacity, timely payment of existing Medicaid Managed Care claims becomes even more critical. DHCF has the power to hold MCOs accountable to improve the functioning and sustainability of a comprehensive, coordinated system prepared to meet the needs of high priority District residents. Additionally, DHCF can support standardization of processes such as billing, credentialing, and prior authorization to reduce provider burden and delays in patient care. We can work together to improve payment and credentialing systems so we can all fully focus on ending persistent, pervasive inequities that drive disparate health and well-being in the District.

DCPCA believes we have strong DHCF support to utilize tools that maximize capacity and efficiency, and we look forward to the Department's partnership to protect health center patients and maintain health center stability.

Good morning Council member Henderson, and thank you for this opportunity. My name is Sal Selvaggio, and I am a retired dentist and member of the Iona Senior Services Citizen Advisory Group, Northwest Neighbors Village, and the DC Coalition on Longterm Care. I have twice testified before you on our current lack of a sufficient healthcare workforce, which is becoming amplified as DC's population becomes older, and more in need of their services.

I have submitted to your office written testimony, but I would like to deviate from that testimony because of some more recent thoughts and experiences. I'll resubmit this new testimony.

From attending these hearings, and listening to the needs of other groups who testify before you, I've come to appreciate the difficult and important decisions you and our other government officials need to make regarding how to spend our tax dollars.

I'd like to suggest the following as a way to move forward:

Have a point person:
Addressing our workforce shortage will take a concerted and creative effort, which will require leadership willing to work across the many agencies that need to be involved to secure the necessary funding. We need a leader willing to spearhead that effort. As the Chairperson of the Committee of Health, I hope you can be, or can designate, such a person.

Use existing resources:
The Mayor's healthcare worker task force included many stakeholders. They came up with a reasoned plan that can become a platform to build upon. Again, in order to do this,

someone needs to take the responsibility of evaluating the task force recommendations and implement a practical way forward.

Work with the DC Coalition on Longterm Care.
They have real world expertise from members involved in business, nonprofits, and groups representing the communities affected. The Coalition can provide insights that can pull together the many moving parts and facilitate addressing this complex problem.

Finally, yesterday, at our last Longterm Care Coalition meeting, we were joined by James, a man who uses a wheelchair and requires care for 14 hours a day to help with his activities of daily living.
He cannot negotiate his Adams Morgan apartment's 9 steps to enter or exit without help. His regular healthcare worker canceled, and he was unable to find a replacement. This has happened multiple times to him. He was asking for our help, and also wants to become involved so what is happening to him doesn't happen to others.

His story, unfortunately, is not an uncommon one. I believe the Coalition has given your office survey data from healthcare worker agencies that verifies that situation, and:
Situations involving people not being able to be released from a hospital bed into their homes because of our healthcare worker shortage that will become more common. Just speak to hospital administrators.

Situations where nursing home and long term care facilities being understaffed will become more common. Just speak to the overworked aides.

Situations where children of aged parents will have to face the emotional and financial consequences of the decision to stay at

home and care for their loved ones or make a living. Just speak to those children who are currently experiencing this.

Councilmember Henderson, you, along with the rest of the Council and the Mayor, have difficult decisions to make about the DC budget. I trust you will consider the impact our healthcare worker shortage is having on our community now, and will have into the future, as a priority issue that needs to be addressed. Thank you.

Healthier You. Healthier Communities.

TESTIMONY OF

Dr. Catherine Crosland
Director for Homeless Outreach Development, Health Care for the Homeless
UNITY HEALTH CARE

Council of the District of Columbia
Committee on Health
Christina Henderson, Chair

Budget Oversight Hearing
Deputy Mayor for Health and Human Services
Department of Health Care Finance

April 5, 2023

Good morning, Chairperson Henderson and Members of the Committee on Health. My name is Catherine Crosland. I am a DC resident, a physician with Unity Health Care ("Unity") who has been caring for people experiencing homelessness in Washington DC for the past fourteen years, and a member of DC's Interagency Council on Homelessness (ICH). Currently, I serve as the Director for Homeless Outreach Development for Unity's Health Care for the Homeless program. Since 2020, I have worked in collaboration with DC's Department of Human Services (DHS) on the COVID-19 pandemic response to meet the needs of people experiencing homelessness in DC. I am pleased to have this opportunity to present testimony as part of the Fiscal Year 2024 Budget process.

I want to thank you for holding today's hearing. In addition, I would like to thank Mayor Bowser, Deputy Mayor Turnage, and their dedicated staffs for their work in assembling the proposed Fiscal Year 2024 budget. To be sure, balancing the many demands of our complex city is not easy.

In February, I was delighted to testify before this Committee's Performance Oversight Hearing on these very issues. During that hearing, I expressed my gratitude at the District's swift and effective action to meet the needs of people experiencing homelessness during the COVID-19 pandemic, including the establishment of Isolation and Quarantine hotel shelters (ISAQ) and the Pandemic Emergency Program for Vulnerable individuals (PEP-V), among other proactive measures to meet the needs of people most likely to experience complications or death from COVID-19.

I am here today to urge the District to consider building on its incredible work and the lessons learned during the pandemic on issues related to medical respite services. Undoubtedly, housing is healthcare, especially for someone experiencing homelessness and, simultaneously, recuperating from an illness. For these individuals, who are too sick to be in the shelter or on the street – but not sick enough to be in the hospital, medical respite care is an indispensable bridge to wellness.

Given the recent downward projections in the District's revenue, now is the time to be investing in medical respite. Simply put, medical respite saves lives and money!

People experiencing homelessness are nearly 5 times more likely to be hospitalized than housed individuals.[1] In addition, the average hospital stay for a homeless patient is double that of a non-homeless patient. Homelessness, therefore, represents a major factor in hospital utilization. Studies confirm, however, that the availability of medical respite care significantly reduces future hospitalizations for individuals experiencing homelessness. In fact, by some estimates, they experience 50% fewer hospital readmissions within 90 days of being discharged compared to people experiencing homelessness discharged to the street or a shelter.[2]

In addition, medical respite care is an effective way to avoid unnecessary and costly inpatient hospital stays for this population. The financial savings associated with providing respite care, when compared to the cost of inpatient hospitalization, are enormous.[3] According to a March 2011 study that examined the subject in Salt Lake City, inpatient hospital care is 10 times more expensive, on average, than medical respite care: $1,359 per day versus $135 per day.[4] Over the span of a year, the study confirmed that Salt Lake City hospitals saved $5.5 million, by partnering with medical respite care centers.[5] Similarly, a Los Angeles-focused study also concluded that inpatient hospital care is approximately 10 times more expensive than medical respite care: $2,279 per day versus $175 to $200 per day.[6] The utilization of respite care,

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[1] "Shelter for convalescence: Hospitals link with respite programs to aid homeless patients through recovery," Modern Health Care, (March 22, 2014) ("Homeless patients use hospitals at a much higher rate than housed patients, studies have found. A 2010 study found about 23 hospitalizations for every 100 homeless people in a year, comparted with five hospitalizations for every 100 people in the general population."). Retrieved from https://www.modernhealthcare.com/article/20140322/MAGAZINE/303229937

[2] National Health Care for the Homeless Council. (March 2011). National Health Care for the Homeless Council Survey of Medical Respite Program. Retrieved from National Health Care for the Homeless Council: https://www.nhchc.org/wp-content/uploads/2011/09/RespiteCostFinal.pdf

[3] "Study Shows that Medical Respite Care for Patients Experiencing Homelessness is Cost-effective for Hospitals," *Association of American Universities,* (May 22, 2108) ("Each day spent in a hospital is about 10 times as expensive as a day spent in medical respite.").

[4] National Health Care for the Homeless Council. (March 2011). *National Health Care for the Homeless Council Survey of Medical Respite Program.* Retrieved from National Health Care for the Homeless Council: https://www.nhchc.org/wp-content/uploads/2011/09/RespiteCostFinal.pdf

[5] Hanks, M. Fourth Street Respite Care. *National Health Care for the Homeless Council (Personal Communication, March 18, 2011)*.

[6] Gregerson, P. JWCH Institute, Inc. *National Health Care for the Homeless Council (Personal Communication, April 8, 2011).*

according to the study, resulted in millions of dollars in reduced health care expenditures in Los Angeles and Orange County.[7]

Unsurprisingly, reductions in health care expenditures for people experiencing homelessness translate into savings for publicly funded health care programs, specifically Medicaid. In 2013, Yale New Haven Hospital (YNHH) launched a 12-bed medical respite care facility for homeless people in partnership with Columbia House, complete with case management. A 2017 study conducted by YHNN estimated that the program saved Medicaid between $12,000 to $25,000 *per patient* in the year following participation in the respite program.[8] As part of the study, YHNN found that "the 30-day readmission rate for respite patients dropped from the 2012 level of 50% to 16.7% by 2016," and included a reduction in the average length of stay from 8.6 days in 2014 to 7 days in 2016.[9]

Furthermore, medical respite permits a more efficient use of shelter resources. When there is someone in the shelter who is too sick to be there, they either cycle in and out of the hospital, as mentioned earlier, or cause a significant drain on the shelter resources and staff who are not equipped to manage their needs. By having enough medical respite beds for those with higher medical needs, the shelters would be able to operate more effectively to meet the needs of the rest of the population.

As the evidence confirms, there are many tangible benefits associated with medical respite care. At present, the District has a limited supply of medical respite care providers: Joseph's House (8 beds); Christ House (33 beds); Hope has a Home Medical Respite Program (16 beds); and the Patricia Handy Place for Women (12 beds). All are excellent programs! The reality is, however, that we need more beds to serve an increasingly older and more medically complex

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[7] "Shelter for convalescence: Hospitals link with respite programs to aid homeless patients through recovery," Modern Health Care, (March 22, 2014). (Treating 1,500 homeless patients in Recuperative Care Centers in Los Angeles and Orange County saved hospitals approximately $12 million, or roughly $8,000 per homeless patent.). Retrieved from https://www.modernhealthcare.com/article/20140322/MAGAZINE/303229937

[8] Crombie, Paula, Director of Social Work, Yale New Haven Health & Cunningham, Alison, CEO of Columbus House, "Medical Respite Care: Reducing Readmissions, LOS, and ED Visits of People Experiencing Homelessness," Connecticut Coalition to End Homelessness. Retrieved from http://cceh.org/wp-content/uploads/2017/02/Medical-Respite-Celebration-v19.pdf

[9] "Yale New Haven Hospital medical respite program puts homeless patients on path to better health," (January 31, 2018). Retrieved from https://www.aha.org/news/insights-and-analysis/2018-01-31-yale-new-haven-hospital-medical-respite-program-puts-homeless.

population experiencing homelessness. We also need more "low barrier" medical respite beds – beds that are not tied to a specific insurance plan, as well as medical respite beds that do not require sobriety. Last year, Unity conducted a survey of hospital care coordinators as well as shelter staff and outreach workers. Based on this informal needs-assessment, Unity estimates the need to be approximately 150 beds. If we subtract the currently operational medical respite beds listed above, there remains a need of approximately 80 additional beds.

Determining precisely how the District should fund these life-saving and cost-effective medical respite beds will require a thoughtful approach. To this end, we urge the District to revisit the work that was initiated as part of the Fiscal Year 2020 budget related to creating a Medicaid funding source for medical respite care services for homeless individuals. Specifically, Subtitle H, Section 5071(a) required the Department of Health Care Finance to submit a report to the Council by September 30, 2022, outlining its

> "(i) Recommendations for the establishment of medical respite care services for homeless individuals, through either: (I) An amendment to the District of Columbia's State Plan; or (II) A waiver pursuant to section 1115 of the Social Security Act, …, for home and community-based services
>
> (ii) The types of services that may be offered to homeless individuals through a medical respite care program; and
>
> (iii) An identification of any potential restrictions on the provision of services identified pursuant to sub-subparagraph (ii) of this paragraph, including the use of prior authorization."

For reasons, which we all fully appreciate, the Department of Health Care Finance was unable to meet this requirement while confronting the COVID-19 pandemic. It is our hope that we can now return our attention to this important task, which will now be informed by our recent pandemic experiences on the matter.

Accordingly, we urge the Committee to incorporate the above language into the FY2024 Budget Support Act and request the report be submitted to the Council by January 1, 2024. In addition, we recommend that the report include an analysis on the appropriate reimbursement rates to sustain these services.

Chairperson Henderson, thank you for the opportunity to testify. I am happy to answer any questions that you or Members of the Committee might have.

Date: April 5, 2023

To: Councilmember Christina Henderson, Committee Chair, Committee on Health, Council of DC

From: Makeda Vanderpuije, Executive Director, LeadingAge DC

Re: Committee on Health – FY 2024 Budget Oversight Hearing - Testimony

Good morning, Chairperson Henderson and Members of the Committee on Health. Thank you for this opportunity to testify before you today. My name is Makeda Vanderpuije and I am the Executive Director of LeadingAge DC, an association representing mission-driven organizations serving aging residents across the District, including nursing homes, assisted livings, affordable housing, home and community based services, senior villages and Life Plan Communities (CCRCs).

Prior to my work at LeadingAge DC, I was a District employee, serving for over four years within DC Health's Office of Health Equity. Across 10 years of experience in public service, I've built expertise in collective action, population health improvement, and equity. I'd like to acknowledge and thank Mayor Bowser, her administration, the Council of the District of Columbia, and all DC government staff for your dedicated service to those who live, learn, work, play, and age here in our nation's capital.

Today I am here to share LeadingAge DC's concern about alarming shortages in the direct care workforce.

Aging residents have so much to contribute to our communities, from sharing hard-earned wisdoms to the appreciation of life's milestones, big and small. LeadingAge DC members, largely not-for-profit organizations, are committed to providing high-quality care, services, and supports that enable aging residents to take full part in community life. For a steadily increasing proportion of residents aged 65 and older, this may include long term care services to assist in activities of daily living, such as dressing, bathing, and using the bathroom. **The direct care workers who provide these essential services to individuals in their homes and in facilities, simply put, are not paid enough**.

LeadingAge DC recognizes DC Council for acknowledging the need to address this issue, most recently through the passing and implementation of the Direct Support Professional Payment Rate Act of 2022. Unfortunately, this Act does not do enough to meaningfully increase the average wage of direct care workers, retain those currently engaged in this work, or attract new professionals required to fulfill current needs. Considering forecasted growth in the older adult population – as much as 24.4 percent by 2023 – this issue poses an imminent community health crisis that demands a sustainable and effective solution.

Direct care workers, often Home Health Aides (HHAs) or Certified Nursing Assistants (CNAs), must attain training and continuing education, maintain current licensure, and demonstrate a high level of skill while assuring the health and safety of older adults. Yet, these workers are paid less than other allied health workers and non-health sector workers whose roles require less training and less

responsibility. Though LeadingAge DC members employ creative strategies in efforts to recruit and retain direct care staff, they remain at a disadvantage, unable to afford to compete with wages paid by hospital systems, staffing agencies, and even entry-level positions at companies like Target and Starbucks. Our vulnerable communities deserve better.

LeadingAge DC is part of the Workforce Subcommittee of the D.C. Coalition on Long Term Care and supports a true living wage of $24 per hour for these essential workers. Higher wages will make a difference, enabling our members to support the financial health and general wellness of their staff, persist in efforts empowering District residents to age with dignity, and prepare for increasing needs and emerging challenges on the horizon. Fair compensation for this workforce, which is overwhelmingly represented by women of color and immigrants, is in alignment with the Mayor's priority to provide a Fair Shot to District residents faced with rising costs of living, stagnant wages, and structural inequity.

We know that this is a very challenging budget year and the decisions made reflect tough choices. We also recognize that this is a national and regional issue exacerbated by the pandemic and other labor market factors.

I must emphasize that LeadingAge DC members are committed to providing high quality and effective care and support to the aging residents who need their services, but in order to do so, they need reimbursement at a level that allows them to cover costs and pay a fair, living wage to direct care workers and other licensed professionals. LeadingAge DC recommends that this Committee earnestly review the Mayor's fiscal year 2024 budget for strategic opportunities to fund and sustain meaningful wage enhancements for direct care workers.

On behalf of LeadingAge DC, I thank you for your time and welcome any questions that you may have.

Respectfully submitted,

Makeda Vanderpuije, MPH

Executive Director, LeadingAge DC

PHI QUALITY CARE THROUGH QUALITY JOBS

Council of the District of Columbia
Committee on Health
Budget Oversight Hearing

April 5, 2023

Testimony of Amy F. Robins
Director of Advocacy, PHI

Thank you for the opportunity to testify at the Council of the District of Columbia, Committee on Health hearing in support of the need to increase the wages for the home care workforce in the District of Columbia.

My name is Amy Robins, and I am the Director of Advocacy at PHI, a New York-based national nonprofit organization that works to transform eldercare and disability services by promoting quality direct care jobs—including home care jobs—as the foundation of quality care.

For more than three decades, PHI has been the nation's leading expert on the direct care workforce through our research, policy analysis, and direct consultation with policymakers, payers, providers, and workers—providing a unique 360-degree perspective on the long-term services and supports (LTSS) system and its workforce in the United States. Over the years, we have also designed a broad range of groundbreaking workforce interventions that optimize and elevate the role of direct care workers through training, advanced roles, enhanced supervision, and more. Throughout our history, PHI has worked successfully at the state and federal levels to promote bipartisan policy initiatives that improve job quality and build this workforce.

I will begin my testimony by describing the direct care workforce, focusing on the home care workers who are the priority for this hearing. From there, I will attest to the imperative for investment in these workers and the broader economic benefits of doing so.

An Essential and Expanding Workforce

According to PHI's analysis of employment data from the Bureau of Labor Statistics, more than 11,000 home care workers (primarily home health and personal care aides) assist older adults and people with disabilities in the District of Columbia (District) every day.[i] Home care workers comprise more than 77 percent of the total direct care workforce, which also includes those who are employed in residential care communities, skilled nursing homes, and other settings. It

is the fifth fastest growing occupational sector in the District, after restaurant workers and fast food and counter workers.[ii]

Home care workers enable members of our families and communities to live and age in place. They provide support with necessary daily activities, such as bathing, dressing, using the toilet, and eating. They assist with meal preparation, housework, and grocery shopping. They help their clients schedule and attend appointments, manage medications, monitor chronic conditions, and identify changes of status or circumstance that may need intervention. They promote independence, help overcome social isolation, facilitate paid employment, and serve as a key link among individuals, family members, and health care and social service providers. In many cases—as seen in sharp relief during the COVID-19 pandemic—they serve as a lifeline for their clients.

Given our aging population and the overwhelming preference for receiving LTSS at home,[iii] the home care workforce more than doubled in the previous decade—adding nearly 6,000 new jobs in the District from 2011 to 2021[iv]. Looking ahead, this workforce is expected to require nearly 3,000 new workers (from 2020 to 2030). When also accounting for home care positions that will become vacant as existing workers leave this workforce or exit the labor force altogether, nearly 24,000 total job openings will need to be filled in home care during the same decade.

Poor Job Quality is Driving a Workforce Crisis

Notwithstanding these workforce projections, home care agency providers and individual consumers are *already* struggling to recruit and retain home care workers.[v] Annual turnover in this workforce is consistently high, estimated at 64 percent in 2021. [vi]

Home care jobs—fulfilled primarily by women, people of color, and immigrants—are consistently poor-quality jobs. In the District, the median hourly wage for home care workers was just $15.71 in 2021 and, due to low wages and high part-time employment rates, median annual personal earnings were estimated at $30,683 in 2020 (the most recent year of data available in each case).[vii] Because of low wages, 31 percent of this workforce live below 200 percent of the federal poverty level, 33 percent are housing cost-burdened (i.e., spend more than a third of their total household income on housing-related costs),and nearly three quarters (74 percent) access some form of public assistance, like Medicaid, food and nutrition assistance, and/or cash assistance. Just over 1 in 4 home care workers hold employer- or union-sponsored health insurance—the rest depend on Medicaid, Medicare, or other public coverage.

Home care wages are not living wages, nor are they competitive. According to PHI's analysis, the median wage for direct care workers (including home care workers, the lowest-paid and largest share of this workforce) in the District falls significantly short of the median wage for all other occupations with similar or even lower-entry level requirements by over $5.00.[viii] PHI's analysis ranked the District last for wage competitiveness— LAST—in the country. Uncompetitive and non-livable wages mean home care agencies are struggling to retain workers who can make more elsewhere or make a similar amount working closer to home. It also means that potential new recruits to the field of home care are more likely to take comparably paying jobs closer to home rather than go through the training and travel needed to become a home health aide.

Drawing workers to jobs in the District from neighboring states of Maryland and Virginia is unlikely to help. While the median wage for direct care workers in Maryland and Virginia are less than the District ($14.62 and $12.34 respectively), median wage for competitive occupations in those states exceeds the direct care median wage in the District ($17.64 and $16.30 respectively). This means those workers have employment options for greater pay closer to home.

Home care jobs are also characterized by insufficient training, few career development opportunities, limited supervision and support, and an overall lack of respect and recognition.[ix] One key challenge related to training for the District to consider is the lack of transferability for direct care credentials. This means that a worker certified as a home health aide in Maryland cannot work in the District without an additional certification—an insurmountable barrier for many aides. Taken together, these challenges drive existing and potential home care workers into more viable employment options and career pathways in other industries—leaving home care employers struggling to maintain services, and consumers and families without the support they desperately need.

The Net Benefits of Investing in Home Care Jobs

Investing in home care jobs—including in wages, benefits, training, and other job quality elements—is a critical strategy for stabilizing and strengthening this workforce to meet the ever-growing need for home care services.

A living wage for home care workers could lift existing workers out of poverty and financial precarity—while also helping address the structural, intergenerational inequities that impact the women, people of color, and immigrants comprising this workforce.[x] Beyond the beneficial

impact for workers and their families, this investment would also yield a reduction in public assistance expenditure. Reducing the 74% of home care workers in the District who rely on public assistance by raising wages, not only enables the upward mobility of those workers and their families, but it also saves the District money that can be used for other investments.

Higher wages and better benefits would also make home care jobs more attractive to new job seekers, which is a necessary step toward building the pipeline into these jobs and filling workforce gaps. Home care agencies would see a reduction in the high costs of recruiting new workers, managing turnover, and paying contract staff—enabling them to spend more on job quality and care quality.

A more stable and sufficient home care workforce would also help overcome service gaps and ensure continuity and quality of care for consumers. This outcome would be invaluable for those who require paid support to live their daily lives with independence, dignity, comfort, and safety—but there is enormous potential value for our health and LTSS system as well. On balance, the evidence indicates that home care can help maintain optimal levels of health and function while preventing or delaying more costly outcomes such as emergency department visits, hospitalizations, and early nursing home admissions.[xi] Because home care workers have historically been overlooked by researchers as well as policymakers (with key exceptions), their specific role in achieving these quality outcomes and cost savings still requires research. Nonetheless, it is clear that they perform a wide range of health-relevant tasks and, especially with targeted training and better integration into the care team, can make a measurable difference.[xii]

Finally, investment in the home care workforce—one of the largest but lowest-paid occupations in our country—could stimulate consumer spending and support economic growth overall. A recent report from LeadingAge, a national association representing nonprofit aging services providers and other mission-driven organizations, estimated that paying direct care workers at least a living wage would add $17 to $22 billion to local economies from 2022 to 2030 as these workers spend their additional income on food, housing, healthcare, transportation, personal items, and other necessities—generating up to 86,000 new jobs in other sectors of local economies. This potential benefit holds true in the current economic context, as economists have shown that while minimum wage increases have a nominal impact on inflation,[xiii] low-income households themselves are particularly vulnerable to inflation, given the focus of their spending on household necessities.[xiv]

Conclusion

While the financial constraints on the District's budget are notable, the direct care workforce deserves an investment that improves their financial security and stabilizes this workforce at a critical time. We encourage the District to help create a robust care infrastructure that will meet the needs of older adults and people with disabilities for years to come**.**

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Testimony of Karla Reid-Witt

DC Council Committee on Health Budget Hearing

Deputy Mayor of Health and Human Services / Medicaid

April 3, 2023

Hello, My name is Karla Reid-Witt. I am a Ward 7 resident, an education, disability, mental health and literacy policy advocate, and a co-founder of Decoding Dyslexia DC. Decoding Dyslexia - DC is a grassroots movement driven by DC families concerned about the limited access to educational interventions for students with dyslexia and other reading difficulties within our schools. We aim to raise awareness and empower families to support their children. We also want to inform policy-makers on best practices for screening, identifying, remediating, and supporting students with dyslexia and reading difficulties in DC.

Reading is a fundamental civil right, but the status quo is not working for the vast majority of DC's school children. They should have access to effective reading and spelling instruction, and it's up to all of us to make this happen.

I am here today to highlight the interconnection between literacy and health. Literacy does fall under the purview of the Committee on Health, the Deputy Mayor of Health and Human Services and Medicaid because it improves health outcomes. Funding literacy initiatives is funding solutions which improve health outcomes.

Low literacy is a contributing factor to health inequities and combating low literacy should be a part of our arsenal of weapons to vanquish it.

"Literacy is distinct from health literacy, which has been defined by the U.S. Department of Health and Human Services (HHS) as the degree to which individuals and organizations find, understand, and use health-related information or services.4 Research indicates that limited language skills and low literacy skills are associated with lower educational attainment and worse health outcomes….Limited literacy is a barrier to accessing health information, [becoming health literate], proper medication use, and utilization of preventive services. Individuals with limited literacy face additional difficulties following medication instructions, communicating with healthcare providers, and attaining health information — all of which may adversely affect their health. Research has also shown a positive correlation between limited literacy skills and chronic conditions, including diabetes and cancer."[1]

Making things even more difficult for those who struggle to read, Medicaid is a complex and confusing system to navigate. Given that the city does not have complete control over the Medicaid system and regulations, I believe that even if DC Medicaid made all possible improvements, Medicaid would still be a difficult system to navigate for beneficiaries. There are mountains of paperwork to read and fill-out, and different parts of the governments to navigate, in addition to MCOs. Success is highly dependent on one's level of literacy.

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1 https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/language-and-literacy#:~:text=Research%20indicates%20that%20limited%20language,attainment%20and%20worse%20health%20outcomes.

What I'm saying is improving the rate of literacy proficiency in DC will improve the functioning of DC Medicaid and, eventually, decrease cost. We can do that by correcting our decades long failure to teach DC students to read. There is so much about Medicaid that we can't not change. Whether DC Medicaid beneficiaries are literate is something we can change. Literacy and health cost go hand in hand.

But this is a budget hearing. So what is the budgetary connection to literacy? We not only need to address the healthcare issues of today, we need to do what we can to mitigate and improve health outcomes in the future. I am asking that the Council and the Deputy Mayor work to make sure there is funding in the budget that supports improvement in how we teach reading so that we can improve health outcomes for children and the adults they will become.

We need funding to train more teachers in the the science of reading and structured literacy, to support schools to purchase and implement structured literacy curriculums, to reduce the number of low literate middle and high school students and to immediately put into effect the recommendations of the DC Literacy Task Force, when their report is released in September.

Please do not wait until the next budget cycle. We have about 95,000 DCPS and charter school students, sixty-nine percent of whom struggle to read. At least fifteen percent of our students have learning disabilities, ninety-five percent of whom struggle to read. A disproportionate number of these students live in Wards 7 and 8. Our kids rely on us to prepare them for the world. They have no control over how good a job we do and we are not doing a good job. We can not continue to send our kids out into the world knowing that our education system may very

well be a contributing factor to a future in which they may be unable to fully access available healthcare. Literacy is a non-medical solution to our healthcare and DC Medicaid beneficiary challenges worthy of funding.

Thank you for your time.

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April 5, 2023

Chairperson Christina Henderson
Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue
Washington, D.C. 20004
The Committee on Health 2024 Deputy Mayor of Health and Human Services Budget Oversight Hearing

Written Testimony of HIPS Advocacy Department

Councilmember Henderson and members of the Committee on Health:

Thank you for the opportunity to address this Committee and D.C. Council. The HIPS Advocacy Department submits written testimony today to support the work activists and supporters of the DecrimPovertyDC campaign and to further raise concerns regarding the Mayor's proposed budget failure to properly fund harm reduction work in DC. The current strategies are not enough and the District needs to fund the creation of harm reduction centers.

The Office of the Deputy Mayor for Health and Human Services is meant to provide leadership for policy and planning for DBH and DC Health. The Office of the Deputy Mayor of HHS can fulfill their duties to DC residents and these departments by fully supporting and working with local harm reduction workers to fund and open two 24/7 harm reduction centers that include overdose prevention sites and drug checking services. The current proposed budget from the Mayor fails to provide any funding for these necessary and life saving facilities, but does provide 9.5 million dollars to fund a *second* District Stabilization and Sobering Center. This is a policy failure on the part of the Mayor and this committee should rectify this by providing the necessary 15 million dollar funding to support harm reduction centers. 24/7 harm reduction centers are what Washingtonians need, want, and deserve. Washingtonians need the Deputy Mayor of HHS to stand alongside them and demand what is best for the health and well-being of all residents who use drugs, 24/7 harm reduction centers with overdose prevention sites.

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Washington DC Needs 24/7 Harm Reduction Centers that Include Overdose Prevention Sites.

At this moment, DC faces an overdose crisis. In 2022, there were 448 opioid-related fatal overdoses. That was an average of 37 deaths per month last year.[1] Nearly 600 Washingtonians died from accidental overdose deaths in 2021.[2] The overdose mortality rate among Black Washingtonians is the highest in the country. At 107 deaths per 100,000 people, the Black overdose death rate is nearly 10 times higher than the white overdose mortality rate in D.C.[3]

This Council needs to push for the creation of a harm reduction infrastructure by ensuring that the 2024 budget includes funding for two harm reduction centers. The Mayor's proposed budget *failed* to include funding for these centers. **This Council has the opportunity to correct this failure by the Mayor and push for the funding of two 24/7 harm reduction centers.**

DecrimPovertyDC's proposed harm reduction center model includes a facility open 24/7 where individuals can obtain harm reduction services such as sterile equipment and information for safer use of substances, fentanyl test strips, referrals to drug treatment providers, primary health care and other social services. The centers also will provide full drug checking services, a service that is crucial given the current state of the adulterated drug supply. People who use drugs run the risk of encountering substances that contain contaminants, toxic substances, or hazardous compounds.

Further, these centers will provide overdose prevention sites, or safe consumption sites. This component features a private room with trained professionals and peers who provide sterile equipment, where people who use drugs (PWUD) can bring their pre-obtained drugs, test the supply for adulterants, safely administer their drug, and access an array of services on site or through referral. According to health workers at the first legally sanctioned overdose prevention centers in the United States, OnPointNYC, **most participants who choose to decrease their substance use and/or enter more comprehensive drug treatment do so in the safe consumption rooms at harm reduction facilities while speaking with overdose prevention trained professionals.**

By funding these centers, we will also be funding, developing, and supporting the healthcare workforce. Trained health workers will be equipped to intervene if an overdose or adverse drug interaction occurs. Staffed drug checking services will help people understand if fentanyl or other substances are in their drugs, reducing overdose death risk and empowering people to make informed decisions. Funding the centers also means expanding mobile outreach worker capacity.

Trained outreach workers will lead community clean-ups, facilitate opioid-overdose reversal training, and raise general awareness about drugs, overdose, and the centers. **This proposed harm reduction infrastructure will be staffed by Washingtonians with lived experience at living wages for the area** - addressing a myriad of issues that our least invested in neighbors chronically face, like underemployment, housing costs, healthcare costs, and discrimination in the current systems they use to access them.

The Mayor's budget provides significant funding for a District Stabilization and Sobering Center (DCSSC) as her response to the tragedies of the overdose epidemic. We have deep concerns about the Mayor's proposed centers, which are being funded without any input from local stakeholders. We are disappointed to see the Mayor put millions of dollars into a project that is being run by a company from Arizona, which is not informed by the expertise of DC harm reduction workers or Washingtonians with lived experience and does not follow the most up to date evidence-based guidelines. **Most importantly, DC residents, harm reduction workers included, know next to nothing about how these centers intend to operate.** Our response to the overdose crisis will cost lives if we don't do every evidence-based measure at our disposal — and we cannot say in good conscience that the proposed DCSSC is good enough.

The most effective route forward must be one that is fundamentally guided by the principles of harm reduction, and the DCSSC and the city's Long.Live.DC campaign neglect the possibilities offered by this truly holistic approach.[4] The DCSSC proposal lacks a wide enough scope to fully provide the services required for people who use drugs by the proposal's failure to provide drug testing and safe consumption sites. Consequently, **if DCSSC is the city's only response to the overdose crisis, the city will not succeed in serving the needs of people who use drugs, and the overdose emergency will continue to rob vulnerable Washingtonians of their lives.**

Although the District has implemented some harm reduction tactics to combat the overdose crisis, including syringe exchange programs and providing residents with Naloxone, these measures have not been enough to successfully curb the number of lives lost due to overdose deaths. The District needs to do more to ensure that we do not lose another person to accidental overdose death. The District needs a much larger investment in public health than we, and other harm reduction workers in DC, can manage at our current capacity. **The proposed harm reduction infrastructure I have raised today, and that DecrimPovertyDC has been campaigning for, will save Washingtonian's lives.**

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<u>The District's Budget Needs to Better Support Existing Local Organizations that are Doing Life-Saving Harm Reduction Work Every Single Day.</u>

In addition to funding two 24/7 harm reduction centers, this Council and the Deputy Mayor of HHS also has the opportunity to better support the already existing local harm reduction workers and organizations that are working non-stop to help support District residents. Organizations like HIPS are overburdened and underfunded to handle the needs of the District, and need to be better supported and funded by the government in order for us to be able to best support Washingtonians who use drugs.

After meeting with DBH representatives and the leadership of Community Bridgers, the Arizona based company that has been awarded the first DCSSC contract, local harm reductionists are deeply concerned about the center and the effectiveness of the current plan. Although the people at Community Bridges seem to care deeply about their work and have done great things for their community in Arizona, they are not situated to provide the care Washingtonians need. Community Bridges plan to rely on already *existing local harm reduction organizations* for guidance, community connections, and to make referrals to will overburden organizations like HIPS. Instead of pushing money to develop new organizations that will heavily rely on the decades of groundwork and community building of local workers, we urge this council to instead provide adequate money to the local organizations that are run for and by Washingtonians. **The District should expand funding to existing local harm reduction organizations and fund the creation of 24/7 harm reduction centers run and staffed by Washingtonians with lived experience, who know what Washingtonians who use drugs need and want.**

The Mayor's proposed budget includes a line item to fund a *second* District Stabilization and Sobering Center, even before the first center opens. We urge this Committee and Council to instead of funding the DCSSC model again, to reroute this money to fund true harm reduction centers that provide drug checking services and safe consumption sites, two evidence-based interventions that save lives, improve health conditions, and better people's lives, and that Community Bridges and the DCSSC model refuse to provide. If we do not provide all evidence-based strategies known to save and improve lives, we are failing to do everything we can to stop the overdose crisis in DC. **We are failing Washingtonians.**

Together, District residents and this Council can end the overdose crisis through embracing and funding a harm reduction infrastructure that was created, designed, and will be run by DC residents with lived experience.

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Thank you for your time and consideration. I am happy to answer any questions you have regarding the overdose crisis and/or the harm reduction centers. Additionally, we can be reached at advocacy@hips.org

Thank you,
HIPS Advocacy Department
Tamika Spellman
Chibundo Egwuatu
Mackenzie Darling

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[1] *Opioid-related Fatal Overdoses: January 1, 2017 to December 31, 2022,* Office of the Chief Medical Examiner, https://ocme.dc.gov/sites/default/files/dc/sites/ocme/Opioid%20related%20Overdoses%20Deaths%206.17.21%20FINAL.pdf (March 17, 2023).

[2] Government of the District of Columbia, Office of the Chief Medical Examiner, "Drug-related Fatal Overdoses: January 1, 2021 to December 31, 2021," https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/2021%20Drug%20related%20Overdoses%20Deaths%20 FINAL.pdf

[3] Drug Overdose Death Rate (per 100,000 population) by Race/Ethnicity: 2020. Kaiser Family Foundation.https://www.kff.org/other/state-indicator/drug-overdose-death-rate-per-100000-population-by-raceethnicity/?dataView=1¤tTimeframe=0&selectedDistributions=white-non-hispanic--black-nonhispanic&sortModel=%7B%22colId%22:%22Black,%20Non-Hispanic%22,%22sort%22:%22desc%22%7D

[4] "Principles of Harm Reduction", National Harm Reduction coalition. https://harmreduction.org/about-us/principles-of-harm-reduction/

Good afternoon, Chairperson Henderson and members of the Committee. My name is Emily Carnevale and I live in 16th Street Heights in Ward 4. I am a community organizer with Jews United for Justice, a community of thousands of Jews and allies committed to advancing social, racial, and economic justice in DC. JUFJ is a member of the Way Home Campaign. My testimony today will focus on reallocating the funding currently being used to evict our unhoused neighbors to instead fund sustainable and humane housing solutions! As a neighbor and resident of the District, I am deeply concerned for my unhoused neighbors who are being overlooked by the Mayor's proposed FY2024 budget, and the Council has a responsibility to make this budget a moral one.

Looking out for one's neighbor is one of the foundational commandments of Judaism. Whether you are Jewish or not, having safe, stable housing is a human right and should not be seen as a luxury or something that someone needs to earn. One should never be penalized for struggling in an unjust world that often puts profit over people.

My Jewish values are not the only reason why I am here testifying before you today. I also bore witness to the recent McPherson Square eviction. On February 15th, 2023, Deputy Mayor of Health and Human Services, Wayne Turnage and the National Parks Service evicted unhoused neighbors living in McPherson Square. There were around 70 people living there permanently – 70 people who lost their homes that day. How is that okay? That day I saw

employees of the National Park Service, members of our government, dressed in hazmat suits, laughing and having conversations like this is normal. Maybe this is their normal, but it shouldn't be – kicking people out of their homes should never be a norm. Instead of investing in destroying homes and lives, the DC government should invest in housing programs that can help save lives. According to WAMU reporting from March 28th, "just 19 people who used to live in McPherson Square have moved into temporary housing or shelter of some kind, and only 3 more have signed leases for new apartments." That means that nearly 50 people who were evicted are still without a home today.

I am asking the Committee today to provide robust oversight of The Office of the Deputy Mayor for Health and Human Services (DMHHS) and to reallocate their funding for encampment evictions to programs that actually support our unhoused neighbors. Unfortunately, it has been UNclear to us and our partners how much money is spent on encampment evictions, due to the Deputy Mayor avoiding questions surrounding this. Chairwoman Henderson and members of the Committee, JUFJ and our partners urge you to hold the Deputy Mayor of Health and Human Services accountable and find out what that number is, so we can use that money to fund programs that support our unhoused neighbors rather than harming them. As we all know, the Mayor insists there is not enough money to fully fund important housing programs, such as the Emergency Rental Assistance Program and housing vouchers, but any penny that is going toward encampment evictions is being grossly misspent!

Thank you Chairperson Henderson and members of the Committee for listening to our concerns today. I hope you will craft a DC budget that provides support and resources for our unhoused neighbors rather than punishing and criminalizing them.

Testimony before the Committee on Health
Budget Oversight Hearing of the Deputy Mayor for Health and Human Services
Delivered by Jesse Rabinowitz, Senior Manager for Advocacy and Policy at Miriam's Kitchen
April 5, 2023

Good afternoon, Chairperson Henderson and members of the Committee. My name is Jesse Rabinowitz. I am a proud Ward 1 voter and the Senior Manager for Advocacy and Policy at Miriam's Kitchen, where we work to end chronic homelessness. Miriam's Kitchen is one of DC's three coordinated street outreach teams. Our amazing outreach workers cover 33 square miles of DC and see firsthand both that housing ends homelessness and that evicting encampments harms our clients. My testimony is informed by in depth conversations with our outreach team, people with lived experience of homelessness, witnessing more encampment evictions than I can remember, and my year as a homeless street outreach social work intern.

Before I dive in, I do want to note our support of DM HHS's work to buy down medical debt. Medical debt is a key driver of homelessness, and we support this effort.

As we have made clear, the Bowser administrations response to homelessness encampments, which can be characterized as eviction for all and shelter or housing for some, is harmful. Continued evictions mirror the mayor's proposed budget in that they both prevent DC from meeting our shared goal of ending homelessness. I'm not going to relitigate this, since I and many other local and national experts, people with lived experience of homelessness, and members of the Council have made this position very clear. I will say, however, that it is alarming that the Council allows DC's criminalization and harassment of our unhoused neighbors to continue unabated.

Where is the money coming from?
Since 2016, neither the Council nor the public has been privy to the spending associated with the Deputy Mayor for Health and Human Services (DM HHS) approach to encampments, despite continual commitments to the Council to release this information. A major role of the Council is to serve as a check and balance on the Mayoral administration. By continuing to allow DM HHS to obfuscate and avoid transparent cost data sharing, the Council is not meeting this obligation.

It's often said that encampment evictions involve many funding streams and are therefore difficult to track. Why then was DM HHS able to share a public cost document, attached to my written testimony, which showed agency costs, including DHS, MPD, DDOT, DBH and DMHHS and detailed over $170,000 in spending to clear encampments between 2015-16? Since this data was released, the pace of encampment evictions has dramatically increased. Encampments are often evicted weekly. Including at least four this month. How much does that cost? The Council has a responsibility to find out.

DM HHS has stated that, since encampment evictions use already existing government and non-profit staffing, there is no additional cost. Is there not a cost when MPD harasses unhoused people instead of addressing violent crime? Is there not a cost when DHS must devote significant resources to encampments instead of implementing housing vouchers? Is there nothing better for DBH or DOH to do

with their time than evict people just trying to survive? Is this the best use of DDOT's time and resources amid a rise in traffic violence? What resources from DPW are being used and to what cost?

Mayor Bowser's budget, as it stands, jeopardizes the progress that DC has made towards ending chronic homelessness. She insists that budgets are tight. That must compel the Council to determine if evicting encampment residents is the best and highest use of DC's scare funds. That cannot be done without knowing what and how many resources DC, under the direction of DM HHS, uses to evict encampments.

Aside from a huge financial cost, there are other costs associated with encampment evictions. There is certainly a cost to outreach workers, who must pivot from getting folks into housing to instead reducing the harm and trauma caused by continual displacement. And, to be sure, there are extreme costs, financial, physical, and emotional, to our unhoused neighbors whose safety is being sacrificed to acquiesce to the wishes of a small yet vocal minority who want to disappear them.

CARES Update

During the Performance Oversight of DM HHS, we heard statistics about how well the CARES pilot program worked. I want to add some additional information. To be clear, from, the start, we supported the portion of the CARES program that got folks into housing quickly. We were opposed to the creation of no tent zones and encampment evictions. Moreover we were and continue to be concerned, as DMHHS is also now concerned, about the fairness and policy implications of providing folks who live in certain encampments housing before those living in less politically volatile encampments, those living outside without tents, and the over 1,300 people living in shelter

However, we must be honest that the numbers presented do not represent the entirety of encampment residents, as many residents were not included in the "by name list". Miriam's Kitchen began working on the CARES pilot program in September 2021. Today, a year and a half later, 7 out of 50 are in PSH. Many of the others are in housing with limited wrap around supports but are not in PSH. Many are considering leaving their housing due to the valid uncertainty in the longevity of this less than transparent housing intervention. In fact, we have removed one outreach worker to provide wrap around case management services in lieu of PSH, meaning that we have one fewer person conducting homeless street outreach. DC has a coordinated entry system and the vouchers are needed to markedly reduce homelessness. We must focus our energy there, not on the continued polices of displacement.

Like the McPherson eviction, spurred by DMMHS, occurred without a plan for housing, the CARES program, as it stands, is not a viable path forward. We all agree that we need to cut through the red tape and move people into housing quickly, and we have proposed many ways to do this, such as removing DCHA from the PSH voucher process and increasing provider pay. Unfortunately, none of these recommendations were reflected in the mayor's budget.

<u>We continue to ignore (and defund) mitigation and harm reduction approaches</u>

DC's approach to encampments goes from zero to 100 without any attempt at mediation. If the concern is human waste, then why did the mayor zero out funding to create public restrooms? If the concern is drug use, why does the mayor's budget not include funding 24/7 harm reduction centers? If the concern is moving people into housing, why does the mayor's budget not add any funding to PSH? If the goal is homeless prevention, why does the mayor's budget gut ERAP and Project Reconnect? We need to address the root causes of encampments, the lack of housing, and not be content to focus on displacement.

[redacted]

Encampment Cleanups: October 1, 2015 - January 8, 2016												
Location	Cleanup Date	Estimated Encampment Scouting Trip and Cleanup Length (30 minute increments)	Approximate Number of Residents Living on Site	Number of Residents Housed	Number of Residents Relocated	DMHHS total cost	DPW total cost	DBH total cost	DHS total cost	DDOT total cost	MPD total cost	
3rd and E Streets, NW (Behind 443 4th building)	October 2015[1]	1 hour	10	4	6	$28.16	$532.00	$413.40	$980.00	$2,830.00	$96.80	$4,470.36
4450 Wisconsin Ave, NW (Tenley-Friendship Library)	October- 2015	30 minutes	8	6	2	$14.08	$532.00	$175.80	$890.00	$230.00	$24.20	$1,855.88
26th and K Streets, NW (Whitehurst Freeway)	November 16, 2015 November 30, 2016 December 3, 2015	25 hours total	25	14	12	$704.00	$20,350.00	$3,064.71	$10,435.00	$80,732.87	$7,260.00	$122,204.60
Southwest Freeway (12th Street exit)	November 1, 2015	1 hour	0	0	0	$28.16	$532.00	$485.10	$470.00	$2,830.00	$96.80	$4,352.15
E Street, NW (towards the Kennedy Center)	November- 2015	1 hour	1	1	0	$28.16	$532.00	$368.54	$770.00	$2,830.00	$145.10	$4,963.80
King s Road, NW (Under 3100 Connecticut Ave Bridge)	November- 2015	5 hours	0	0	0	$140.80	$3,722.00	$182.22	$350.00	$2,830.00	$484.00	$7,688.30
295 overpass at Sousa Bridge	December- 2015	1 hour	1	0	1	$28.16	$532.00	$593.26	$250.00	$230.00	$48.40	$1,611.82
Land First Streets, NE (under the bridge)	December- 2015	30 minutes	4	1	3	$14.08	$532.00	$91.34	$935.00	$540.00	$48.40	$2,151.82
First Street along the I-Street Bridge, NE	December- 2015	30 minutes	4	0	4	$14.08	$532.00	$174.67	$680.00	$3,095.00	$48.40	$4,334.15
3149 16th Street, NW (Old DPR headquarter)	December- 2015	1 hour	7	0	0	$28.16	$532.00	$115.43	$275.00	$230.00	$48.40	$1,218.99
1636 R Street, NW	December- 2015	1 hour	1	1	0	$28.16	$532.00	$259.23	$470.00	$230.00	$48.40	$1,557.85
320 Florida Ave, NE (behind Burger King)	December- 2015	3 hours	3	0	3	$84.48	$532.00	$91.34	$480.00	$2,830.00	$290.40	$4,259.22
600 Pennsylvania Ave, SE	January- 2016	1 hour	1	0	1	$28.16	$532.00	$343.71	$570.00	$230.00	$48.40	$1,799.27
Total:			65	27	32	$1,168.64	$29,634.00	$6,197.56	$16,933.02	$109,667.87	$8,687.80	$172,288.89

[1] Due to increase crime in the area the timeline of the encampment was advanced, only 13 days' notice was provided, residents were notified of this change.
[2] The $90,732.87 for DDOT costs at 26th and K Streets, NW (Whitehurst Freeway) includes erection of a fence.

[redacted]

April 5, 2023

Geoff Gilbert
Beloved Community Incubator
Legal and Technical Assistance Director

Testimony before the Committee on Health
Re: DC Health Regulation of Home Kitchens & Vending Carts

My name is Geoff Gilbert and I am the Legal and Technical Assistance Director at Beloved Community Incubator. I organize with street vendors part of Vendors United // Vendedores Unidos.

We ask that the Deputy Mayor for Health and Human Services and the Committee on Health ensure that the Department of Health has all of the resources and support it needs in order to implement the Street Vendor Advancement Amendment Act of 2023 (B25-68), which the Council passed earlier this week, in a way that is fair and accessible for all vendors.

To the best of our knowledge, DC Health currently employs only 11 inspectors for all restaurants, commercial kitchens and home kitchens throughout the District. For decades street vendors have been required to seek approval of the menu of food they are able to sell as part of the license application process before a food vendor is able to begin operations. Historically, DC Health has only allowed street vendors to sell half smokes and hot dogs. DC Health has long had the authority to inspect and create regulation for the production and sale of food from home kitchens and from street vending carts, yet it has chosen over and over again not to do so. Rather than promoting safe food practices in home kitchens and at street vending carts, DC Health has chosen to narrowly restrict the type of food that can be prepared and sold from home kitchens and street vending carts. These regulatory choices have kept street vendors trapped in the formal economy and subject to police violence, as vendors have been denied the opportunity to obtain licenses to prepare the food that their customers demand from their home kitchens and street vending carts.[1]

The Street Vendor Advancement Amendment Act of 2023 permits street vendors to prepare and sell all pre-packaged cooked foods and whole or pre-packaged cut fruit from home kitchens and street vending carts, and directs DC Health to develop regulations that support street vendors to do so in a safe manner. DC is a culturally vibrant city and food vendors have long sold many

[1] See “Where the Sidewalk Ends Part II: A Vision for Decriminalizing and Investing in Street Vendors,” Beloved Community Incubator (October 2022), https://www.belovedcommunityincubator.org/vending-decrim.

different types of food in addition to hot dogs and half smokes, including soul food, Caribbean food and Latin American food from many countries, primarily El Salvador and Mexico. Many vendors also sell fresh cut fruit. This food is deeply desired by the community - food street vendors rely on repeat customers and word-of-mouth marketing in order to make a living.

It is incredibly important that DC Health reverse its historic practice of placing unfair burdens on street vendors that keep vendors trapped in the informal economy. We are excited to work with the Committee on Health and DC Health in order to ensure that DC Health develops regulatory rules for home kitchens and street vending carts that are fair and accessible for vendors.

Sincerely,

Geoffrey Gilbert

Geoff Gilbert
Beloved Community Incubator
Legal and Technical Assistance Director

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Deputy Mayor for Health and Human Services

Fiscal Year 2024
Budget Oversight Hearing

Testimony of
Wayne Turnage
Deputy Mayor for Health and Human Services

Before the
Committee on Health
Council of the District of Columbia
The Honorable Christina Henderson, Chairwoman

April 5, 2023
9:00 A.M.
The John A. Wilson Building
1350 Pennsylvania Avenue NW
Washington, DC 20004

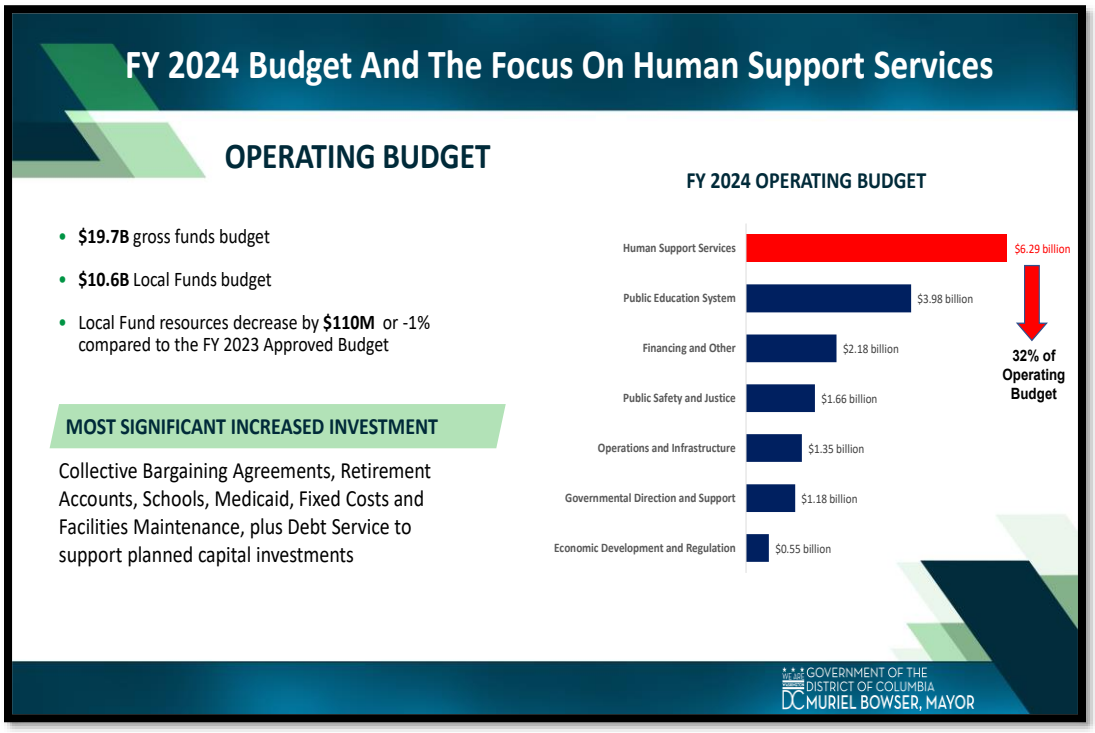
Introduction

Good morning, Chairwoman Henderson, and members of the Committee on Health. My name is Wayne Turnage, and I serve as both the Deputy Mayor for Health and Human Services (DMHHS) and the Director of the Department of Health Care Finance (DHCF). Thank you for inviting me to testify on behalf of the Bowser Administration concerning the Fiscal Year 2024 (FY24) proposed budget for Office of the Deputy Mayor for Health and Human Services. As with previous years, the Mayor's commitment to funding critical health care services is evident, notwithstanding the significant fiscal challenges she faced in this budget and financial plan.

I am joined today by my Chief of Staff Ciana Creighton who manages both the day-to-day operations of DMHHS and the office budget. Compared to other agencies, DMHHS has a relatively small budget that is comprised almost entirely of FTE funding. Thus, Ciana in coordination with our AFO Adran Reid, must take great care in managing our resources to ensure staff have what is needed. I am also joined by our Policy Director Bryan Harrison and other staff.

At the Mayor Council Breakfast on March 22, 2023, Mayor Muriel Bowser emphasized that the FY24 Proposed Budget is reminiscent of the budget from 2011, which was racked by recession. This year, a deflated revenue forecast in the out years of the financial plan, and elevated levels of spending carried over from the infusion of federal funds in 2020 and 2021, left the city with a $1.7 billion gap that had to be quickly, but thoughtfully addressed. Due to the diligent work of the Mayor's budget team, the FY24 Proposed Budget is balanced and DMHHS has sufficient funding to meet the agency's needs. This difficult fiscal environment is an unfortunate reality due to a myriad of factors – the end of ARPA funding, persistent inflation, and a downtown that has not fully recovered, due in part, to wide scale telework that has suppressed foot traffic in the area. What has not wavered is Mayor Bowser's commitment to health and human services. In fact, like

every other year the largest component of the operating budget is health and human services – this year at $6.29 billion dollars, or 32% of the overall operating budget for the District.



For the first time since the beginning of the pandemic we were able to resume in-person budget engagement forums. At the forums, deputy mayors outlined the critical aspects of their respective clusters to residents. In return, residents had an opportunity to engage around the city's policy priorities and state their concerns for consideration in the budget formulation process.

Health and Human Services Cluster Budget Highlights

The Office of the Deputy Mayor for Health and Human Services (DMHHS) supports the Mayor in coordinating a comprehensive system of benefits, goods, and services across multiple agencies to ensure that children, youth, and adults -- with and without disabilities -- can lead healthy, meaningful, and productive lives. DMHHS supports the health and human services cluster agencies, and liaisons with the Office of the City Administrator (OCA), and Executive

Office of the Mayor (EOM). As most of the cluster investments have been or will be covered in agency budget hearings, I will focus only on the FY24 budget for my office.

The DMHHS Budget

The Mayor's FY24 proposed budget supplies $2,588,900 in funding to support our important work with cluster agencies and EOM. The agency local budget of $2.2 million is mostly for employee salary and fringes. There is a total of 13.75 FTEs in DMHHS. The breakdown is as follows:

- The Chief of Staff who coordinates the work of the office and manages the budget.
- A policy team formed of a policy director, one senior and legal policy advisor, and two policy advisors.
- The encampment response team led by the Deputy Chief of Staff who is supported by an encampment program coordinator as well as two encampment navigators.
- An Age-Friendly DC coordinator.
- A communications position and two support staff.

Also, the Interagency Council on Homelessness (ICH) – a strategic think tank – is adjacent to DMHHS and includes a six-person team of policy experts. We work closely with ICH, discussing both the encampment activities of my office, as well as broader housing strategies for the city's homelessness system.

As part of formulation, DMHHS' proposed local funds budget includes $71,069 to allow for cost-of-living salary increases and $270,080 in reductions to meet the MARC. It should be noted that the encampment program coordinator position, and one of DMHHS' support staff are paid through DHCF, while the two encampment navigators are paid through DHS since the work of encampments is along the homelessness continuum – the mission of DHS. Finally, the advisors

on the ICH are paid via MOU from DHS due to a Council action which placed these funds in the DHS budget rather than DMHHS.

As for the non-personal please see the major highlights below:

- $20,000 for staff training and travel.
- $7,100 for vehicle maintenance and repairs for encampment work.
- $151, 445 for professional service and contracts.
- $17,000 for office support.
- $23,000 for printing, duplicating, and like activities.
- $5,000 for employee tuition.

Conclusion

Mayor Bowser's FY24 Budget displays a continued commitment to our DC values even in the wake of a challenging fiscal environment. We know that there is health in all policies and the role of the Deputy Mayor's Office is critical in supporting the health and human services agencies of the District. I am proud of the cluster agencies for their innovation and hard work while addressing some of the most vexing human service challenges in the city.

This concludes my testimony and I look forward to working with you in your role as the Chair of the Committee on Health. My staff and I are happy to answer any questions you and the Committee may have at this time.

<u>Service Gap & Unmet Need</u>
Experienced by
District Residents Living with the Diagnosis
"<u>Hoarding Disorder</u>"

Testimony to the
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH,
COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON,
<u>BUDGET OVERSIGHT HEARING</u>
taking place on WEDNESDAY, APRIL 5, 2023
regarding
Office of the Deputy Mayor for Health and Human Services

Respectfully submitted April 22, 2023, from
Hilary Kacser, Public Witness
(she/her/hers; last name: "KACK-sir" \\ SAG-AFTRA Actor, Educator, Advocate
DisordeRThePlay.blogspot.com "DisordЯ, The Play," *about Pakrat Patty, the self-identified Hoarder who comes out of the Clutter closet, uses humor to educate about Mental Health, Stop Stigma, & Advocate Recovery. Opening keynote: http://mentalhealthsf.org/joinus-18th-conference-on-hoarding-cluttering/ *
DBH Behavioral Health Planning Council Member
BHPC Planning & Accountability Committee Member \\ DBH Stakeholders Association)

Committee on Health Chair At-Large Councilmember Christina Henderson and Committee Councilmember Zachary Parker, Committee Councilmembers, Committee Legislative Staff and Councilmember Christina Henderson Staff,

Thank you very much for your attention to us public witnesses and for this opportunity to testify before you at the Wednesday, April 5, 2023, Committee on Health Budget Oversight Hearing regarding the Office of the Deputy Mayor for Health and Human Services.

<u>Unmet Need</u>
In the District of Columbia, an estimated over 40,000 District residents struggle with the diagnosis defined in 2013 by the American Psychiatric Association as "hoarding disorder."

<u>Trauma Informed Language</u>
This testimony will refer to the diagnosis alternatively, such as HD, as collecting behavior, hoarding and clutter, or HC, in the effort to stop shame and stigma often directed or implicit toward this health condition. Shame and stigma are barriers to getting help for this serious behavioral health condition and public health challenge.

Extent & Community Impact

Everyone who works in the field – outside in the community going into peoples homes – knows how widespread hoarding and cluttering are – everyone from the property manager, to the home health aide, to the cable guy, to the first responder.

DC FEMS know only too well how collecting behavior can lead to residential fires with vastly swifter burn speed, with the heavy fuel load resulting from large amounts of possessions in the home.

First Queries

Your consideration of DBH FY24 budget must include funding answers to the following minimal, preliminary questions.

1. Is the Office of the Deputy Mayor for Health and Human Services working on HD?

2. Does the Office of the Deputy Mayor for Health and Human Services consider whether DC Department of Behavioral Health (DBH) now has, or should have, any mandate to address HD?

3. Does ODMHHS know whether DBH asks about clutter in home living spaces as part of intake screening?

4. If not, what would it take for ODMHHS to work with DBH to add such a question to intake screening?

5. Does ODMHHS know whether DBH Core Service Agencies (CSAs) ask about clutter in home living spaces as part of intake screening?

6. If not, what would it take for ODMHHS to work with DBH to add such a question to intake screening performed by CSAs?

Surely adding a question about clutter in home living spaces to intake screening costs precious little. Wouldn't such a simple measure, to uncover this vast, masked area of behavioral health unmet need, be highly cost effective?

Current DC Intervention – Not Provided by DBH

Department of Aging and Community Living is apparently devoting some resources to helping residents clean out their homes, in collaboration with Adult Protective Services. While this is perhaps better than nothing, especially in extreme cases of public safety hazard to self and others, people should not get to that extreme point in the first place. ODMHHS should not let people get to that point. APS is extreme, crisis, triage intervention, with sometimes devastating resulting. In some DACL/APS cases, individuals – who should instead be receiving (and should ***have*** been receiving) out patient behavioral health care from DBH – these individuals end up in long term nursing care – because their behavioral health needs have for so long gone unmet.

With great gratitude to DBH, at the start of FY23, DBH worked with colleagues at Department of Aging and Community Living to bring attention to HD through a DACL presentation at the October 27, 2022, DBH MHRS/SUD Clinical Director's meeting, about DACL interventions in cases of extreme HD, featuring Elaine Murry, Program Manager, DACL Office of Community Services. DACL is to be commended for undertaking to provide support; however, a great deal more needs to be done. DACL's work is not Trauma Informed, and DACL are not providers of behavioral health care. DACL intervention commonly bringing in Adult Protective Services re-traumazes individuals and addresses only the symptoms – and the physical space – but not the person nor their behavioral health condition.

Fund HD Now for Early Intervention & Cost Saving

ODMHHS needs to allocate funding in the FY24 budget to support DBH just to begin to conceive of providing recovery-oriented, person-centered behavioral health care for District residents living with HD. Radical intervention for extreme triage cases does not provide access to recovery. ODMHHS needs to address this problem long before it gets to crisis.

ODMHHS must ensure that DBH provides pathways to care. In the absence of any pathways to care forHD, DACL involvement of APS deters patients from receiving needed and medically indicated support. DACL and APS are not behavioral health providers. Funding must be found by ODMHHS and allocated to DBH to begin addressing providing care to treat – or at least even acknowledge the existence of – this critical hoarding and collecting service gap and potentially life threatening behavioral health condition.

As to price tag and budget oversight, long term nursing care and putting a District resident out of their home cannot be cost effective. Extreme intervention should be prevented, long before its need arises.

- We should have early intervention.
- Intervention should be trauma informed and should include behavioral health care.

Where is the early intervention?

Where is ODMHHS in this scenario?

Equity

The HD diagnosis is very challenging, but that challenge does not justify ignoring this serious, DSM-5 behavioral health condition. HD cuts across race, socio-economic, age, ethnic, gender orientation. You daily can see the unhoused individual who is barely able to push multiple, overflowing shopping carts, and you appreciate that having too many possessions is a health condition not limited to those people with access to considerable means.

Early intervention is critical.

For the housed person, living with HD, to be put out of their home, and for them to be rehoused – not by their own choosing -- into nursing home care, is a grievous behavioral health inequity. District residents living with HD, who experience this outrageous loss of autonomy and who are forced to lose their homes under APS' radical intervention for crisis collecting behavior, are only those District residents who do not have their own private means.

Youth and Behavioral Health Services in Schools

Our community needs ways to build rapport in order to build access to essential behavioral helath services in schools. Research indicates that symptoms of HD ("hoarding disorder") present as early as age ten years old. Our youth are not only living with this untreated behavioral health issue themselves, but they are also living with other individuals experiencing collecting behavior.

Something must be done.

Seniors

Our tendency is to associate the behavioral health condition of hoarding and cluttering with age. As seen in "Data Point" numbers 5 and 6 (below, pages 6v and 7), HC affects individuals at all ages. As we age, howe ver, two things happen. One, the longer we live, the more time we have to acquire more belongings – if we live without early intervention. Two, as we age and our physical capacities begin to diminish, the risk of harm increases – if, untreated, we have reached a crisis point – and we lose our ability to move, maneuver, and navigate around along our "goat paths."

A Note on Liability

The integration of Substance Use and Mental Health into an Integrated Behavioral Health Care approach has served well residents of the District of Columbia. One drawback subsequent to that integration has been the cessation of direct provision of services by the District. DC government now outsource outpatient care, with DBH contracting for services which are provided by Core Service Agencies (CSAs).

The real difficulty arises, however, in the fact that the only behavioral health provider who actually enters the patient's or consumer's home is the Community Support Worker (CSW). That person works for the CSA, but that CSW is not an employee of the CSA. CSAs sub-contract again, and who does the liabilty lie with, if the home is a place that puts the individual at risk? Liability lies with the one sub-contracted (and no doubt underpaid) CSW.

(While on this topic, let us note that DBH does not mandate CSAs to provide Case Management services. CSAs do not provide Case Management. But the acronym by which "Community Support Workers" are known – CSW – contains letter that are very easy to interchange with the letters not only for a Social Worker (SW), but also for a Case Worker (CW). CSAs routinely refer to CSWs as Case Workers – which they explicitly are not.)

Perhaps it would be within our FY24 budget for ODMHHS to examine the efficacy of care when the liability falls exclusively on the the CSW, the individual working with clients alone in the field, without any employee protection, but only in the role of an independent contractor.

Case Study

This witness respectfully requests the Committee and the Deputy Mayor to consider the following, actual, reality based scenario.

For decades an individual was living in a rented apartment and deemed by their neighbors to be good as a friend and fellow apartment building dweller. After this person lived there for many, many years, essentially spending their life time in that home, however, late in that person's life, significant problems developed in the building, including rodent infestation, eventually traced back to this individual's apartment.

The city was involved in cleaning the apartment, a monumentally expensive task. Consider the budgetary allocation: consider the clean up expense and the bill for the cost of the individual's being housed now in a nursing home. Lack of early intervention – and subsequent necessity for crisis triage – not only severely violated that individual's humanity, but also generated significant additional expense for that person's nursing home care and accommodation, a cost paid by Medicaid at taxpayer expense. Keep in mind, please: this individual lived independently and could have continued to live independently – except for the fact that their HD had been allowed to progress to such an extreme case, because there was no intervention earlier.

Early intervention requires us to get past the shame and stigma.

- How many people come forward and say openly that they have this problem?
- How many people, who have an HC problem, along with many other behavioral health issues, don't even realize that the collecting behavior is actually a pathology?
- If they did realize HD is a bona fide, behavioral health diagnosis, how many people may feel they can't get help?

Not being able to get help for a DSM-5 behavioral health diagnosis is not how things should be in Washington, DC, in our behavioral health care system that is supposed to be person centered and recovery based. Committee Chair Henderson, and DC Council Committee on Health members, in his work with our team of talented agency directors and their respective staffs to facilitate efficient delivery of a comprehensive set of benefits across multiple agencies, ensuring that children, adults, and persons with disabilities are able to live quality lives, please ask Deputy Mayor for Health and Human Services Wayne Turnage, M.P.A., how people fit into that grand effort who live with "Hoarding Disorder."

Start This Conversation – A Possible Path

You today, to address this severe service gap and unmet need in our city, could fund one possible pathway forward, by expending a relatively small amount of money.

Evidence shows that "Peer Response Team" treatment for hoarding disorder provides a high level of effectiveness. Julian Plumadore co-authored the evidence based research published by Cambridge University Press. Also an expert behavioral health trainer, Julian Plumadore could come to DC for a week to train stakeholders – including DBH's well developed cohort of Consumer and Family Affairs Certified Peer Specialists. (Plumadore resume and other credentials are attached, following.)

Julian Plumadore supervised the peer arm of the 3-year "Help for Hoarding" study in collaboration with the University of California San Francisco, which demonstrated that peer-led support groups for hoarding and cluttering are therapeutically equivalent to clinician-led groups. Plumadore co-authored a peer workforce development toolkit including best practices for recruiting, hiring, and retaining peer-identified employees and integrating them into an existing team, and oversaw volunteer recruitment, onboarding, supervision, and retention.

Plumadore can provide training and ongoing consultation for the peer professional development component of an HC program in DC. Training, targeted towards peers who could actually be doing field work, benefits anyone involved, especially Program Managers/Clinical Coordinators, who should plan to attend, both to know what information a peer is receiving, and also to fill in any gaps in their own knowledge base about hoarding and cluttering services and supports.

FY24 Budget Cost: Under $30,000

Your investment of the fee of $17,500 + travel and lodging at 2023 IRS rates for a 5-day DC training is provides extreme value to District residents in the form of evidence based, effective results that help people recover from HD. Full week of training includes technical support on establishing the DC Peer Response Team. Community Engagement and Development Director of Peers Envisioning & Engaging in Recovery Services (PEERS https://peersnet.org), Julian Plumadore promotes innovative peer-based wellness strategies and creates culturally rich, community based mental health programs that honor diverse experiences to eliminate stigma and discrimination.

Plumadore is even happy to follow up with ODMHHS via virtual consultation for up to one hour, free of charge, to answer any questions and explore next steps.

Talk about value return on investment.

Conclusion

This DC behavioral health problem is not going away just because it is closeted. Many District residents silently struggle in secret with collecting behavior, a behavioral health condition potentially life threatening. Long before that crisis point, HD affects quality of life and mental health for many, many residents in the District of Columbia.

HD is a behavioral health challenge particularly drenched in shame and stigma. Same and stigma we know deter getting needed help and care.

Silencing the problem does not make it go away.

Thank you again to the Committee and Chair At-Large Councilmember Christina Henderson for this opportunity to request you urge Deputy Mayor for Health and Human Services Wayne Turnage

Grateful to answer any questions that may potentially arise for you.

Some Data Points:

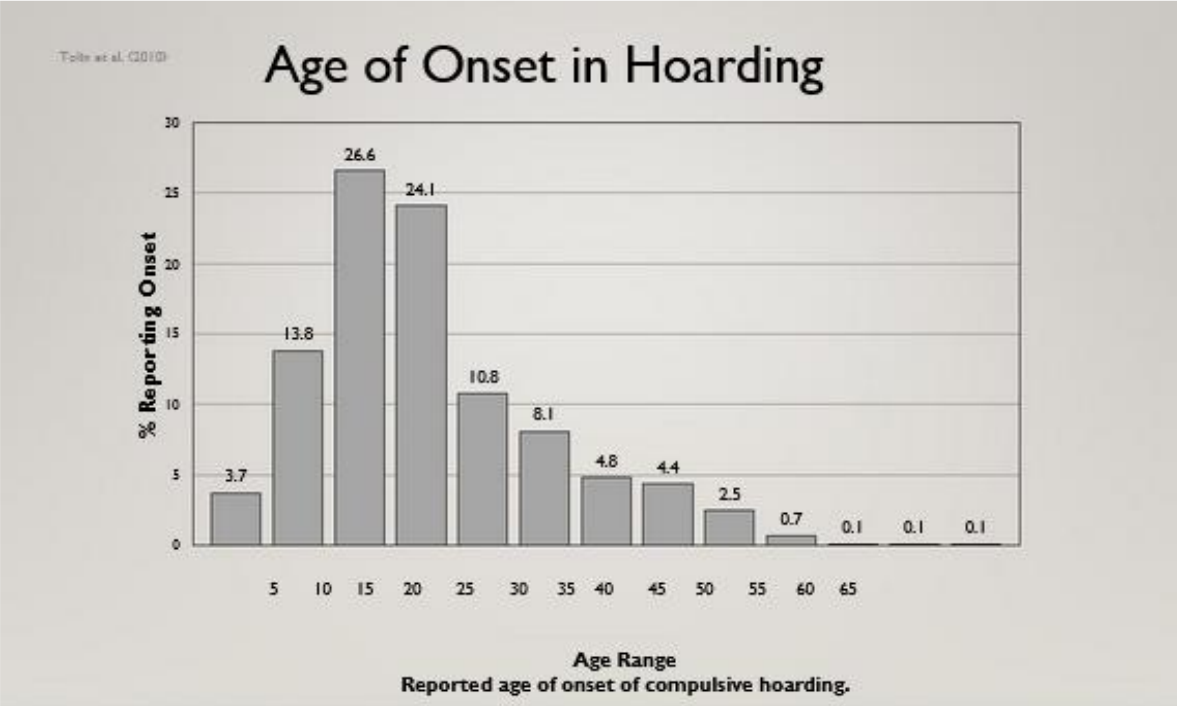
1. **"Randomised Clinical Trial of Community-Based Peer-Led and Psychologist-Led Group Treatment for Hoarding Disorder"** 2018 scientifically reviewed, academic journal study, co-authored by Julian Plumadore published by Cambridge University Press, on evidence based, effective protocol.
Abstract: https://www.cambridge.org/core/journals/bjpsych-open/article/randomised-clinical-trial-of-communitybased-peerled-and-psychologistled-group-treatment-for-hoarding-disorder/5804DDCE80DB0294AC378B6280CFB413
Full article: https://www.cambridge.org/core/services/aop-cambridge-core/content/view/5804DDCE80DB0294AC378B6280CFB413/S2056472418000303a.pdf/randomised_clinical_trial_of_communitybased_peerled_and_psychologistled_group_treatment_for_hoarding_disorder.pdf
Article concludes: "**Peer-led groups were as effective as psychologist-led groups**, providing a novel treatment avenue for individuals without access to mental health professionals."
Co-author Plumadore is available to train DC stakeholders, as outlined above, as well as in **attached support materials about Mr. Plumadore**.)

2. **"Hoarding is a Serious Disorder — And it's Only Getting Worse" –** ***The Washington Post***, states six percent of people struggle with HD – that equals over 40,000 District residents – plus countless additional friends, family, neighbors, and service providers affected by relationships with people living with Collecting Behaviors. http://www.washingtonpost.com/national/health-science/hoarding-is-serious-disorder--and-its-only-getting-worse-in-the-us

3. "**1 dead in Hillcrest Heights house fire" –** tragic civilian death in Hillcrest house fire involved **"excessive storage conditions"** according to Alan C. Doubleday, Assistant Fire Chief, Prince George's County. (Helpful language demonstrates the Fire Chief's person centered sensitivity to challenges experienced by people living with this diagnosis.) http://wtop.com/prince-georges-county/2017/09/1-dead-fire-hillcrest-heights

4. **DBH MHRS/SUD Clinical Directors' Meeting October 27, 2022, DACL presentation on HD**
Elaine Murry, MSW, LICSW, LCSW-C, Program Manager, Office of Community Services, Department of Aging and Community Living, 202-730-1741, www.dacl.dc.gov Ms. Murry shared that in some cases DACL's only recourse, for somebody who cannot change their behavior to prevent public safety risk, is for that individual to be placed – not by that person's own individual free choice –- in nursing home care. The risk of exposing oneself to a charge of self neglect and the consequent loss of autonomy and self determination, to this witness' anecdotal knowledge, has deterred multiple District residents from seeking support.

5. **"Median age of onset was between 11 and 15 years, with most respondents reporting symptom onset before age 20."** *Depression and Anxiety* journal, "Course of compulsive hoarding and its relationship to life events" David F Tolin, Suzanne A Meunier, Randy O Frost, Gail Steketee 2010 https://pubmed.ncbi.nlm.nih.gov/20336803/
https://onlinelibrary.wiley.com/doi/full/10.1002/da.20684



6. **"The median age of onset for symptoms was between 10 and 20 years"** *Aging & Mental Health* journal, "Age of onset and progression of hoarding symptoms in older adults with hoarding disorder" Mary E. Dozier, Ben Porter, Catherine R. Ayers 2016 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5612663/

7. Institute for Challenging Disorganization https://www.challengingdisorganization.org/2023-icd-conference

8. Mental Health Association of San Francisco Information on Hoarding, Cluttering, and Collecting Behaviors https://www.mentalhealthsf.org/collecting-behaviors-hoarding-disorder/

9. International OCD Foundation Hoarding Disorder (HD) website https://hoarding.iocdf.org/

10. **"HOARDING: A Dangerous Secret" – Metropolitan Washington Council of Governments** In 2006 – almost two decades ago – described HC issues region wide in a 75 page report http://www1.mwcog.org/uploads/committee-documents/tVhbWVY20061106110151.pdf

11. **Diagnostic and Statistical Manual of Mental Disorders – 5th Edition** (**DSM-5,** American Psychiatric Association, 2013) defines Hoarding Disorder (HD) and Clinical Assessment for Hoarding Disorder. https://hoarding.iocdf.org/professionals/diagnosing-hoarding-disorder/ https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t29/

12. **American Psychiatric Association** Expert Q&A: Hoarding Disorder

https://www.psychiatry.org/patients-families/hoarding-disorder/expert-q-and-a
https://www.psychiatry.org/patients-families/hoarding-disorder/what-is-hoarding-disorder

13. **"When talking a person who hoards, focus on safety rather than the clutter. Be empathetic. Match the person's language. If they call it hoarding, then you can call it hoarding." – National Fire Protection Association (NFPA)** https://www.nfpa.org/-/media/Files/Public-Education/Resources/Safety-tip-sheets/HoardingTipSheet.ashx
"Many fire departments are experiencing serious fires, injuries, and deaths as the result of compulsive hoarding behavior." – **NFPA** https://www.nfpa.org/Public-Education/Fire-causes-and-risks/Behavioral-risks/Hoarding

Let's not let HD in our DC community get that far.

How much longer must we wait for our Deputy Mayor for Health and Human Services to address this challenge, and with early intervention? Let it not be until more extreme urgency arises.

The District can be pro-active and progressive with effective, evidence based, early intervention by engaging our existing certified peer specialists to provide sensitive and trauma-informed response services, respecting individual autonomy and rights, for community members in the District suffering from HD. DC's Deputy Mayor for Health and Human Services must act to provide training about Hoarding Disorder and thereby begin the effort to address HD. This training not only helps District residents living with Hoarding Disorder, but, in addition, de-stigmatizing HD also opens up people's acceptance of talking about Mental Health and substance use conditions – across the spectrum, including even our terrible opioid crisis and rising rate of suicide – facilitating a thriving recovery-oriented system.

Thank you for the opportunity to share with you and for your attention to this tragic, closeted challenge.

Please advise how we can allocate funds to bring evidence based, effective training protocol to the District.

Grateful to answer any questions that may potentially arise for you.

Wishing you and all our community members District wide
Peace, good health, & justice,

~~Hilary

<u>Julian Plumadore Credentials (attached below)</u>

Jules Plumadore

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jplumadore@gowithgoldfeather.com | 510-309-3470

Work History

Goldfeather Consulting
Oakland, CA

Senior Consultant — **10/20 - Present**

Summary

- I'm the founder of a consulting network providing person-centered, evidence-based training and technical assistance on topics related to mental health and wellness through the lens of social justice.

Achievements

- Develop and deliver original-content trainings and webinars on hoarding and cluttering supports and services; peer workforce development; community crisis response without police intervention; and other subjects relevant to behavioral health
- Offer technical assistance on behavioral health topics to nonprofits, universities, and government entities
- Provide ongoing consultation to the California Mental Health Services Authority (CalMHSA) for the development of a statewide Peer Support Specialist certification exam

Peers Envisioning and Engaging in Recovery Services (PEERS)
Oakland, CA

Interim Executive Director — **4/20 – 9/20**

Summary

- I served as Interim Executive Director for a community-based mental health nonprofit run by and for a diverse coalition of people with shared experience of mental health conditions.

Achievements

- Identified opportunities for growth and oversaw long-range organizational planning, change management. fundraising, and capacity building
- Established and maintained relationships with community leaders, partner organizations, and funders

PEERS
Oakland, CA

Community Engagement and Development Director — **1/20 – 4/20**

Summary

- I led strategic planning initiatives to expand unrestricted funding opportunities and broaden the organization's reach to program participants, donors, and community partner organizations.

Achievements

- Designed, supervised, and managed outreach strategy for a hoarding and cluttering program centered around the Buried in Treasures skill-building group
- Crafted marketing and communications strategies to improve community outreach and expand the organization's reach
- Established measurement-based practices to evaluate outcomes in outreach, training, and fundraising activities
- Developed a fee-for-service training program, including curriculum and training materials, and managed Scopes of Work for service delivery to community partners

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PEERS
San Francisco, CA

Senior Programs Manager **2/19 – 12/19**

Summary

- I supervised and managed a team of 7 and oversaw programs including outreach and engagement, data collection and reporting, communications, and the Lift Every Voice & Speak (LEVS) mental health advocacy speakers bureau

Achievements

- Oversaw all aspects of community programs, including budget development and tracking; event coordination; vendor relations; data collection, reporting, and quality assurance; and outreach and engagement strategy and implementation
- Developed an original, evidence-based speakers bureau curriculum for the LEVS program, including a train-the-trainer process, a Facilitator's Guide, and a Speakers Manual
- Updated and standardized internal policies and procedures for participant accessibility and equitable staff recruitment, hiring, and retention

Mental Health Association of San Francisco (MHASF)
San Francisco, CA

Training and Community Engagement Manager **8/15 – 2/19**

Summary

- I developed, marketed, booked, and delivered original trainings to government agencies, secondary and post-secondary schools, and over 50 public and private sector organizations, and coordinated conferences and community events.

Achievements

- Supervised the peer arm of the 3-year Help for Hoarding study in collaboration with UCSF, which demonstrated that peer-led support groups for hoarding and cluttering are therapeutically equivalent to clinician-led groups
- Co-authored a toolkit on peer workforce development, including best practices for recruiting, hiring, and retaining peer-identified employees and integrating them into an existing team
- Co-led fundraising and grantwriting initiatives resulting in over $10 million
- Oversaw volunteer recruitment, onboarding, supervision, and retention
- Co-coordinated annual Tools for Change and International Hoarding and Cluttering conferences, including managing event logistics, speaker recruitment, communications, marketing, and registration.

MHASF
San Francisco, CA

SOLVE Program Manager **8/13 – 7/15**

Summary

- I supervised the Sharing Our Lives, Voices, and Experiences (SOLVE) mental health advocacy speakers bureau with over 75 speakers.

Achievements

- Collaborated with K-12 and post-secondary educators to ensure voices of lived experience are represented in their curricula, resulting in speaker placements at Berkeley and Galileo High Schools, the MFT and Summer Bridge programs at the California Institute of Integral Studies, and the Community Health program at San Francisco State University

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Certifications

- Organizational Leadership in Diversity, Equity, and Inclusion (Rice University, 2023)
- Level I Certificate of Study in ADHD (Institute for Challenging Disorganization, 2019)
- Level I Certificate of Study in Time Management/Productivity (Institute for Challenging Disorganization, 2019)
- Foundation Certificate in Chronic Disorganization (Institute for Challenging Disorganization, 2019)

Publications

- "Randomised clinical trial of community-based peer-led and psychologist-led group treatment for hoarding disorder," *BJPsychOpen Press*, Vol. 4, Issue 4, July 2018, pp. 285 – 293
- "Contributions of self-criticism and shame to hoarding," Psychiatry Research, Vol. 262, 2018, pp. 488-493
- "How is hoarding related to trauma? A detailed examination on different aspects of hoarding and age when hoarding started," *Journal of Obsessive-Compulsive and Related Disorders*.,Vol. 16, 2018, pp. 81-87

Jules Plumadore

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Jules Plumadore is the Founder and Senior Consultant of Goldfeather Consulting, a network of peer-identified consultants offering mental health training and technical assistance that is both evidence-based and experience-tested. Goldfeather consultants have contributed to national conversations on mental health and bring lived experience as well as professional expertise on subjects including hoarding and cluttering challenges, peer workforce development, community crisis response, language change, and more.

Jules draws on his own lived experience of mental health challenges as well as his leadership in community-based mental health. Having worked in high-profile community-based roles at every professional level, from part-time Peer Responder to Executive Director, Jules' unique insights into mental health and workplace culture have helped to spark conversation and create change at organizations like the San Francisco Public Library system, Zuckerberg San Francisco General Hospital Psychiatric Emergency Services, the Institute on Aging, and the California Institute of Integral Studies.

Jules is an internationally-recognized peer expert in supports for hoarding and cluttering. An original member of the Mental Health Association of San Francisco's innovative Peer Response Team, Jules has been a featured presenter at the International Conference on Hoarding and Cluttering; shared his expertise with periodicals including the New York Times and Al Jazeera America; and contributed to groundbreaking research with UCSF on peer-led supports for hoarding and cluttering. He has trained hundreds of Bay Area supportive housing staff members on harm reduction practices for hoarding and cluttering, was part of the first team of Buried in Treasures skill-building group facilitators on the West Coast, and is a member of the Institute for Challenging Disorganization (ICD).

Jules works collaboratively with other values-aligned trainers, consultants, and community partners to make Goldfeather Consulting a catalyst for transformative change in mental health.

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GOLDFEATHER CONSULTING FEE SCHEDULE – 2023

HOURLY CONSULTATION RATES

Tiers	Topics	Fee
Tier 1: Nonprofit Organizations (budget <$1 million)	• Hoarding and cluttering community-based program design • Integrating and supporting peer employees in an existing workforce • Peer certification, professional development, and career path planning • Developing transitional age youth/LGBTQ+ supports for hoarding and cluttering challenges • Crisis response implementation • Additional topics upon request	$75/hr
Tier 2: Nonprofit Organizations (budget >$1 million)	• Hoarding and cluttering community-based program design • Integrating and supporting peer employees in an existing workforce • Peer certification, professional development, and career path planning • Developing transitional age youth/LGBTQ+ supports for hoarding and cluttering challenges • Crisis response implementation • Additional topics upon request	$100/hr
Tier 3: • Private sector businesses • Universities • Government agencies	• Hoarding and cluttering community-based program design • Supporting organizational wellness and staff mental health • Crisis response implementation • Additional topics upon request	$135/hr

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TRAINING CREATION & DELIVERY FEES[1]

Tiers	Qualified Clients	Half-Day (3 hours)	Full-Day (6+ hours)
Tier 1	Nonprofit organizations (budget <$1 million)	$1000	$1750
Tier 2	Nonprofit Organizations (budget >$1 million)	$1500	$2250
Tier 3	• Private sector businesses • Universities • Government agencies	$2000	$3500

SPEAKERS' FEES[2]

Tiers	Qualified Clients	Per hour
Tier 1	Nonprofit organizations (budget <$1 million)	$100
Tier 2	Nonprofit Organizations (budget >$1 million)	$200
Tier 2	• Private sector businesses • Universities • Government agencies	$300

[1]Includes pre-training consultation meeting, training development, travel costs within the San Francisco Bay Area, and 1 training delivery. Additional deliveries of a previously delivered training will be assessed at a 40% discount. Travel outside the Bay Area will be assessed at 2023 IRS standard rates. Contractor retains the rights to the training.

[2] Speakers' fees are prorated at training rates for the appropriate tier; for example, a 30-minute speaking engagement at a community-based nonprofit organization would be $150 per speaker, and $300 per speaker for a private sector business.

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2024 Budget Hearing

Testimony of
Wayne Turnage
Deputy Mayor for Health and Human Services
and
Director, Department of Health Care Finance

Before the Committee on Health
Council of the District of Columbia
The Honorable Christina Henderson

Wednesday, April 5, 2023
9 a.m.
The John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Introduction

Good morning, Chairwoman Henderson, and members of the Committee on Health. I am Wayne Turnage, Deputy Mayor for Health and Human Services (DMHHS) and Director of the Department of Health Care Finance (DHCF). It is my pleasure to report on Mayor Muriel Bowser's Fiscal Year 2024 (FY2024) Fair Shot Budget and Financial Plan for DHCF. As with previous years, the Mayor's commitment to funding critical health care services is evident in this budget, notwithstanding the fiscal challenges she faced – challenges which are discussed later in this section.

I am joined today by DHCF staff who played a central role in developing the agency's budget proposal for the Mayor's consideration. Much of the work in formulating DHCF's proposal to the Mayor was conducted by members of my Executive Management Team which includes both my Senior Deputy Director and Medicaid Director, Melisa Byrd, and our Senior Deputy Director of Finance, Angelique Martin, who due to an unavoidable conflict with a medical appointment cannot be here today. Angelique has assembled one of the most talented finance teams in the city, including James Simms, and our newly minted actuary Joseph Brennan – both of whom are in attendance at this hearing. Their discerning and penetrating insight is perfectly complimented by the comprehensive data analytical work conducted under the outstanding stewardship of senior staff member and Director of Data Analytics, April Grady.

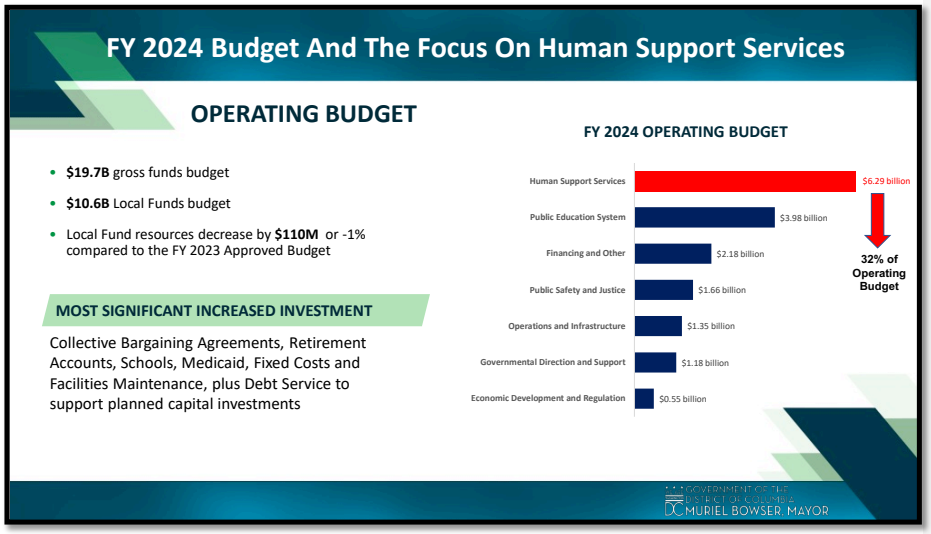
These two divisions – Reimbursement and Finance and Data Analytics – worked very closely with Darrin Shaffer, our Agency Fiscal Officer, and members of his talented staff to develop a proposal that is financially responsible while funding the broad sweep of health care programs delivered under the auspices of DHCF. Clearly, without the collective efforts of this group, DHCF's very complex budget could not have been rationally formulated.

The Financial Environment Impacting Budget Formulation For DHCF

At this time last year, Mayor Bowser submitted a record budget, buoyed by an economy that appeared ready to free itself from a two-year economic stranglehold of a devastating global pandemic. Unemployment was down, consumer spending was on the rebound, and the revenue losses from one of the District's leading economic indicators for the city – the restaurant industry – were significantly abated. But, one year later, the District's economic fortunes have become more complicated. Several revenue sources are trending favorably for FY2023, which prompted the Chief Financial Officer (CFO) to provide an upward revision in the expected revenue for the current fiscal year. However, over the remainder of the District's financial plan, through FY2027, a deteriorating commercial real estate market and more pessimistic expectations about the impact of the United States' monetary policy, caused the CFO to make significant downward adjustments in the city's out-year forecasts.

When these downward adjustments of more than $463 million are considered with the District's pre-forecast expenditure patterns, the projected financial plan was more than $1.7 billion out of balance. Because of the prominent role that health and human services agencies – especially DHCF – retain in the District's budget (see graph on page 4), the Mayor's efforts to solve a $1.7 billion problem across the financial plan has significant implications for DHCF. With reduced federal support and a declining real estate revenue base, the Mayor, nonetheless, put forth a FY2024 budget that is built on $19.7 billion in total operating dollars, with a local fund allocation of $10.6 billion.

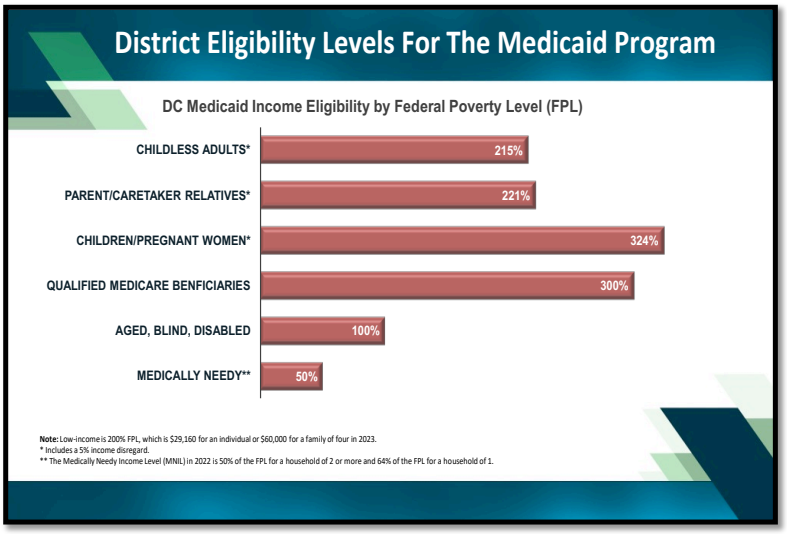
In the planning for this budget, the Mayor eschewed the use of virtual town halls to capture community input and returned to in-person budget town halls that were held on two



separate days. In these town halls, the deputy mayors outlined their cluster agencies' mission and goals before residents who were given the opportunity to weigh in on how they would allocate the city's resources among competing financial demands. This process provided communities across the city a window into the formulation process, giving them an opportunity to voice their views on how the city should spend residents' resources to address the many evident needs.

Overview of DHCF's Program Structure

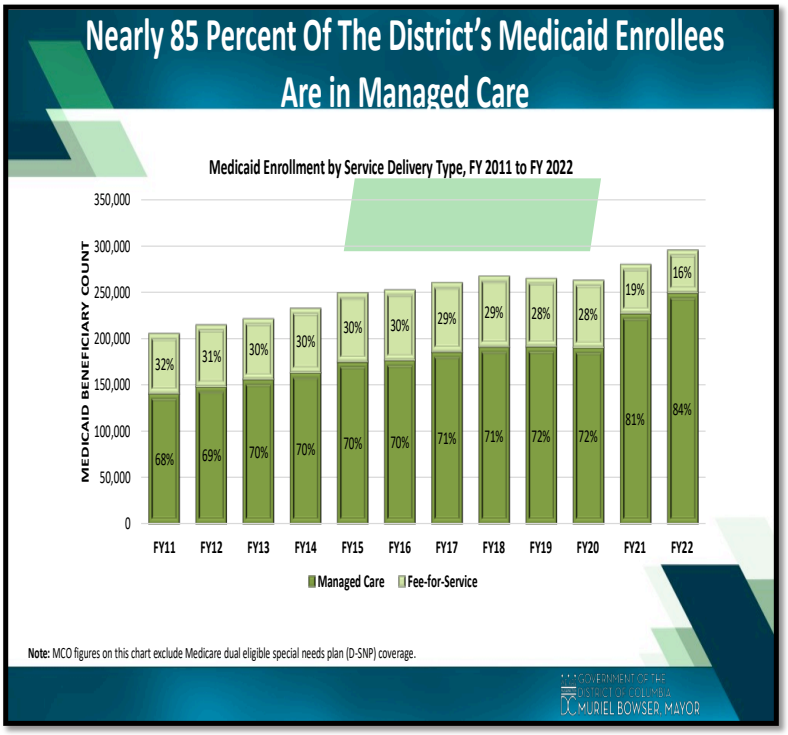
The Medicaid program is a federal-state program where mandatory eligibility groups and benefits are set by the federal government, while allowing states the flexibility for determining additional eligibility groups, benefits, and how care is delivered. In the District, we fund some of the highest eligibility levels in the country, making most low-income adults in the District eligible for the Medicaid program (see graph below). Additionally, many children and pregnant women, with low- or moderate-income levels, are also eligible.



Per federal guidance, we are now in the process of renewing health coverage for all Medicaid, Alliance, and ICP beneficiaries. This process started in July 2022 for Alliance and ICP beneficiaries and April 1, 2023, for Medicaid beneficiaries. As mentioned in the oversight hearing, our goal is to maintain enrollment and limit disruption of access to services for beneficiaries and families who remain eligible for these benefits.

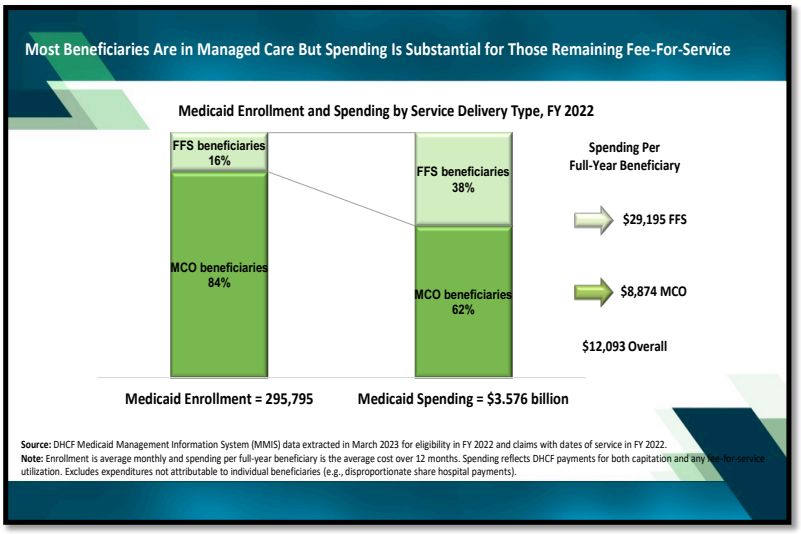
The array of benefits available through the Medicaid program consist of both federally mandated and optional services. We have broad flexibility to design a package of benefits for our Medicaid program within federal guidelines. Certain benefits, such as inpatient hospital and physician services, are mandatory, while others, such as prescription drugs and doula services, may be provided as a state option. We pride ourselves on a comprehensive service package and the proposed FY2024 budget maintains these benefits as a foundational component of our program.

DHCF's Bifurcated Program Structure. Most of our Medicaid beneficiaries access health care services through a managed care plan. Since FY2020, participation in managed care has grown from approximately 70 percent to nearly 85 percent in FY2022 (see graph below). The most recent increase in managed care is attributed to the February 2022 launch of the District Dual Choice program that serves individuals enrolled in both Medicare and Medicaid. The remaining beneficiaries receive care through the Medicaid Fee for Service (FFS) program, which is administered directly by DHCF, and we pay providers for the health care delivered to this non-managed care population.



This increase in managed care is purposeful – in 2019, DHCF announced its intent to transition a large share of FFS beneficiaries into the managed care program to increase these members access to coordination and case management services. These services are key components of the managed care program and are not widely available in fee for service program.

As shown by the graphic below, there are significant differences in the per-person spending in managed care compared to the FFS program. Specifically, on an annual basis, the per-beneficiary cost of managed care spending is approximately $8,800. Comparatively, the cost for FFS program is more than three times higher at nearly $30,000 annually. Our goal remains to move an even larger share of high-cost beneficiaries with more acute health problems, into managed care.



The Medicaid Funding Match. As a partner in the Medicaid program, the federal government funds both direct services and administrative functions. Federal dollars are allocated

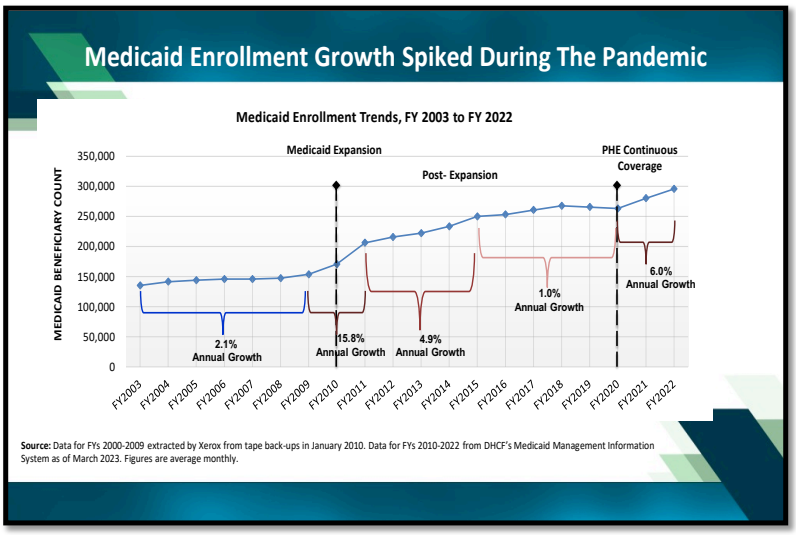
through a federal medical assistance percentage policy known as FMAP. The level of FMAP varies by state and, with few exceptions, is inversely related to a state's per capita income. Unlike other states, the District's FMAP is statutorily set at 70 percent and remains constant year over year. The 70 percent FMAP applies to direct services like physician and managed care services. Higher FMAP percentages are available for certain enrollment groups, and the federal government also subsidizes DHCF's administrative costs, and our technology system design and development projects. During the federal Public Health Emergency, the District benefitted from an increased FMAP of 6.2 percentage points, but this is now phasing out and will decrease each quarter until the end of the calendar year when it returns to 70 percent.

The Building Blocks For DHCF's Budget

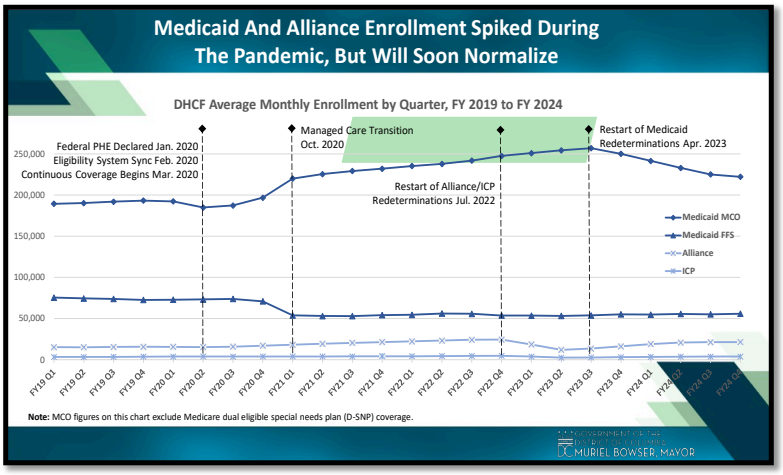
DHCF's budget formulation is driven by three key elements: 1) Medicaid and Alliance program enrollment; 2) service utilization; and 3) provider rates. Significant budget savings in the Medicaid program cannot be achieved without impacting one or more of these three areas. However, for part of the budget's financial plan, federal maintenance of effort requirements prohibit DHCF from making changes to eligibility levels or certain benefits. As we do each year, and with these limitations in mind, DHCF initiated budget formulation from the ground up – meaning we analyzed enrollment and utilization trends to project these outcomes for the coming year. Provider rates, including any rate changes, and expected policy changes are also appropriately factored into our estimation process to determine anticipated program costs.

Enrollment. It is important to note that as an entitlement program, a resident who is deemed eligible for Medicaid cannot be denied enrollment. Additionally, during the Public Health Emergency, Medicaid was under a continuous enrollment requirement – meaning no active beneficiaries could be disenrolled from the program, even if their income exceeded

allowable eligibility thresholds. The result is we have more people in the program than ever witnessed in the District. Notably, since 2020, the annual enrollment growth rate has been six percent compared to one percent for the immediate years prior (see graphic below). At a historical high, Medicaid now pays for the health care of just over 300,000 District residents. Thus, if all other variables remained constant, program costs would continue to increase simply because of increased enrollment.



The continuous enrollment requirement ended on March 31, 2023, and Medicaid eligibility renewals resumed for the first time since March 2020. Over the next 14 months, every Medicaid beneficiary will be required to recertify their eligibility. We expect some individuals will no longer be eligible for the program and that enrollment will normalize towards the end of Fiscal Year 2024, as shown in the figure on page 10. It is important to note that for purposes of this budget and financial plan, DHCF's enrollment projections extend through FY2025. Beyond that date, any projections would be unreliable, subject to wide error margins.



Service Utilization. In terms of utilization, at the beginning of the Public Health Emergency, we witnessed a precipitous decline in beneficiary utilization of Medicaid. Notably, many beneficiaries postponed or otherwise delayed health care treatment, especially during the first year of the pandemic for fear that they would contract the virus in a medical care setting. Once vaccines were identified and widely distributed, however, utilization began a return to historical norms and this trend is captured in our budget estimates for Medicaid and Alliance.

Provider Rates. The remaining variable that impacts DHCF's budget formulation is provider rates. In addition to eligibility flexibilities during the Public Health Emergency, DHCF was also able to increase provider rates, which drove payments up to levels that exceeded provider cost in many cases. Our ability to provide enhanced rates ends at the conclusion of the Public Health Emergency (May 11, 2023). We fully anticipate that some provider rates will return to normal by the end of May while others will phase out between May and November, 2023. These anticipated changes are fully reflected in the Mayor's proposed budget for DHCF.

Components of DHCF's Budget. DHCF's proposed budget is nearly $4.3 billion, and it reflects funding from multiple sources. The table below shows each funding source, the proposed FY2023 budget amount, and the year over year comparison from FY2023 to FY2024. Overall, a surge in inflation, an increase in federal Medicaid payments, and higher planned spending in federal grants are the key factors driving DHCF's proposed budget growth by 15 percent, despite key targeted reductions. Dedicated taxes which are used to defray managed care costs, and support staff salaries, grew by 9 percent. Local budget growth compared to the FY2023 approved budget, was comparatively modest at 3.3 percent – an increase of $31.9 million. The availability of enhanced FMAP through the first quarter of FY2024, likely dampened local fund growth.

DHCF's FY2024 Year Over Year Comparison by Appropriated Fund

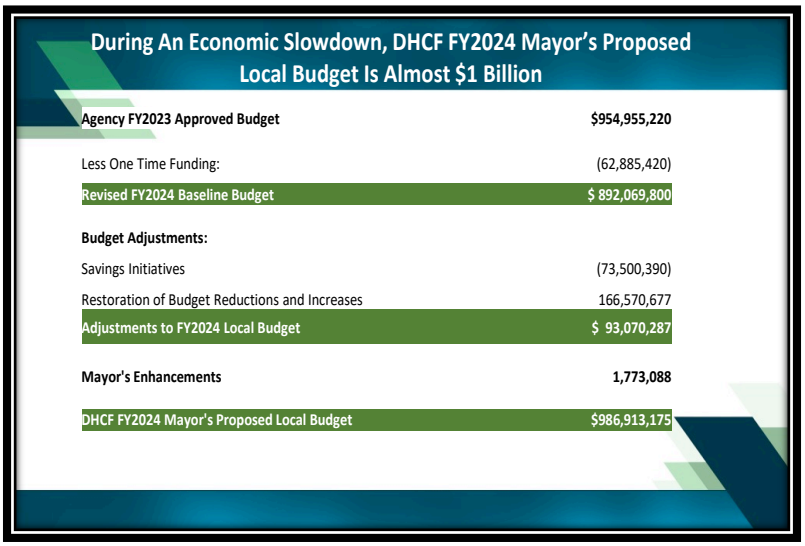
Appropriated Fund		FY 2023 Approved Budget	FY 2024 Proposed Budget	YoY Budget Change	% Change
0100	Local	954,955,220	986,913,175	31,957,954	3.3%
0110	Dedicated Taxes	105,105,077	114,535,958	9,430,881	9.0%
0150	Federal Payments	2,000,000	-	(2,000,000)	-100.0%
0200	Federal Grants	5,174,115	4,550,493	(623,622)	-12.1%
0250	Federal Medicaid Payments	2,663,283,089	3,180,056,342	516,773,254	19.4%
0400	Private Grants	365,701	100,000	(265,701)	-72.7%
0600	SPR Revenue (Type)	5,643,542	8,805,546	3,162,004	56.0%
0700	Intra Districts	-	-	-	0.0%
Grand Total		3,736,526,743	4,294,961,514	558,434,771	15.0%

Variance Explanation

- **Local:** Increase in local funds to support the Mayor's investments in health care and replace enhanced FMAP received in previous years due to the Public Health Emergency
- **Dedicated Taxes:** Alignment of budget to anticipated revenue collection to support provider payments and administrative cost. DHCF will use $10.1M in fund balance; available due to prior years of receiving EFMAP which required less dedicated tax (or local) match
- **Federal Payments:** The District ARPA funded projects were sunset at the end of FY23; The Transportation for Alliance Pregnant Mothers ($480k) and Practice Transformation Efforts ($1.5M) will be funded through other resources
- **Federal Grants:** the SUD grant expired in FY23; it is not accounted for in FY24 budget
- Federal Medicaid: The FY23 Approved budget assumed the EFMAP would sunset during FY22, the budget will be adjusted upward to align with the EFMAP reducing the delta between FY23 and FY24. FY24 aligns with anticipated Medicaid participation, including one quarter of EFMAP at 1.5% (or 71.5%)
- **Private:** DHCF did not awarded the grant in FY23
- **O-Type:** Alignment of budget to anticipated revenue collection and reflection of the utilization of fund balance in 3rd party Collections of $3.1M

Understanding the Local Fund Budget. The Mayor approved a number of actions to build the local fund budget. Under the current process, the Mayor's budget office initiates the process by establishing a baseline funding amount that is determined by the previous year's

approved budget. For DHCF, this amount was $954.8 million – a figure that was adjusted downward by backing the one-time funding enhancements from FY2023 out of the baseline starting point. This 6.5 percent reduction generated the agency's budget target of $892 million (see table below).



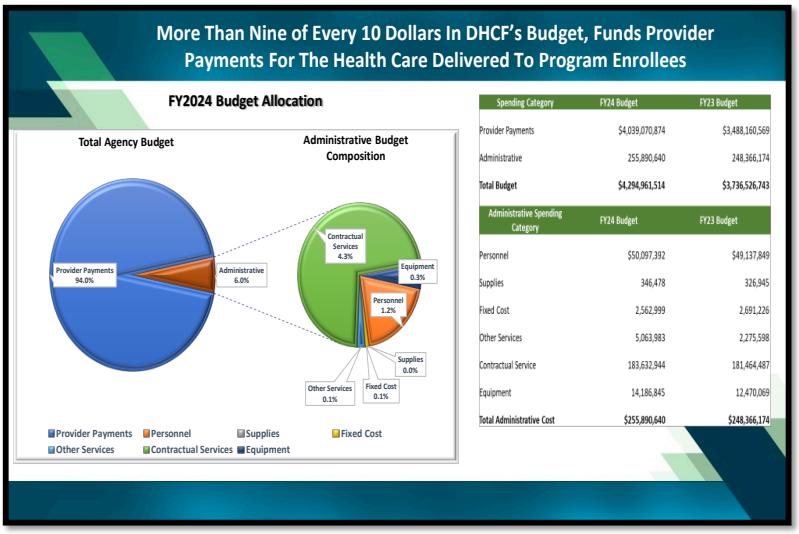
During An Economic Slowdown, DHCF FY2024 Mayor's Proposed Local Budget Is Almost $1 Billion

Agency FY2023 Approved Budget	**$954,955,220**
Less One Time Funding:	(62,885,420)
Revised FY2024 Baseline Budget	**$ 892,069,800**
Budget Adjustments:	
Savings Initiatives	(73,500,390)
Restoration of Budget Reductions and Increases	166,570,677
Adjustments to FY2024 Local Budget	**$ 93,070,287**
Mayor's Enhancements	**1,773,088**
DHCF FY2024 Mayor's Proposed Local Budget	**$986,913,175**

DHCF staff then offered program reductions of $73.5 million but these savings initiatives were largely rejected by the Mayor, who ultimately restored $166 million to our budget – for a net adjustment of $93 million. After adding another $1.8 million in program enhancements to support Produce RX and the staff cost for long-term care eligibility processing – staff were transferred to DHCF from DHS – the agency's final proposed budget created a total local fund budget of $986.9 million.

Limited Administrative Spending. The local funds in DHCF's budget are sufficient to draw down $3.1 billion in federal Medicaid payments, creating a total fund budget of $4.3 billion. Yet, despite this considerable budget, DHCF remains an extraordinarily lean operation.

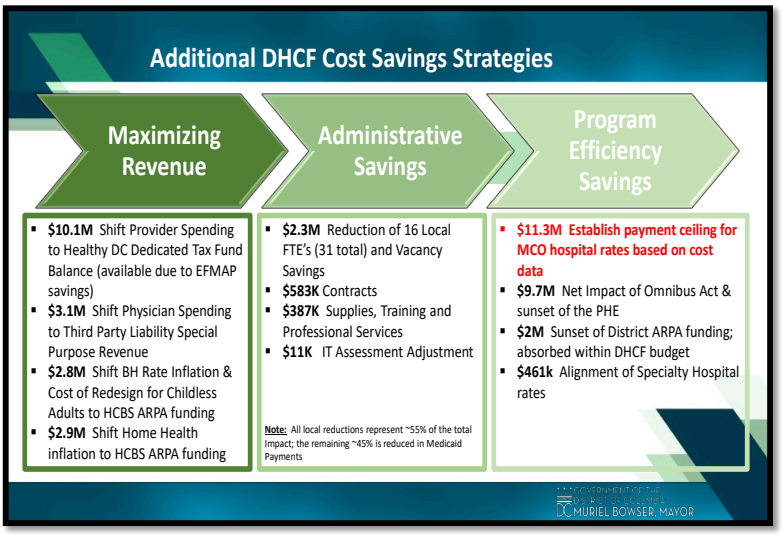
Fully 94 percent of these funds are dedicated to provider payments. The remaining six percent is allocated for administrative cost and most of these resources are paid to vendors for contract services. Only 1.2 percent of DHCF's budget is allocated for agency staff (see graphic below).



Spending Category	FY24 Budget	FY23 Budget
Provider Payments	$4,039,070,874	$3,488,160,569
Administrative	255,890,640	248,366,174
Total Budget	**$4,294,961,514**	**$3,736,526,743**

Administrative Spending Category	FY24 Budget	FY23 Budget
Personnel	$50,097,392	$49,137,849
Supplies	346,478	326,945
Fixed Cost	2,562,999	2,691,226
Other Services	5,063,983	2,275,598
Contractual Service	183,632,944	181,464,487
Equipment	14,186,845	12,470,069
Total Administrative Cost	**$255,890,640**	**$248,366,174**

Key Savings Reduction. The Mayor's proposal for DHCF is built on strategic cost shifting, administrative savings, and program efficiencies. Through cost shifting, we saved nearly $19 million in local spending. The largest savings was generated by using available fund balance from the Healthy DC Dedicated Tax to offset $10.1 million in managed care costs (see graphic on next page). The surplus in the funds was generated by savings from the enhanced FMAP received by the District. Similar cost shifts were executed to pay for physician cost (using Special Purpose Revenue), and behavioral health and home health rate inflation (using federal ARPA funds for Home and Community-Based Services). Together, these strategies generated $8.8 million. Also, as



with other agencies, DHCF's most significant administrative savings were generated by a sweep of 16 staff positions which generated $2.3 million in savings.

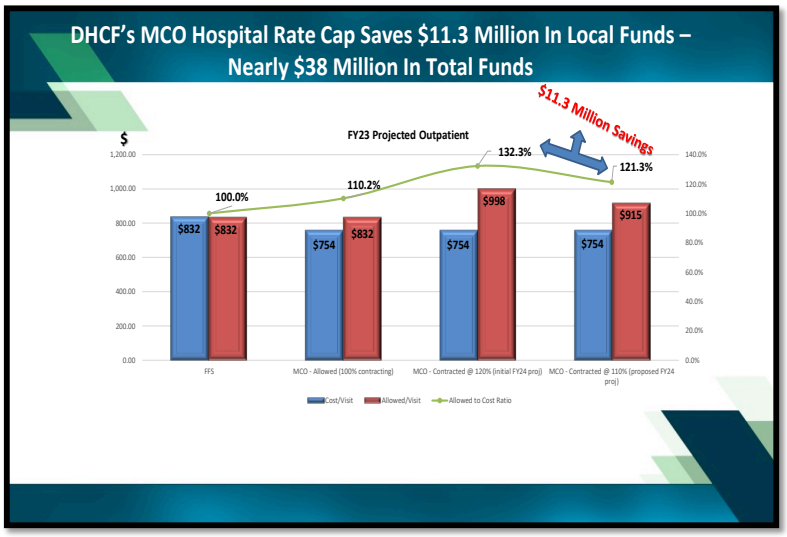
Capping Managed Care Hospital Costs. Two years ago, DHCF established a requirement that every health plan in the program, must contract with every acute care hospital in the city. The penalty for failure to comply could result in a termination of the relevant health plans' contracts if we determine that they did not negotiate with the hospitals in good faith. We developed this policy to give Medicaid and Alliance managed care members equal access to each hospital in the city, regardless of the managed care plan in which they were enrolled. This policy can mitigate the problem of adverse selection – a situation where members with more severe medical conditions decide to disproportionately enroll with a given plan – but, it also has the unintended effect of weakening the negotiating leverage of the health plans. While hospitals face the same penalties for non-compliance, it can be imprudent to remove a hospital from the

entire Medicaid program, especially if the doctors in the relevant facility deliver care to a large portion of Medicaid enrollees.

In addition to the requirement of universal contracting, DHCF employs a reimbursement policy that establishes a minimum floor for managed care hospital rates. The health plans are not permitted to pay hospitals below this floor which is set at 100 percent of FFS hospital cost. Because the FFS population has higher acuity levels and receive certain more expensive benefits, such as transplants, that the individual health plans' populations do not, the baseline managed care hospital rates which are tied to FFS cost, are inflated above the expected cost experiences for health plans before the contract negotiating process is initiated.

This is demonstrated in the graphic on the next page which reports FFS and managed care (MCO) cost per visit, allowed cost per visit, and an allowed cost to ratio. As shown by the bar on the far-left side of the graphic, the FFS cost per visit is $832, which is also the FFS allowed cost per visit. This, however, is higher than the $754 MCO *actual* hospital cost per visit. This means that MCO hospital baseline rates paid at 100 percent of FFS cost, compute to an allowed MCO hospital cost to ratio of 110 percent of MCO hospital actual cost per visit. In other words, when MCOs pay hospitals the minimum rate allowed by DHCF, the resulting payment is still higher than the MCOs' actual hospital cost per visit at 110 percent.

For budget formulation, DHCF used the actuarially proposed FY2024 MCO contracting adjustments to estimate the cost of the outpatient hospital rates without a cap. As shown, we initially projected the MCO hospital contracting rates at 120 percent of the allowed FFS cost without a cap. This creates an MCO hospital rate that is 132 percent of



cost. This is not acceptable for a public plan and is likely not sustainable long-term, even in periods of less fiscal stress.

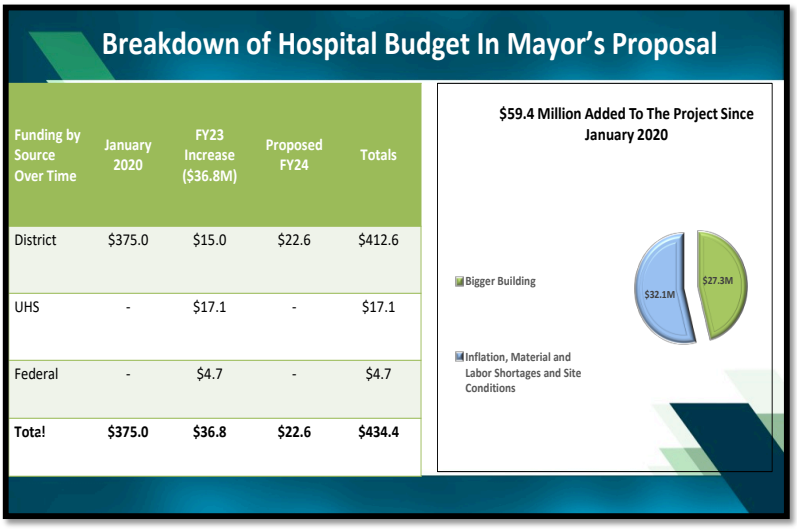
Therefore, to address this problem, the Mayor's budget establishes the Medicaid Hospital Provider Reimbursement Act of 2023 in the Budget Support Act. This subtitle requires DHCF to fund Medicaid MCO hospital care rates at a level that ensures outpatient hospital reimbursement has a minimum floor of 100 percent of the FFS rate and a maximum level of 110 percent of the fee-for-service outpatient methodology set forth in the Medicaid State Plan. It is important to note that this range is above the MCO hospital cost per visit and, most of the hospitals in the Medicaid program already operate within this range.

For inpatient rates, the language imposes a minimum floor of 98 percent of costs and a maximum equal to the negotiated rates in place as of March 31, 2023. The goal of

course, is to tap down any upward pressure on inpatient rates during this period of fiscal stress.

Budget Allocation For Cedar Hill Hospital

Madam Chairwoman, the final item to be covered in my testimony is the Mayor's budget proposal for the new hospital. As the table below indicates the Mayor's has added $22.6 million to the hospital budget, bringing the project total to $434.4M. Thus, $59.4 million have been added to the project since January 2020. Of this new amount, $27.3 million were added to make the facility bigger, while $32.1 million were allocated to offset the higher costs due to continued inflation, raw material and labor cost increases, medical equipment, computer chip shortages, and unanticipated construction and design issues. With these investments, the hospital remains on schedule and keeps our cost increases to less than half the national average over the last 3 years – a significant accomplishment in these historically challenging economic times. Barring the emergence



of future unforeseen costs, the resources proposed in the Mayor's FY2024 budget are sufficient to ensure that hospital's construction is completed on-time in December 2024 and the facility can open to patients in early 2025.

Conclusion

Madam Chairwoman, this concludes my testimony for today. There can be little question about the difficult financial environment in which the Mayor's FY2024 Fair Shot budget was crafted. Despite the negative revenue growth in the out years of the District's financial plan, the Mayor preserved the key features of the health care programs administered by DHCF – high eligibility levels, an expansive system of benefits, and provider reimbursement rates that do not threaten access to care. We look forward to working with you and other members of the Committee to address any questions that have surfaced since the Mayor's budget submission.

Thank you.

ATTACHMENT
G

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
PUBLIC HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH
ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

DC Health (Public Witnesses)

ON

Monday April 10, 2023, 9:00 a.m.
Virtual Meeting via Zoom Video Conference Broadcast
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

1. Diana Castillo, Mary's Center
2. Fernanda Ruiz, Home Visiting Director, Mary's Center
3. Felix Hernandez, Advocacy and Fatherhood Program Manager, Mary's Center
4. Camila Perez, Community Health Worker, Mary's Center
5. Antonella Natal, Community Health Worker, Marys Center
6. Kiaira Wilkerson, Family Support Worker, Mary's Center
7. Cristela Buruca, Family Support Worker, Mary's Center
8. Carolyn Babeindreier, Start Program Supervisor, Mary's Center
9. Janet Phoenix, Assistant Research Professor, Campaign to Reduce Lead Exposure & Childhood Asthma

10. Kimberly Perry, Executive Director, DC Action

11. Nisa Hussain, Early Childhood Program Manager, DC Action

12. Rachel 00Johnston, Senior Director of Operations and School Support, DC Charter School Alliance

13. Micaela Deming, Policy Director, DC Coalition Against Domestic Violence

14. Beverley Wheeler, EdD, Chief Knowledge Officer, D. C. Central Kitchen

15. Andrea Boudreaux, Executive Director, Children's School Services, Children's National Hospital

16. Rachel Clark, Policy Director, Redstone Global Center for Prevention and Wellness at The George Washington University School of Public Health

17. Carrie Stoltzfus, MPH , Director, Food & Friends, Inc.

18. Aimee Berenson, Food & Friends, Inc.

19. Ashley Matejka, Director of Community Wellness, Latin American Youth Center

20. Leah Castelaz, Policy Attorney, Children's Law Center

21. Jacqueline Bowens, President & CEO, District of Columbia Hospital Association

22. Deja Williams, Health Equity Organizer, SPACEs In Action

23. Sebrena Rhodes, Organizer, Empower DC

24. Sarah Barclay Hoffman, Director of Policy, Early Childhood Innovation Network

25. Kowshara Thomas, Executive Director, Joseph's House

26. Hugo Mogollon, Executive Director, FRESHFARM Markets, Inc.

27. Patricia Quinn, Vice President of Policy and Partnerships, DC Primary Care Association

28. Mark Miller, DC Long-Term Care Ombudsman

29. Gordon Chaffin, Public Witness

30. Dean Brenner, Alzheimer’s Association

31. Donna Banzon, Director of Healthy Markets, Martha's Table

32. Aaliyah Polite-Wright, Food and Nutrition Resource Navigator, Martha's Table

33. Nadia Gold-Moritz, Executive Director, Young Women's Project

34. Karen Doyne, Public Witness

35. Lisa LaFontaine, Chief Executive Officer, Humane Rescue Alliance

36. Nia Bodrick, MD, President of the American, Academy of Pediatrics, DC Chapter

37. Geoff Gilbert, Legal and Technical Assistance Director, Beloved Community Incubator

38. Charlene Flaherty, Director of Policy and Advocacy, Community of Hope

39. Solomon Palmer, Public Witness

40. Travis Ballie, Public Witness

41. Carolyn Price, Executive Directors, Washington DC Pharmacy Association

42. Kuma Padua, Public Witness

43. Austin Chikwendu, Senior Director of DC Region, Capital Area Food Bank

44. Dianne Harris, Director of Health Services, Friendship Public Charter School

45. Bailey McFadden, Youth Health Peer Educator, The Young Women's Project

46. Hanna Floyd, Youth Health Peer Educator, The Young Women's Project

47. Langford Wiggins, Community Safety Working Group Chair, DC for Democracy

48. Rachel Unger, Public Witness

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
PUBLIC HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH
ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

DC HEALTH

ON

Wednesday April 12, 2023, 12:00 P.M.
Virtual Meeting via Zoom Video Conference Broadcast
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Government Witness

1. Sharon Lewis, Interim Director of DC Health

Testimony of Claudia Schlosberg, J.D.
Consultant
Castle Hill Consulting, LLC

On behalf of the Nurse Family Partnership

Submitted to the
Committee on Health
FY 2024 Budget Hearing
Department of Health Care Finance

Hearing Held on April 5, 2023

Chairperson Henderson and members of the Committee on Health, thank you for the opportunity to submit written testimony regarding Mayor Bowser's proposed FY 2024 Budget for the Department of Health Care Finance. I am Claudia Schlosberg, the Founder of Castle Hill Consulting. I am testifying today in my capacity as a consultant to the National Service Office of the Nurse Family Partnership.

The Nurse Family Partnership is a community health program that pairs registered nurses with high-risk, first-time mothers with economic barriers to provide home visits during pregnancy and through the first two years of the child's life. NFP has more than 40 years of proven, clinically tested results, including three clinical trials and years of longitudinal research, showing that NFP improves maternal health and birth outcomes, including reducing pregnancy-induced hypertension, a medical condition that can lead to one of the hypertensive causes of maternal death. Nurses also address other risk factors, such as preeclampsia, which is associated with preterm births and maternal deaths, as well as substance use, intimate partner violence and mental health, also associated with maternal deaths. Studies show other long-term benefits of NFP including but not limited to a 48% reduction in child abuse and neglect, 56% fewer emergency room visits for accidents and poisonings through age 2 and a 67% less behavioral and intellectual problems in children at age 6. State and federal cost savings average $26,898 per family served.

Because of the Council's commitment to provide grant funding of $150,000 a year beginning in FY 2021 for the First-Time Mother's Home Visiting Program, Mary's Center successfully raised $2.4 million dollars in private foundation funds and launched the first NFP program in DC in July 2021. As of today, the program has enrolled more than 86 mothers throughout the District and has welcomed 53 healthy babies.

Earlier this year, Mary's Center formalized an agreement with Martha's Table to expand access to NFP to mothers with economic barriers who reside in Southeast DC. Contingent on identifying additional funding, Mary's Center has agreed to launch a second team of four NFP nurses to be housed at Martha's Table to focus on serving families East of the River. With

private funding scheduled to end next year, I am asking the Council to support adding evidence-based home visiting as a benefit that can be funded through our Medicaid program. This is already being done in 37 other States. Leveraging the Medicaid program's federal match will mean that Mary's Center not only will be able to sustain its existing program but will be able to add a second team of four nurses to focus on serving moms in Wards 7 and 8 at cost of only $187/month per family. **On an annual basis, the total cost to sustain and expand this program is less than $450,000. Given the time for planning and approvals of a new State Plan Amendment and the time needed to recruit and train additional nurses, the local cost in FY 2024 is estimated to be only $300,000.**

Why is this important. According to the latest data released by the Department of Health in January, (see attached slides), while DC has made some progress on improving perinatal health outcomes, adverse health outcomes continue to disproportionately affect Black women and women impacted by economic and racial inequality living in Wards 7 and 8. Specifically,

- Similarly In 2016-2020, the percentage of preterm births among all Medicaid financed births in DC was 12.6%, which was significantly higher than the percentage of preterm births financed by private insurance (8%). Again, the highest percentage of pre-term births were in Wards 7 (13.4%) and Ward 8 (13.6%). The report shows that in 2020, preterm births in Ward 7 rose to 14.3% but declined to 12.4% in Ward 8. Of 1,816 pre-term births in DC in 2019-2020, 60% were born to non-Hispanic Black mothers.
- Mothers whose births were Medicaid financed were almost two times more likely than mothers with private insurance to have a low birthweight baby. Prevalence of low birthweight babies was highest in Wards 7 and 8. Of 1,746 low birthweight babies born in 2019-2020, 65% were born to non-Hispanic Black mothers.
- The infant mortality rate was significantly higher among infants whose births were financed by Medicaid (9.4 per 1,000 live births) compared to infants whose births were financed by private insurance (2.9 per 1,000 live births). During the five-year period between 2016 and 2020, Wards 5, 7, and 8 had the highest infant mortality rates of 6.0, 9.9 and 12.9 per 1,000 live births, respectively, with Ward 8 having a significantly higher rate than all other wards, except Ward 7. During 2019–2020, Wards 5, 7, and 8 accounted for 45% of all live births, yet 61% of all infant deaths. Of 296 infant deaths in 2019-2020, 74.7% were born to non-Hispanic Black mothers.
- In 2029-2020, the first ranked cause of infant mortality was congenital anomalies, followed by accidents. Maternal complications from pregnancy ranked third at 11.8%.

Surely, if in this tight budget year, we can find $750,000 to invest in four new pickle ball courts, we can find the funds needed to support proven, evidence-based interventions to reduce Black infant mortality and improve perinatal health outcomes for families impacted by racial and economic inequity across the District. Accordingly, we are asking the Committee on Health to approve $300,000 to provide Medicaid coverage for evidenced based home visiting beginning in FY 2024.

Thank you for the opportunity to testify.

Key Take Aways from DC Health's Perinatal Health and Infant Mortality Report 2019-2020

Prepared by Claudia Schlosberg
Castle Hill Consulting, LLC
202-486-0822
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March 28, 2023

Infants Born to Black Women on Medicaid Disproportionately Experience Adverse Health Outcomes

- In 2015-16, the percentage of preterm births among all Medicaid financed births in DC was 12.4%, which was significantly higher than the percentage of preterm births financed by private insurance (8.8%). The highest percentage of pre-term births were in Wards 7 & 8.
- Similarly In 2016-2020, the percentage of preterm births among all Medicaid financed births in DC was 12.6%, which was significantly higher than the percentage of preterm births financed by private insurance (8%). Again, the highest percentage of pre-term births were in Wards 7 (13.4%) and Ward 8 (13.6%). The report shows that in 2020, preterm births in Ward 7 rose to 14.3% but declined to 12.4% in Ward 8.
- Mothers whose births were Medicaid financed were almost two times more likely than mothers with private insurance to have a low birthweight baby. Prevalence of low birthweight babies was highest in Wards 7 and 8.
- The infant mortality rate was significantly higher among infants whose births were financed by Medicaid (9.4 per 1,000 live births) compared to infants whose births were financed by private insurance (2.9 per 1,000 live births). During the five-year period between 2016 and 2020, Wards 5, 7, and 8 had the highest infant mortality rates of 6.0, 9.9 and 12.9 per 1,000 live births, respectively, with ward 8 having a significantly higher rate than all other wards, except Ward 7. During 2019–2020, Wards 5, 7, and 8 accounted for 45% of all live births, yet 61% of all infant deaths.
- In 2015-16, the first ranked leading cause of infant death during this time period was maternal complications of pregnancy, which accounted for 16% of infant deaths in DC. In 2029-2020, the first ranked cause of infant mortality was congenital anomalies, followed by accidents. Maternal complications from pregnancy ranked third at 11.8%.

Source: Data from Perinatal Health and Infant Mortality Report, DC Department of Health , April 5, 2019, p. 26-54 and 2019-2020 Report, p. 27-60. DC Health calculated percentages within each race/ethnic category. Above percentages compared the race/ethnicity of women with the specific health outcomes category.

Health Characteristics of DC Women Prior to Pregnancy

	DC Overall		Non-Hispanic White		Non-Hispanic Black		Hispanic		Non-Hispanic Asian/Pacific Islander	
Year	2015-16	2017-18	2015-16	2017-18	2015-16	2017-18	2015-16	2017-18	2015-16	2017-18
Total Births	19,425	17,939	6,050 (32%)	5,998 (33.4%)	9,650 (50%)	8,290 (46.2%)	2,670 (13.7%)	2,701 (15%)	903 (4.6%)	830 (4.6%)
Previous pre-term birth	624	877	63 (10.1%)	115 (13.1%)	475 (76%)	627 (71.5%)	68 (11.0%)	121 (13.7%)	12 (3.2%)	10 (1.1%)
Obese	3,737	3,981	327 (8.8%)	446 (11.2%)	2,803 (75%)	2,799 (70.3%)	537 (14.3%	679 (17%)	47 (1.2%)	34 (0.85%)
Smoking	776	645	57 (7.3%)	57 (8.8%)	680 (87.6%)	559 (86.7%)	27 (3.5%)	23. (3.6%)	10 (1.3%)	4 (0.62%)
Diabetes	187	226	15 (8.0%)	29 (12.8%)	122 (62.2%)	137 (60.6%)	38 (20.3%)	49 (21.7%)	11 (5.8%)	11 (4.86%)
Hypertension	459	565	68 (14.8%)	68 (12%)	340 (74.0%)	434 (76.8%)	39 (8.5%)	53 (9.4%)	9 (2.0%)	7 (1.4%)

Source For 2015-16 Data: Perinatal Health and Infant Mortality Report, DC Department of Health , April 5, 2019, p. 20. DC Health calculated percentages within each race/ethnic category. Above percentages compared the race/ethnicity of women with the specific health characteristic.

Source For 2017-18 Data: Perinatal Health and Infant Mortality Report, DC Department of Health , March 2022, p. 23. DC Health calculated percentages within each race/ethnic category. Above percentages compared the race/ethnicity of women with the specific health characteristic.

Health Characteristics of DC Women During Pregnancy

	DC Overall		Non-Hispanic White		Non-Hispanic Black		Hispanic		Non-Hispanic Asian/ Pacific Islander	
	2015-16	2017-18	2015-16	2017-18	2015-16	2017-18	2015-16	2017-18	2015-16	2017-18
Total Births	19,425	17,939	6,050 (32%)	5,998. (33%)	9,650 (50%)	8,290 (46.2%)	2,670 (13.7%)	2,701 (15%)	903 (4.6%)	830 (4.6%)
Prenatal Care Third Trimester	1,232	874	113 (9.2%)	128 (14.6%)	941 (76.4%)	573 (65.6%)	135 (11%)	138 (15.8%)	30 (2.4%	27 (3.0%)
No Prenatal Care	464	329	14 (3.0%)	17 (5.2%)	411 (78%)	282 (85.7%)	33 (7.1%	20((6.1%)	2 (0.4%)	5 (1.5%)
Smoking	487	381	26 (5.3%)	28 (7.3%)	444 (91.2%)	337 (88.4%)	15 (3.1%)	12 (3.1%)	2 (0.4%)	2 (0.5%)
Gest. Diabetes	662	923	138 (20.8%)	205 (22.2%)	314 (47.4%	423 (45.8%)	153 (23.1%	208 (22.5%)	53 (8.0%)	85 (9.2%)
Gestational Hypertension	1,072	1,509	356 (33.2%)	466 (30.8%)	573 (53.5%	824 (54.6%)	106 (9.9%)	171 (11.3%)	32 (3.0%)	42 (2.8%)
Eclampsia	81	48	29 (35.8%	8 (16.67%)	48 (59.3%)	29 (60.4%)	12 (14.8%)	8 (16.7%)	2 (2.5%)	3 (6.3%)

Source: Data from Perinatal Health and Infant Mortality Report, DC Department of Health , April 5, 2019, p. 22. DC Health calculated percentages within each race/ethnic category. Above percentages compared the race/ethnicity of women with the specific health characteristic.

Birth Outcomes

	DC Overall		Non-Hispanic White		Non-Hispanic Black		Hispanic		Non-Hispanic Asian/ Pacific Islander	
	2015-16	2019-20	2015-16	2019-20	2015-16	2019-20	2015-16	2019-20	2015-16	2019-20
Preterm Births	2,038	**1,816**	470 (23.4%)	433 (23.8%)	1,235 60.6%)	1,086 **(60%)**	240 (11.8%)	238. (13.1%)	81 (4.0%)	50 (2.75%)
Low-Birth-weight	1,960	**1,746**	391 (20%)	354 (20.3%	1,287 (65.7%)	1,137 **(65%)**	199 (10.1%)	183 (10.5%)	72 (3.7%)	62 **(3.6%)**

	DC Overall		Non-Hispanic White		Non-Hispanic Black		Hispanic		Non-Hispanic Asian/ Pacific Islander	
	2015-16	2016-20	2015-16	2016-20	2015-16	2016-20	2015-16	2016-20	2015-16	2016-20
Infant Mortality	487	**296**	26 (5.3%)	30 (10.1%)	444 (91.2%)	221 **(74.7%)**	15 (3.1%)	24 (8.1%)	2 (0.4%)	--

Impact of Leveraging DC Medicaid to fund NFP

Costs for NFP			
	FY 23	FY 24	Program Cost to Serve 200 Families
Total cost 100 participants (includes admin and supervisory costs)	$888,010		
Total cost of adding capacity to serve an additional 100 participants		$609,602	$1,497,612
Total Cost per family/year	$8,880	$6,096	$ 7,488
Local Share of Costs for NFP Per Member Per Month if Funded by Medicaid			
Local Share of Cost per Family/Per Year	$ 2,664	$ 1,829	$ 2,246
Cost per Family per month	$ 222	$ 152	$ 187
Annual Cost to serve -100 Families	$266,400	$182,900	$224,600
Annual Cost to Serve 200 Families			$449,200

Washington DC Pharmacy Association

Presentation to the DC City Council
Committee on Health
April 10, 2023

Good morning,

To Council member Henderson, other council members and committee members attending today.

I am Carolyn Rachel-Price RPh, a pharmacist who has practiced in the District of Columbia for over 30 years. I retired from DC Government and I currently serve as a consultant pharmacist and the Executive Director of the Washington DC Pharmacy Association.

The Washington DC Pharmacy Association (WDCPhA) was established in 1975 as the unification of the District of Columbia Pharmaceutical Association (founded circa 1852) and the Washington Pharmaceutical Association (founded in 1947). In 2025 we will proudly celebrate 50 years of service to the pharmacy community and the residents and friends who live and work in the District of Columbia.

As the official representative of pharmacist, the WDCPhA is active locally and nationally representing the District at professional conferences and meetings. As a member of the American Pharmacist Association (APhA) House of Delegates, I am one of three delegates who represent DC at the national level during APhA meetings. We participate with the APhA House of Delegates to sign onto national legislative efforts, participate in discussions with our colleagues from around the country and work to help develop policies that will affect pharmacists and the pharmacy community.

There is growing national consensus that pharmacists are critical front-line workers who have the clinical expertise to engage in telehealth services, virtual counseling and patient-education visits, and other innovative patient services. We can also expect pharmacist-provided services to continue to grow annually in response to a national realignment in requirements for healthcare services. Locally, the WDCPhA advocates for pharmacy by working collaboratively with the Citywide Rx Coalition to educate legislators, government agencies and the pharmacy community with the goal of attaining fair reimbursements for services that pharmacists routinely provide.

WDCPhA currently has three (3) key initiatives that we are actively supporting:

1. Immunization Authority – There are currently 2,231 pharmacists licensed to practice in the District. Of these, 828 pharmacists have Vaccination & Immunization Authority.

   According to the American Pharmacist Association, during the pandemic well over 300 million Covid-19 shots were administered nationally; and as of April 5, 2023, over 1.9 million were administered in the District, of which 80% were administer by pharmacists.

2. The PRep Act – On Jan. 30, 2023, the Biden administration announced its intent to end the national emergency and public health emergency declarations for Covid-19 on May 11, 2023. These emergency declarations have been in place since early 2020, and gave the federal government flexibility to waive or modify certain requirements in a range of areas

3. Provider Status for DC Pharmacists:

As of December 22, 2022 the National Alliance of State Pharmacy Associations (NASPA) 'Provider Status End-of-Year Legislative Update' states that:

› 178 bills pertaining to pharmacist scope of practice, payment for pharmacist-provided patient care services, and/or the designation of pharmacists as providers were introduced in 38 states in the 2022 state legislative sessions. Several of the bills focused on addressing public health concerns, including immunization authority, contraceptive prescribing authority, and HIV PrEP and PEP prescribing authority.

› As of December 2022, 44 bills in 26 states have passed their respective legislatures and have been signed into law, and 8 bills in 6 states are awaiting a governor's signature.

› Maryland HB 1219 / SB 661 • Revised the definition of "health care provider" to include pharmacists.

› Virginia SB 672 / HB 1323 • Authorizes pharmacists, and pharmacy technicians under supervision of a pharmacist, to initiate treatment and dispense/administer vaccines for COVID-19, nicotine replacement and other tobacco cessation therapies, and tests for COVID-19.

As you can see, laws have been enacted across the country expanding the scope of practice for pharmacists. It is now time for the District of Columbia to pass legislation so that pharmacists are not only recognized as providers "under the law," but are also equitably reimbursed for services provided.

The WDCPhA and the Citywide Pharmacy Coalition is hosting a 'Provider Status Summit' on April 28, 2023 at the Howard University College of Pharmacy, where we will continue discussions on draft provider status legislation. We look forward to collaborating with DC City Council Committee on Health to get this legislation across the finish line.

Thank you.

Testimony to the Committee on Health
For the Budget Oversight Hearing on the Department of Health
Nadia Gold-Moritz
Executive Director, Young Women's Project
April 10, 2023

Good afternoon Chair Henderson and members of the Committee. Thank you for this opportunity to testify. My name is Nadia Gold-Moritz. I am the Executive Director of the Young Women's Project (YWP). I'm also a Ward 4 resident and have two kids in DCPS high schools. YWP builds the leadership and power of DC youth so that they can transform institutions to expand rights and opportunities. Our youth leaders work on three fronts – as organizers (educating, engaging, mobilizing their peers, working as teams to make decisions), as advocates (presenting testimony to city Council, convening accountability meetings of Agency leaders, developing and passing policies) and as system rebuilders (developing programs, creating new peer-led systems, integrating youth into decision making). *We advocate from the bottom up with an eye toward implementation. And we focus only on DC public high schools.* YWP has built a citywide network membership of hundreds of youth educators and advocates in all wards and most schools. *Right now, YWP has 120 youth leaders representing 22 DC public schools and has trained and engaged 225 so far this year,* mostly BIPOC youth and young women from all wards, mostly 4, 7 and 8.

YWP engaged youth through two programs. **The *Youth Health Educator Program (YHEP)*** develops youth as sexual health advocates who work to reduce DC's unintended teenage pregnancy and STI rates through peer education, resource provision, and clinic referral initiation. *During the 8 years of YHEP, we employed 1,475 youth who reached 50,381 of their peers, distributed 659,053 condoms and made 15,208 clinic referrals.* Several of our YHEP educators testified at the DOH Performance Oversight hearing. *The work of these educators has a profound impact on school-based health outcomes, reducing teen pregnancy and STIs, and on the lives of the youth educators who improve their educational success, earn money, and take on leadership roles in their schools and communities. The* ***Youth Justice Campaign (YJC)*** *team includes 80 youth in 16 schools working together as part of YWP's Mental Health Campaign, launched in 2019 to strengthen school-based mental health programming, connect youth to services, reduce stigma, and expand access to mental health education.* Founded in 1994 as organization by and for young women, YWP has a staff of 5, delivers in person programming daily in our Dupont office and several libraries**.** Young people work side-by-side adults on our Board of Directors, Staff, and volunteers. We are value-driven, anti-racist, and feminist, grounded in youth development and partnership, and work every day to dismantle oppression and rebuild institutions.

I'm here today to talk about the need to increase sexual health education, condom distribution, and clinic access in the schools. DC Health has significantly reduced their work in these areas since FY2021. We have three budget and policy rcommendations for the FY2024 budget that will help jump start this work.

DOH Recommendation 1: We ask that the Committee allocate $300,000 within the Department of Health (DOH) HAHSTA budget to issue an RFP for a School-Based Sexual Health Education & Condom Distribution Program that would fund 2-3 organizations to collectively hire and train 165 youth (5 from each of 33 high schools) do one on one and classroom based health education, condom distribution, and connect youth to clinic services in all DCPS and DCPSC high schools with a collective reach of 10,000 youth.

Recommendation #2: We ask that the Committee allocate $100,000 to support a staff position within DOH-HAHSTA who can coordinate the Wrap MC certification program and condom distribution efforts in DC public high schools.

Recommendation #3: We ask that the Committee direct DOH to resume annual collection and reporting of teen pregnancy data including the number of pregnancies per 1,000 females aged 15-19 years for District of Columbia residents. By January 31, 2024, DOH shall submit to the Council a progress report on the collection and reporting of data from 2018-2022.

On the sexual health education front, during the past 10 years, YWP has worked closely with DOH (HAHSTA and CHA) to help them implement a range of sexual health programming including sex education, condom distribution, STI and HIV testing, connecting youth to DOH school based clinics, and other work. In 2020 when Covid 19 hit and schools closed, DOH ended it's peer sexual heatlh education programming and funding. DOH stopped certifying youth educators through the Wrap MC program, stopped the condom distribution program in schools, stopped STI and HIV testing in the schools, stopped doing sexual health education events (which were part of the Sex Is campaign), and stopped collecting data on teen pregnancy. These responsibilities need to resume. Our youth educators worked remotely during the Covid school closing, still reaching 1000s of youth through instagram and text message and mail order condoms. They disseminated 3,162 health promotion messages via Instagram that directly engaged 11,018 peers and improved the sexual health knowledge of 4,003 peers, and made 324 clinic referrals. During the past two year, YWP picked up many of the DOH school-based sexual health responsibilities through our Youth Health Educator Program (YHEP). At this point, we are supplying schools with condoms and safer sex materials, distributing condoms at 16 schools, doing classroom based and one on one sexual health education, and designing and distributing virtual resources to

connect youth to clinics. However, YHEP is program is grant funded and only able to reach part of the school population (10 schools, 40 youth educators). Teen pregnancy rates have not caught up with us since youth relationships became much more phone focused during Covid and have not transitioned back yet. But they will. We need to get in front of the issue.

Why we need school based sexual health and condom distribution: Health educators are a cost effective, high impact program investment that has a profound impact on preventing unwanted pregnancies and improving youth health outcomes:

1. **Peer Educators reduce unintended pregnancies and STIs among teens.** By 12th grade, the majority of DC teens (72% of men, 57% of women) are having intercourse. Youth educators are there to make sure that it happens safely – with decision making support, clinic referrals, and safer sex materials. *Youth are already successfully taking on these roles for sexual health education. For example, i*n 2020, YWP's Youth Health Educator Program (a partnership with DOH and DCPS) trained 267 youth educators who conducted 19,444 one-on-one interventions; answered 1,763 sexual health questions; distributed 81,857 condoms and other safer sex materials; and made 1,244 clinic referrals. DOH need young people to make its pregnancy prevention programs work. The work of these educators has a profound impact on school-based health outcomes, reducing teen pregnancy and STIs, and on the lives of the youth educators who improve their educational success, earn money, and take on leadership roles in their schools and communities.

2. **DOH's sexual health programming (The *Sex Is...* program and WRAP MC) is currently dormant.** The *Sex Is...* program and campaign is no longer doing community outreach and even DC Health's own Youth Advisory Council (DC YAC) is now focused mostly on mental health. On top of that, the Wrap MC Youth Certification Test (certifying youth and adults to distribute condoms in schools) has been down for months. After calling DOH multiple times and requesting for the link to be fixed, our youth were only met with empty promises. School condom deliveries from DOH have stopped. In order to avoid overtaxing nurses and school counselors who are leading some of this work, a revitalized *Sex Is…* program would allow students and teachers to serve as Wrap MCs and meet standards stated in DC's 2009 Condom Availability Policy (*Linked Here*). This program would support a new stream of youth and adult peer educators into DCPS and DCPCS schools who could lead the condom distribution and education work that is falling through the cracks of the current system. Grounded in young development and DC Health's Peer Education Standards (*Linked Here*), the *Sex Is…* program and campaign embodies a more aggressive commitment in delivering

sexual health programs, education, and outreach in DC. Condom distribution and wellness opportunities should be offered at every school, available every day. Youth respondents in our Sexual Health survey stated that they would participate in a range of sexual health education activities including Youth Classroom Presentations (71.8%), Condom Distribution Events (68%), School Assemblies (60.9%), and Youth-Led Afterschool Workshops (53.2%). YWP youth and adult staff would be pleased to work alongside the *Sex Is…* program and campaign team to develop next steps.

3. **Peer educators fill the gaps in school-based sex education**. Within our Sexual Health survey we found that 70.3% of respondents have received 0 Hours and/or No Instruction on Sexual Health this year. This can be seen even within the 2021 DC YRBS (*Linked Here*) report as well, 59.7% of respondents reported that they have not been taught about AIDS or HIV infection in school. Yet, 28.5% of DC youth have had sex to date according to DC's YRBS. DC public schools do not yet have comprehensive sexual health education. The DC Health Education Standards passed in 2016 have not yet been fully implemented. Further, only 12 out of 212 public schools have health-only teachers and most schools are not meeting the legal requirements for health education of the Healthy School Act. YWP Youth educators are filling the gaps. We reached 9,620 youth through *64,132 one-on-one interventions in 2019 and 8,318 so far in 2020.* Youth health educators work to combat negative stereotypes and biases toward marginalized groups, including LGBTQ+ people, creating more positive and inclusive environments in their friend groups, schools, and communities. According to the YRBS DC Report (2017), lesbian, gay, or bisexual (LGB) high school students thought about or attempted suicide and experienced bullying at a significantly higher rate than their heterosexual peers. LGB high school students were also more than 2x more likely to experience teen dating violence. Finally, high school LGB students were 45% less likely to use a condom during their last sex than heterosexual peers. YWP's trainings are comprehensive and inclusive to people of all identities. In turn, YWP's health educators decrease any negative biases they have toward marginalized groups and work to improve inclusivity and respect amongst their peers.

4. ***Peer educator positions provides much needed part time jobs to DC youth. YWP trained and hired more than 1,500 youth in our 10 years of working with DOH on sexual health****. For most of our youth educators, this is their first job and they are eager to get ready for the work force, earn a pay check, and explore health careers.* Youth educators work 4-6 hours a week including 2.5 hours of in-office or virtual training each week and 2.5 hours of field work and receive a stipend that averages $10.50 an hour. Most of our youth are contributing to family bills, pay their phone bills and even buy a week of groceries for their

families. Youth who stay with the program longer, take on more responsibility and receive promotions and raises. Engaging youth as staff (versus volunteers) allows YWP to maintain high performance expectations, deepen work readiness training, and increase youth recruitment and retention rates, and allowing for predictability of attendance. YHEP educators are closely supervised, receive weekly support, and are expected to perform a range of work duties including condom distribution, reproductive health education, and clinic referrals. problems.

5. **YHEP strengthens the health, capacities and life options for our youth educators has a significant positive life impact on the youth educators in the areas of education, work readiness, and own health:** More than 90% of our seniors apply and are accepted into college . None of our youth dropped out of school; none are truant. More than 85 report significant increases public speaking, understanding health care systems, solving community problems, and improving their own health. Participants have demonstrated significant growth in all Adult Preparation Subject areas including: 1) financial management; 2) stress management; 3) time management; 4) college and education readiness; 5) career readiness; 6) goal setting and decision-making. Youth educators received extensive training in sexual health and HIV prevention, peer education, training, counseling, facilitation, adult-youth partnership, project development, data collection, and physical and mental health -- as well as -- work readiness, college prep, and academic strengthening.

6. **Peer educators save DC taxpayers millions of dollars each year in unplanned pregnancy costs.**. The average cost to provide medical and economic support during pregnancy and the first year of infancy is $16,000 per teen birth, according to an analysis conducted by Power to Decide. Peer educators reach thousands of youth, preventing hundreds of pregnancies each year.

7. **Youth Educators have a demonstrated track record as part of DOH's pregnancy prevention work**: Peer educator funding ($100,000) was first placed in the budget by Committee on Health (CM Alexander) in the FY2016 budget and competitively bid. YWP received several grants between 2016-2020 to train & support peer educators, distribute condoms, connect youth to clinics. During this time*, we employed & trained 1,225 youth who reached 40,381 of their peers, distributed 529,053 condoms and made 14,208 clinic referrals.* YWP was awarded $214,000 in a three year grant from in FY2020 through a competitive grant process and have continued to implement the program without interruption. However, this funding was cut by Director LaQuandra Nesbitt in the Mayor's FY2021 DOH budget – the same year that DOH-

HAHSTA was dismantled and school based sexual health work (peer educators, condom distribution, clinic referrals, STI testing) ended and has not resumed since.

8.

YWP's School-Based Mental Health Programming

YWP's work is organized into two programs. The *Youth Health Educator Program (YHEP)* develops youth as sexual health advocates who work to reduce DC's unintended teenage pregnancy and STI rates through peer education, resource provision, and clinic referral initiation. *During the 8 years of YHEP, we employed 1,475 youth who reached 50,381 of their peers, distributed 659,053 condoms and made 15,208 clinic referrals.* The 2023 YHEP Team, *including 50 youth on the ground in 18 schools,* conducted a Youth Sexual Health Survey, taken by 529 youth across 24 DC High Schools. Last year we engaged 121 youth advocates who reached 11,000 peers and launched Sexual Health Virtual Wellness Centers (VWCs)) that provide comprehensive sexual health information, resources, and services. Working in partnership with DCPS and DC Health, YHEP educators earn $10 an hour, work 4-6 hours a week, and receive extensive sexual health training on topics including peer education, clinic access, STIs, HIV/AIDS, pregnancy, menstruation, reproductive anatomy, healthy relationships, consent, condoms and lube, condom negotiation, hormonal contraception, gender and sexuality, sexual harassment, and adulthood preparation subjects such as communication, conflict resolution, financial management, stress management, time management, college and education readiness, career readiness, goal setting, and decision-making. Peer educators are integrated into classroom health education, serve as resources for school-based health centers, and assist community-based clinics with outreach. *are currently meeting with principals, counselors, and health teachers in 10 schools* mental health solutions *that include expanded mental health education including youth-led sessions, expanded counselor outreach and student engagement, additional data collection, and the development of Virtual Wellness Rooms for Counselors as a way to distribute information.*

T*he *Youth Justice Campaign (YJC) develops youth as advocates and organizers to advance a bold agenda based on the real-life issues, and leverage their power through collective action to improve rights, resources, and accountability. *Our 2022-23 YJC team includes 80 youth in 16 schools working together as part of YWP's Mental Health Campaign, launched in 2019 to strengthen school-based mental health programming, connect youth to services, reduce stigma, and expand access to mental health education. Youth Advocates, work 4-6 hours a week, receive 100+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and then work in our schools to collect data, educate and connect peers to resources, and work with adult leaders to address the youth mental health crisis. In 2023, Youth Advocates completed a 2023 Youth Mental Health Survey (including Disaggregated Results), presented 45 Performance Oversight*

Testimonies. In 2022, we educated 4,000 youth and launched **Student On-line Support (SOS) Virtual Wellness Centers** in 13 schools.

Thank you for your consideration and support. We look forward to working with the Committee on these important issues.

SPACEs in ACTION

Hola Mi nombre es Sonia Orantes soy del Guatemala y tengo 59 anos de los cuales los ultimos 28 anos fueron cuando emigre a este pais llamado el pais de los suenos. Son nacida y creida en republica dominicana y creci tambien a mis 4 hijos junto a mi esposo Israel Baret con el cual hoy ya cumplimos 40 anos de casados.

Para mi el valor mas importante ser responsable y tener mucho respeto, especialmente hacia los ninos.
Soy muy creyente de Dios y gracias a El y mis padres hoy soy la mujer que soy. Otro valor que tiene mucha importancia para mi es mi familia directa, con la cual hemos emegrado juntos.

Los ninos necesitan amor y comprension y nosotras las maestras sabemos que estan muchas horas con nosotros entonces la responsabilidad que tenemos y sentimos nosotros por ellos todos los dias, ya que sus padres los dejan aqui confiando en nosotras, por eso mis valores son responsabilidad y respeto y eso es lo que yo ensene en casa tambien.

Estos programas de Healthy Steps, Healty futures son muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación de estos programas de prevención e intervención temprana de DC
Tambien Home visit que es importante aumentar los fondos para
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También solicitamos que los $ 500,000 para los programas de visitas domiciliarias de DCHealth que DC Health eliminó recientemente del presupuesto de un programa para el año fiscal 2023 continúen invirtiéndose en servicios de visitas domiciliarias en el Distrito.

Gracias, miembros del concejo, por escuchar mi testimonio.

Sonia

SPACEs in ACTION

Buenos días miembros del consejo,

Mi nombre es Mercedes Ferreira.

Soy hija, madre, hermana, amiga, maestra de educacion temprana, soy de Santo Domingo vine a Washington DC el 84, mis hijos fueron a la escuela aqui,

Mis valores son la sinceridad y la familia
Estos valores me importan o se alinean con lo que soy porque si tu familia tiene fortaleza puedes lograr todo, si tienes buenas amistades como tu familia estas rodeada de amor y apoyo. Yo soy una persona que me gusta la sinceridad, y pienso que es la base perfecta para poder tener buen cimiento para las amistades y la familia

Yo llegue a este pais en el 84, me case tuve hijos, logre sacar mi CDA y empeze a trabajar en un centro con ninos pequenos y me encanta
Cada dia que estoy con los ninos me llenan de alegria, me gusta mucho verlos sonreir, jugar comer, ver la ternura, como aprenden y ser parte de su dia y de su vida.
Cuando tengo dias grises ellos me levantan el animo

A mi me gustaria que piensen en los ninos especiales, ellos necesitan mas atencion, dedicacion y las familias de ellos tambien, yo entiendo porque yo pase por eso con mi primer hijo, y entiendo que los padres no quieren aceptar y es dificil hacerlo.
Pero en el momento que aceptamos que nuestro nino es especial recien podemos ayudarlos, cuando estamos en negacion no los ayudamos, mas bien los perjudicamos

Las educadoras podriamos tener capacitaciónes para poder ayudar a estos ninos y padres
Con capacitaciones nosotras poder ayudarlos de mejor manera
Por eso son buenos los programas como Healthy Steps, Healty Futures, HomeVisiting
Ayudan a los padres a los ninos con intervension temprana

SPACEs in ACTION

Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias por darme su tiempo
Mercedes Ferreira

Good morning council members,

My name is Mercedes Ferreira.

I am a daughter, mother, sister, friend, early education teacher, I am from Santo Domingo, I came to Washington DC in 1984, my children went to school here,

My values are sincerity and family
These values matter to me or align with who I am because if your family has strength you can achieve everything, if you have good friends like your family you are

surrounded by love and support. I am a person who likes sincerity, and I think that it is the perfect base to be able to have a good foundation for friendships and family

I came to this country in 1984, got married, had children, managed to get my CDA and started working in a center with small children and I love it.
Every day that I am with the children they fill me with joy, I really like to see them smile, play eat, see the tenderness, how they learn and be part of their day and their life.
When I have gray days they cheer me up

I would like you to think about special children, they need more attention, dedication and their families too, I understand why I went through that with my first child, and I understand that parents do not want to accept and it is difficult to do so.
But the moment we accept that our child is special, we can only help them. When we are in denial, we do not help them, rather we harm them.

The educators could have training to be able to help these children and parents
With training we can help them in a better way
That's why programs like Healthy Steps, Healthy Futures, HomeVisiting are good
Help parents to children with early intervention

Healthy Steps, Healthy futures is very important to our communities for our children, nephews, grandchildren, and neighbors I think they should continue to support maintaining funding for two of DC's successful early intervention and prevention programs
Also Home visited is essential, we ask to increase funds for
CFSA and DC Health have an overall $1 million increase in existing home-visiting grants at DC Health and CFSA
We also request that the $500,000 for DCHealth home visiting programs that DC Health recently removed from an FY 2023 program budget continue to be spent on home visiting services in the District.

Thanks for giving me your time.
Mercedes Ferreira

Good morning/afternoon Councilmember **Henderson** and committee members.

My name is Karissa Warren. I am a parent, I work in school nutrition, and I am a member of SPACE's In Action.

My testimony today will focus on supporting the DC Healthy Steps Program. I have always believed in helping others and making sure all kids have a fair chance in life, which is why the Healthy Steps Program is so important.

My daughter, Leila, is the reason behind almost everything I do. Her wellbeing is my first priority. I come from a lower middle class family, and my parents weren't always able to provide everything I needed on their own. I want to make sure my daughter, and all kids, have the best chance to succeed, and that is why we need programs like Health Steps.

The money's there, it's just about allocating it to the right programs. And if we need to raise revenue, raising taxes on wealthier people who can afford to pay higher taxes is the right solution so we can fund a good program that changes people's lives. Lower income families need it, and the resources are there.

The next action step should be to maintain funding for the DC Healthy Steps Program. Continued funding for Healthy Steps will ensure more families can be served and benefit from this successful birth-to-three program.

Thank you, Councilmember Henderson and committee members, for hearing my testimony.

SPACEs in ACTION

Buenos dias miembros del Consejo

Mi nombre es Rosa Pelaez

Buenos dias mi nombre es Rosa Pelaez soy hija, hermana, madre, inmigrante, soy Cristiana y soy parte de la comunidad en Washington DC hace muchos años.
Tengo 5 hijos, mis hijos van a las escuelas aqui, mi iglesia, mis amigos y familia estan en Washington DC.

Mis valores son mi Fe y mi familia, son el motor de mi vida, gracias a Dios puedo estar aqui y disfrutar a mi familia. Por mi fe y mi familia soy quien soy, y me gusta ayudar a los demas.

Yo soy duena de un Homedaycare y como maestra de ninos en la primera infancia, es algo que me apasiona, los ninos son el futuro de este pais y si yo puedo poner un granito de arena para que estos ninos tengan un mejor futuro, yo me siento feliz de poder tener la oportunidad de hacerlo.

Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias por su tiempo
Rosa Pelaez

SPACEs in ACTION

Good morning Council members

My name is Rosa Pelaez.

Good morning, my name is Rosa Pelaez, I am a daughter, sister, mother, and immigrant, I am a Christian and I have been part of the community in Washington DC for many years.
I have 5 children, my children go to school here, my church, my friends and my family are in Washington DC.

My values are my Faith and my family, they are the engine of my life, thank God I can be here and enjoy my family. Because of my faith and my family I am who I am, and I like to help others.

I am the owner of a Homedaycare and as an early childhood teacher, it is something that I am passionate about, children are the future of this country and if I can do my bit so that these children have a better future, I will I am happy to have the opportunity to do so.

Healthy Steps, Healthy futures is very important to our communities for our children, nephews, grandchildren, neighbors I think they should continue to support maintaining funding for two of DC's successful early intervention and prevention programs
Also Home visited that it is important to increase funds for
CFSA and DC Health an overall $1 million increase in existing home visiting grants at DC Health and CFSA

We also request that the $500,000 for DCHealth home visiting programs that DC Health recently removed from a FY 2023 program budget continue to be spent on home visiting services in the District.

Thanks for your time
Rose Pelaez

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Vicenta Brito
Soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Soy de Republica Dominicana llevo aqui 3 anos, mis hijos estan grandes y trabajo con ninos y me gusta mucho
Mis valores la honestidad, ser responsable, la veracidad, el respeto todo esto influye en mi vida personal, me asegure de ensenarles a mis hijos que tengan estos valores y tambien trato de ensenarles a los ninos en el centro donde trabajo gracias a esto soy una mujer de bien.

Apoyando El programa de intervencion temprana Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Vicenta Brito

SPACEs in ACTION

Buenos días miembros del concejo,

Mi nombre es Yessenia Aguilar y desde la escuela secundaria ya queria estudiar algo con ninos especialmente con los edad temprana. Soy naida y criada en Washington DC. por mis padres mexicanos.

Los valores más importantes en mi vida son mis padres que se sacrificaron mucho para darme educacion en este pais. Otro valor muy importante es la educacion y principalmente la educacion temprana.

El respeto hacia los demás y hacia mi misma, El amor, la solidaridad, la voluntad para hacer las cosas, la gratitud por todo lo que Dios me brinda cada día, la Responsabilidad, la empatía entre otras cosas más.

Para poder seguir los estudios uno necesita estudiar y seguir preparandose para que ellos tengan una mejor educacion ya que cuidar ninos no es una tarea facil y cada nino es unico.

El cuidado infantil es un componente esencial de la vida de las familias y empresas del Distrito. No habrá oportunidad de remodelar DC atrayendo y reteniendo familias jóvenes sin cuidado infantil asequible. La educacion es un derecho de cada niño.
Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Yessenia

Gracias, miembros del concejo, por escuchar mi testimonio.

SPACEs in ACTION

Mi nombre Sandra Benitez y no tengo hijos todavia. Soy muy joven todavia y tengo poca experiencia con ninos ajenos pero eh cuidado a muchos sobrinos, primos y otras relacionados con mi famila directa y ahi me di cuenta que criar de ellos seria el futuro de mi carrera.

Mis valores mas importantes son mi familia ya que somos de El Salvador y considero que todas las familias necesitan ayuda especialmente cuando hablamos de educar a ninos que seran el futuro de este pais.

Estoy aprendiendo como asistente y pronto sere maestra ya que estoy estudiando. La educacion temprana es muy importante y seguir estudiando tambien pero es bien dificil ya que los sueldos son los mismos y los gastos aumentan sin medidas. Vivir en esta pais es bien caro tambien entonces si los sueldos no suben y los gastos aumentan muchas veces a las maestras nos toca irnos a buscar trabajo a cualquier lado, con tal de poder cubrir los gastos del hogar. Estamos educando para un mejor futuro.

Como Educadora se que la intervencion temprana es importante por eso pienso que Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.
Sandra

SPACEs in ACTION

Mi nombre es Vanesa Castro soy del El Salvador y vine a este pais cuando tenia 10 anos y pude terminar la escuela y graduarme en este pais. Ahora tengo la bendicion de ser mama hace 8 meses y entiendo mas aun lo dificil que es crecer a ninos saludables y educados principalmente con muchos valores. Comence a un ano a cuidar a los ninos y estoy pasando mis clases del CDA para poder seguir avanzando en la vida

Mi famila a sido muy religiosa y estricta y creo que como todo en la vida tiene que haber un balance. Creo que si mi hijo crece en la iglesia catolotica ya que eso te hace una mejor persona y te hace pensar mucho
Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.
Vanesa Castro

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Gildy.
Soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.

Mis valores son mi Fe, mi familia, mi fe me llena el alma y me hace feliz ayudar a los demas, como venimos a este pais generalme solos la fe es importante, mi familia es todo para mi, la motivacion de ser mejor todos los dias, de salir adelante, doy gracias a Dios de pueder estar aqui y disfrutar a mi familia.

Estos valores me importan o se alinean con lo que soy porque por mi fe y mi familia soy quien soy, y me gusta ayudar a los demas.
Estoy muy feliz porque mi familia me apoyaron para que yo siga estudiando, mi esposo se quedaba con mi hija para que yo saliendo del trabajo vaya a estudiar, soy educadora de educacion temprana y me gusta mucho mi trabajo, los ninos son el futuro de del mundo.

Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Gildy Mendez

SPACEs in ACTION

Good morning council members

My name is Gildy.
I am a daughter, sister, mother, friend, woman, and part of the community in Washington DC.

My values are my faith, my family, my faith fills my soul and makes me happy to help others, since we come to this country generally alone, faith is important, my family is everything to me, the motivation to be better every day. days, to get ahead, I thank God that I can be here and enjoy my family.

These values matter to me or align with who I am because of my faith and my family I am who I am, and I like to help others.
I am very happy because my family supported me so that I could continue studying, my husband stayed with my daughter so that I could go study after work, I am an early education educator and I really like my job, children are the future of the world.

Healthy Steps, Healthy futures is very important to our communities for our children, nephews, grandchildren, neighbors I think they should continue to support maintaining funding for two of DC's successful early intervention and prevention programs
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CFSA and DC Health an overall $1 million increase in existing home visiting grants at DC Health and CFSA

Thank you council members for listening to my testimony.

Gildy Mendez

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Yesenia Zelaya soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Mis valores son mi Fe y mi familia gracias a estos valores soy la mujer de hoy la fe nos une, nos hace mejores personas, y la familia es lo mas lindo que puedes compartir con ellos tus felicidades, tus triunfos y debemos ensenarles valores.
Soy casada llevo 3 anos en este pais mi hija va a la escuela en DC y tengo un bebe, mis hijos son la luz de mis ojos, me siento tan agradecida de poder estar con ellos.

Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

SPACEs in ACTION

Good morning council members

My name is Yesenia Zelaya, I am a daughter, sister, mother, friend, woman, and I am part of the community in Washington DC.
My values are my Faith and my family thanks to these values I am the woman of today faith unites us, makes us better people, and family is the most beautiful thing that you can share with them your happiness, your triumphs and we must teach them values.
I am married I have been in this country for 3 years my daughter goes to school in DC and I have a baby, my children are the light of my eyes, I feel so grateful to be able to be with them.

Healthy Steps, Healthy futures is very important to our communities for our children, nephews, grandchildren, neighbors I think they should continue to support maintaining funding for two of DC's successful early intervention and prevention programs
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Thank you council members for listening to my testimony.

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Vilma Mendez y soy madre de 2 hijos de 25 y 19 anos de los cuales estoy muy orgullosa. Soy nacida en El Salvador y llegue hace muchos anos con la ilusion de crecer a mis hijos con mas oportunidades.

Los valores más importantes en mi vida son mi familia y la iglesia cristiana, ya que combinando esos dos lugares puedo tambien ayudar mejor a desempenarme en mi trabajo ya que es ahi donde yo puedo aplicar los valores que son tan importantes para mi. Me quede cuidando de ellos hasta los 5 anos y luego volvi a trabajar

Yo comence cuidando ninos en la iglesia y ahora amo ser maestra de educacion temprana y me gusta mucho porque puedo poner mi granito de arena ayudando, ensenando a los ninos y asi ellos tener un futuro mejor.

En mi trabajo sabemos que todo a la edad temprana es bueno y intervencion temprana es muy buena los programas de Healthy Steps, Healty futures son muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en estos programas de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.
Vilma Mendez

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Julia Bermejo soy mujer, hija, madre, latina y parte de la comunidad en DC.
Soy de Mexico llegue a este hermoso pais el 80, en este momento soy divorciada tengo 4 hijos, y tengo la custodia de mi nieto al que quiero mucho
Soy una mujer luchadora, independiente de fe, trabajar con los ninos me da fuerza, me da alegria verlos como aprenden, como son dulces.
Tengo la bendicion que mi nieto puede venir al centro donde trabajo, la educacion temprana es tan importante, todos los ninos deberian tener acceso a esto, asi estan listos para la escuela.
Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Julia Vermejo

SPACEs in ACTION

Mi nombre es Sulyn Jiron soy de El Salvador y llegue hace muchos anos a este pais.

Hace poco tiempo volvi a reencontrarme con Dios y eso hizo que mis 3 hijos vuelvan a conectarse con El tambien y eso me da mucho valor a mi ya que encontrarnos con el hace que seamos mejores personas.

Mis valores son la familia y mi nueva comunidad de la iglesia en la cual puedo sentirme apoyada para crecer hijos mas sanos y que sean personas de buena Fe.

Yo soy madre, hija, esposa y una gran trabajadora para este pais, por eso estoy feliz con el bono que nos dieron, ya que con eso podre hacer muchas cosas importantes que tengo en mi vida. Ellos son mi fuente de mayor inspiracion y por ellos doy la vida.

Se que la prevencion y intervencion temprana son de lo mejor por eso Healthy Steps, Healty futures son importantes para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Sulyn

SPACEs in ACTION

Mi nombre es Maria Cruz soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Yo soy de El Salvador tengo 9 anos en este pais, y muy feliz de estar aqui
Yo trabajo en el la noche para poder cuidar a mi hijo durante el dia.
La educacion temprana es muy importante para los ninos yo tengo un nino y por el momento yo lo veo porque quiero disfrutarlo lo mas que pueda
Mi nino cuando estaba pequeno, lo revisaron por que no hablaba, mas bien no necesitaba pero estoy programas son muy buenos para la comunidad, soy una ayuda para los padres, debemos apoyar, Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.
Maria Cruz

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Leticia Gordillo,soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Los mejores valores son una buena educacion, si la educacion temprana es con amor y se le da buenos valores, por ejemplo: responsabilidad, paciencia, ayudar al prójimo y muchos otros mas
Con esto tendremos unos buenos jovenes, que respeten que ayuden, yo en mi hogar se lo enseno a mis hijos, estos valores son los que los llevaran a un buen camino.
Soy nacida en Mexico, tengo 3 hijos, llevo como educadora 4 anos y sigo con las capacitaciones que necesito para mejor en mi trabajo.

Me gustaria tener mas acceso a capacitaciones, para poder aprender mejores maneras de ensenar a los ninos de mejor calidad y diferentes maneras.
Yo estoy muy feliz que me dieron el bono, nos ayudo mucho, tambien nos sentimos valoradas con ese incentivo.
Hay muchos temas que se deben de hablar como los salarios de las educadoras y seguro medico,

Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.
Leticia Gordillo

SPACEs in ACTION

Good morning council members

My name is Leticia Gordillo, I am a daughter, sister, mother, friend, woman and I am part of the community in Washington DC.
The best values are a good education, if early education is with love and good values are given, for example: responsibility, patience, helping others and many others.
With this we will have some good young people, who respect that they help, in my home I teach it to my children, these values are what will lead them to a good path.
I was born in Mexico, I have 3 children, I have been an educator for 4 years and I continue with the training I need to improve my job.

I would like to have more access to training, so I can learn better ways to teach children in better quality and different ways.
I am very happy that they gave me the bonus, it helped us a lot, we also feel valued with that incentive.
There are many issues that should be discussed such as the salaries of educators and health insurance,

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Thank you council members for listening to my testimony.
Leticia Gordillo

SPACEs in ACTION

Mi nombre es Maria Gomez y soy nacida aqui pero mis padres son de Mexico.

Hace poco tiempo volvi a reencontrarme con Dios y eso hizo que mis 3 hijos vuelvan a conectarse con El tambien y eso me da mucho valor a mi ya que encontrarnos con el hace que seamos mejores personas.

Mis valores son la familia y mi nueva comunidad de la iglesia en la cual puedo sentirme apoyada para crecer hijos mas sanos y que sean personas de buena Fe.

Yo soy madre, hija, esposa y una gran trabajadora para este pais, por eso estoy feliz con el bono que nos dieron, ya que con eso podre hacer muchas cosas importantes que tengo en mi vida.
Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.
Maria Gomez

SPACEs in ACTION

Mi nombre es Eugenia Hernandez y vivo en Washington Dc hace 16 años y fui madre dos veces en esta área.

Mis valores son mis dos niñas y valoro mucho el tiempo con ellas, ya que trato de salir del trabajo a tiempo para poder darles tiempo de calidad y educarlas mejor. Siento que ellas me necesitan cada vez mas, entonces puedo ayudar a muchos niños mas incluyendo a mis propias hijas.

Comencé a estudiar desde el año pasado pero desde que cuidaba a mis hijas ya empecé a estudiar clases de padres, talleres de nutrición y educación temprana asique ahi comence a cuidar unos niños desde mis casa y asi estuve por muchos años, hasta que decidi buscarme un trabajo en un lugar y aprender mas sobre ellos y sus necesitdades especialmente.

Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación de estos programas de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Eugenia

Buenos días miembros del concejo

Mi nombre es Jahayra Venegas
Soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.

Mis valores son más importantes en mi vida son:
El respeto hacia los demás y hacia mi misma, El amor, la solidaridad, la voluntad para hacer las cosas, la gratitud por todo lo que Dios me brinda cada día, la Responsabilidad, la empatía entre otras cosas más.

Feliz me hace despertar cada día y saber que Dios me da otra oportunidad para hacer lo que mas me gusta . Además lo más importante es luchar cada día por conseguir mi título y demostrar a mis hijos que la edad no es obstáculo para no poder seguir adelante.
Hoy en día soy una mujer que lucha por conseguir sus objetivos, que lucha por cumplir sus metas tanto profesionales como personale

Tengo 44 años de edad, soy de Educadora, llevo aquí en Estados Unidos 8 años
Tengo 3 hijos varones el primero tiene 18 años, el segundo tiene 14 y tiene 6 años . Me encanta la cocina, bailar, pasear, cantar, disfrutar del aire libre, pero sobre todo disfrutar de mis hijos.

Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Jahayra Venegas

Good morning council members

My name is Jahayra Venegas.
I am a daughter, sister, mother, friend, woman, and part of the community in Washington DC.

My values are most important in my life are:
Respect for others and myself, love, solidarity, the will to do things, gratitude for everything that God gives me every day, responsibility, and empathy, among other things.

Happy makes me wake up every day and know that God gives me another opportunity to do what I like the most. In addition, the most important thing is to fight every day to get my title and show my children that age is not an obstacle to not being able to move forward.
Today I am a woman who struggles to achieve her goals, who struggles to meet her goals, both professional and personal.

I am 44 years old, I am an Educator, I have been here in the United States for 8 years
I have 3 sons, the first is 18 years old, the second is 14 and he is 6 years old. I love cooking, dancing, walking, singing, enjoying the outdoors, but above all enjoying my children.

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Thank you council members for listening to my testimony.

Jahayra Venegas

SPACEs in ACTION

Mi nombre Evelyn Torres Velasco y tengo hijos en este pais y tambien en el mio que es El Salvador. Tambien tengo mi madre en mi pais la cual necesita ayuda tambien ya que vivimos en un pais muy pobre y con pocas oportunidades, asique hay que trabajar duro por ellos tambien. Uno se viene para aca para mejorar su vida, pero en realidad es todo my dificil si no tienes un social bueno, entonces aca tenemos que comenzar de cero.

Todos creemos que venir a este pais se le solucionan las cosas pero cuando uno se da cuenta lo unico que hace es trabajar y pagar cosas y muchas veces no llegamos a fin de mes porque los salarios nuestros son muy bajitos y a mi toco comenzar de nuevo porque soy madre soltera y un solo sueldo no alcanza para alimentar la familia.

Estoy aprendiendo como asistente y pronto sere maestra ya que estoy estudiando. La educacion temprana es muy importante y seguir estudiando tambien pero es bien dificil ya que los sueldos son los mismos y los gastos aumentan sin medidas. Vivir en esta pais es bien caro tambien entonces si los sueldos no suben y los gastos aumentan muchas veces a las maestras nos toca irnos a buscar trabajo a cualquier lado, con tal de poder cubrir los gastos del hogar, pero tambien nos merecemos esta ayuda. Estamos educando para un mejor futuro.

Debemos apoyar programas de prevencion temprana como Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.
Evelyn

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Maria Marcos
Soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Soy nacida en Mexico, tengo 42 anos, llegue a este pais en el 2002, trabajo en la industria de restaurantes y tengo un hijo.
Cuando mi hijo estaba pequeno yo tenia que llevarlo a un centro para que me lo cuiden y gracias a la profesora que hablo conmigo para decirme que deberia hablar con Early Stage que es un programa que trabajan con los ninos y lo diagnosticaron con autismo, yo agradezco tanto a las que estaban cuidando a mi hijo ya que son como las mamas subtituras cuando nosotras no estamos, y los cuidan con mucho amor y con mucha paciencia, que las profesoras esten pendientes de nuestros hijos, y gracias a eso mi hijo tuvo intervencion temprana y gracias a eso mi hijo esta muy bien ahora
Por eso yo apoyo
Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Maria

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre Elizabeth Ventura, soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.

Mis valores son mi fe, my familia y salir adelante, estos valores la fe la paso a mi familia, ayudar al prójimo, es importante para mi que pasar mis valores a mi familia mis hijos y me encanta poder trabajar con los ninos

Yo soy educadora de educacion temprana y me gusta mucho porque puedo poner mi granito de arena ayudando, ensenando a los ninos tambien pasando un poquito de mis valores, respeto, y otros mas

Estos programas son muy importantes para los ninos que tambien deben ser apoyados ya que son programas de prevención temprana.
Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

SPACEs in ACTION

Good morning council members

My name Elizabeth Ventura, I am a daughter, sister, mother, friend, woman and I am part of the community in Washington DC.

My values are my faith, my family and getting ahead, these values I pass on to my family, helping others, it is important for me to pass my values on to my family, my children and I love being able to work with the children

I am an early education educator and I like it a lot because I can do my bit by helping, teaching the children, also passing on a little bit of my values, respect, and others.

These programs are very important for children who should also be supported as they are early prevention programs.
Healthy Steps, Healthy futures is very important to our communities for our children, nephews, grandchildren, neighbors I think they should continue to support maintaining funding for two of DC's successful early intervention and prevention programs
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Thank you council members for listening to my testimony.

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Any Cruz y son nacida y criada en el Salvador y vine a esta pais a ser parte de la comunidad latina trabajadora de Dc y la principal razon por la que vine a este pais fue porque vivimos en un pais muy pobre y necesitamos ayudar a nuestras familias.

Los valores más importantes en mi vida son mi familia directa como mis hijos estando al lado de ellos y apoyarlos en sus proyectos. Y tambien mi familia del Salvador ya que ellos necesitan de nosotros que estamos aca con mas oportunidades. Por eso una emigra para estos lados.

Me hace feliz saber que hay programas como Healthy Steps, Healty futures son muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación de estos programas de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Any

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Claudia Flores
Soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Soy de El Salvador, llevo mucho tiempo aqui, a mi me gusta trabajar con ninos y gracias a Dios puedo tener la felicidad de trabajar con ninos dia a dia.
Trabajo en educacion temprana y siento que recien nos estan reconociendo un poco el trabajo que hacemos, no maestras de educacion temprana lo hacemos con mucho carino, dedicacion y a mi me gusta mucho poder ayudarles a los ninos aprendiendo, ensenandoles y tambien a las familias.
El bienestar en los ninos y en las familias es muy importante y ayudarlos a llegar a programas que puedan necesitar por eso pienso que Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Claudia Flores

Buenos dias miembros del Consejo,

Mi nombre es Blanca Rodriguez, soy inmigrante, esposa, madre, mujer, amiga.
Yo naci en El Salvador, vine a este pais hace 13 anos, me case y tengo una hermosa hija y soy educadore en Washington DC.

Soy Educadora desde el 2015, cuando empeze con el CDA tenia muchos temores, pero mi sueno es ser profesora, estoy muy felis de haber encontrado organizaciones y programas que me ayudaron a hacer mi sueno realidad, llegar donde estoy y para poder ser la persona y profesional en la que me he convertido.
Me siento feliz de tener la oportunidad que este país me ha brindado.

Mis valores son mi fe, mi familia son lo mas grande que tengo en mi vida,
Gracias a mi fe y a mi familia tengo la paciencia, tengo la fuerza de seguir adelante, de querer ser una mejor persona y poder lograr mis suenos.
Ayudar a otras personas a seguir adelante, que con esfuerzo podemos lograr nuestros suenos.

Soy educadora desde el 2015 mi sueño es ser profesora y gracias a Dios y a mi familia estoy en el proceso de volverme profesora.
Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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el año fiscal 2023 continúen invirtiéndose en servicios de visitas domiciliarias en el Distrito.

Gracias por su tiempo.
Blanca

SPACEs in ACTION

Good morning Council members,

My name is Blanca Rodriguez, I am an immigrant, wife, mother, woman, friend.
I was born in El Salvador, I came to this country 13 years ago, I got married and I have a beautiful daughter and I am an educator in Washington DC.

I have been an Educator since 2015, when I started with the CDA I had many fears, but my dream is to be a teacher, I am very happy to have found organizations and programs that helped me make my dream come true, to get where I am and to be the person and professional that I have become.
I am happy to have the opportunity that this country has given me.

My values are my faith, my family are the greatest thing I have in my life,
Thanks to my faith and my family, I have the patience, I have the strength to keep going, to want to be a better person and to be able to achieve my dreams.
Help other people to move forward, that with effort we can achieve our dreams.

I have been an educator since 2015, my dream is to be a teacher and thanks to God and my family I am in the process of becoming a teacher.

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Thanks for your time.
White

SPACEs in ACTION

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Cecilia Romero soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Yo soy de El Salvador llevo muchos anos aqui, tengo hijos que ya estan grandes, como
Mis valores son la fe, my familia, con la fe llegamos a ser buenas personas, ayudamos al proximo y eso es les benceno a mis hijos, nieto.
Estos programas son muy buenos porque como madre se que es pasar por estas cosas, a mi hijo lo ayudaron bastante cuando esta pequeno y gracias a eso ahora el esta bien por eso Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Cecilia Romero

Mi nombre es Benita Polanco Baret.

Hola Mi nombre es benita Polanco Baret tengo 58 anos de los cuales los ultimos 28 anos fueron cuando emigre a este pais llamado el pais de los suenos. Son nacida y creida en republica dominicana y creci tambien a mis 4 hijos junto a mi esposo Israel Baret con el cual hoy ya cumplimos 40 anos de casados.

Para mi el valor mas importante es DIOS gracias a El y mis padres hoy soy la mujer que soy. Otro valor que tiene mucha importancia para mi es mi familia directa, con la cual hemos emegrado juntos y seguimos creciendo la familia junto a mis 12 nietos que estan creciendo en el are metropolitana.

Tanto Dios como mi familia tienen la misma importancia ya que desde nina creci en el campo y comece a ir a la iglesia desde mis 11 anos y cuando me sente a hablar con El pude comprender lo que la palabra AMOR y hasta el dia de hoy eh seguido con esos valores religiosos con mi familia y comunidad.

Aplique por primera vez a Medicaid luego de trabajar por 19 anos en la libreria del consejo y luego la ley cambio y me despidieron inventando noticias de que el gobierno esta decayendo y me sacaron de mi puesto.
Luego en 30 de septiembre del 2013 y me quitaron el seguro medico por ninguna razon y por no hablar bien el ingles ni conocer bien el sistema electronico entonces lo deje solamente.

En el ano 2013 luego aplique para CARITAS y me lo aprobaron ya que tenia un trabajo de medio tiempo y con eso podia recibir algo de ayuda medica. Despues de 3 anos comence trabajando mass horas y lamentablemente perdi mi cobertura llamada CARITAS, y luego de una par de meses llego COVID y tuve que volver a aplicar. En agosto 2020 tuve una cita y recien ahoa confirme que no tenia seguro y me dejaron en espera por varios meses hasta que concrete con mi poliza y finalmente me aprobaron el dia 9 de Agosto del ano 2021 y recien ahora pude hacerme ver con los medicos para saber cual era mi estado de salud.

SPACEs in ACTION

Yo creo que lo mas importante aqui es estar unido y no tener miedo
Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
Tambien Home visit que es importante aumentar los fondos para
CFSA y DC Health un aumento general de $1 millón en las subvenciones existentes para visitas domiciliarias en DC Health y CFSA
También solicitamos que los $ 500,000 para los programas de visitas domiciliarias de DCHealth que DC Health eliminó recientemente del presupuesto de un programa para el año fiscal 2023 continúen invirtiéndose en servicios de visitas domiciliarias en el Distrito.

Gracias por su tiempo

Benita Polanco

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Marta Martinez soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.

Mis valores son la fe, ser paciente, la familia, estoy valores que me inculcaron mi familia me hacen quien yo soy hoy y quiero que mi hija sea una buena mujer en el futuro es importante la educacion temprana,ya que es el momento donde podemos ensenarle a los ninos pequenos buenos valores, apoyando a los padres en lo que se necesitan con lo de educacion.
Tengo una nina que ahora esta en la escuela en DC, yo llevo 7 anos que soy asistente de educacion temprana, disfruto estar ensenandoles a los ninos, son tan dulces, en alguin momento mas adelante me gustaria continuar mis estudios.
Los pagos de los maestros, educadores son muy bajos me gustaria pedirles que vean como nuestros pagos no alcanzan, seria muy bueno que con toda la responsabilidad que tenemos de ensenar, cuidar y criar los pagos sean mejores

Para los ninos y los padres estos programas deben ser apoyados Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Maria Martinez

SPACEs in ACTION

Good morning council members

My name is Marta Martinez, I am a daughter, sister, mother, friend, woman, and I am part of the community in Washington DC.

My values are faith, being patient, family, these values that my family instilled in me make me who I am today and I want my daughter to be a good woman in the future. Early education is important, since it is the moment where we can teach young children good values, supporting parents in what they need with education.
I have a girl who is now in school in DC, I have been an early education assistant for 7 years, I enjoy teaching the children, they are so sweet, sometime later I would like to continue my studies.
The salaries of teachers and educators are very low. I would like to ask you to see how our payments are not enough. It would be great if, with all the responsibility we have to teach, care for and raise, the payments are better.

For children and parents these programs should be supported Healthy Steps, Healthy futures is very important for our communities for our children, nephews, grandchildren, neighbors I think they should continue supporting to maintain funding in two of the successful prevention and intervention programs early DC
Also Home visited that it is important to increase funds for
CFSA and DC Health an overall $1 million increase in existing home visiting grants at DC Health and CFSA
We also request that the $500,000 for DCHealth home visiting programs that DC Health recently removed from a FY 2023 program budget continue to be spent on home visiting services in the District.

Thank you council members for listening to my testimony.

Maria Martinez

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Amalia Martinez
Soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Soy de El Salvador llegue aqui el 2014, soy madre soltera, tengo una nina, cuando llegue trabaje en lo que encontre, estoy feliz que termine trabajando con ninos en un centro, me gusta mucho
En donde trabajo tenemos ninos especiales y necesitamos ayuda para poder darles una mejor educacion, para poder ayudarlos en lo que necesitan al igual que a los padres.

Mis valores son tratar de dar carino a los ninos, emocional seguridad, esto tambien esta en mi vida diaria ayudando a nuestra comunidad dando carino, ensenando a los ninos que estan en mi cuidado

Pienso que es triste que trabajando con ninos, ensenandoles, dandoles carino, y todo sea un trabajo que no esta bien pagado, mucha gente me dice que trabajando de limpieza se gana empezando los 25$ la hora y cuidando ninos es el suelo minimo y tenemos que tener CDA, asociado y todo eso para un sueldo minimo
Tenemos que pensar que tenemos que darles tanto a los ninos, somos las madres substitutas, en los centros, y lo hacemos con mucho amor, pero el pago debe mejorar.

Personalmente no conocia estos programas pero al escuchar de que se tratan son de mucho beneficio para nuestras comunidades y me parece que debemos apoyar Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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el año fiscal 2023 continúen invirtiéndose en servicios de visitas domiciliarias en el Distrito.

Gracias, miembros del concejo, por escuchar mi testimonio.

Amalia Martinez

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Benedicta Lenis Canales
Soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Soy nacida en Peru, llevo muchos anos aqui en los USA y mi hija ya esta grande gracias a Dios esta bien.
Yo soy educadora de educacion temprana y me gusta mi trabajo porque puedo estar con los niños y les ensenos valores, educacion Espanol, a cantar me hace feliz verlos sonriendo.
Como educadora es muy importante que traten de subir el sueldo a las educadoras.

Tambien debemos apoyar Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Benedicta Lenis

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Karina Lopes soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.

Mis valores son el respeto es muy importante, para todos, tambien ser independiente, la justicia por todos estoy valoresque me inculcaron soy la mujer luchadora que soy y a diario les digo a mis hijos que deben de ser justos, independientes y respetuosos

Soy Karina soy madre de familia de 3 hermosos hijos varones, casada, soy nacida en El Salvador, trabajo como educadora de temprana edad en DC
En El Salvador tengo una Licenciatura en Relaciones internacionales con posgrado en Educacion
Tuve la oportunidad de entrar a estudiar a UDC lo que es el asociado y me gustaria continuar con estudios para poder ser mejor educadora para los ninos y tambien poder ayudar a los padres para que ellos tambien puedan ensenar a sus ninos o simplemente con un consejo de educadora, llevo 3 anos trabajando con los ninos y es muy lindo poder ser parte de los ninos en los primeros momentos donde aprenden tantas cosas.
Los rangos salariales que hay en las Educadoras de Educacion Temprana no me parece justo, porque estamos ganando lo minimo y los cosineros ganan $26 la hora y nosotras como maestras con la responsabilidad con los ninos, debemos prepararnos, para poder enseñarles, cuidarlos, estar con ellos de la mejor manera con mucha pasiencia y carino.
Personalmente yo estoy aqui por amor a los ninos porque en otros trabajos se puede ganar mas.
Me parece que Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.

Karina Lopez

Good morning council members

My name is Karina Lopes, I am a daughter, sister, mother, friend, woman, and I am part of the community in Washington DC.

My values are respect is very important, for everyone, also to be independent, justice for all I am values that they instilled in me I am the fighting woman that I am and every day I tell my children that they must be fair, independent and respectful

I am Karina, I am the mother of a family of 3 beautiful sons, married, I was born in El Salvador, I work as an early childhood educator in DC
In El Salvador I have a Bachelor's Degree in International Relations with a postgraduate degree in Education
I had the opportunity to enter UDC to study what the associate is and I would like to continue with studies to be a better educator for children and also to be able to help parents so that they can also teach their children or simply with advice from Educator, I have been working with children for 3 years and it is very nice to be able to be part of the children in the first moments where they learn so many things.
The salary ranges that exist in the Early Education Educators do not seem fair to me, because we are earning the minimum and the cooks earn $26 an hour and we, as teachers with responsibility for the children, must prepare ourselves, to be able to teach them, take care of them, be with them in the best way with a lot of patience and affection.
Personally, I am here for the love of the children because in other jobs you can earn more.
I think Healthy Steps, Healthy futures is very important to our communities for our children, nephews, grandchildren, neighbors I think they should continue to support maintaining funding for two of DC's successful Early Intervention and Prevention Programs
Also, Home Visiting that it is important to increase funds for

CFSA and DC Health an overall $1 million increase in existing home visiting grants at DC Health and CFSA
We also request that the $500,000 for DCHealth home visiting programs that DC Health recently removed from a FY 2023 program budget continue to be spent on home visiting services in the District.

Thank you council members for listening to my testimony.

Karina Lopez

COMMITTEE ON HEALTH
BUDGET OVERSIGHT HEARING ON
the Department of Health
Wednesday, April 10, 2023, at 9:00 a.m.
Annisha Marie Perry Testimony

My name is Annisha Marie Perry. I'm a sophomore at Anacostia High School and a youth organizer with Black Swan Academy. I'm testifying for low barrier programs, confidential mental health screenings, mandatory therapists - and non mandated reporters, and access to varying mental health and well-being services. I think there should be more social workers in schools and also having different counselors in schools, not just having one of the two focusing on everything at once. I also think there should be more social workers in schools so kids could have more time to talk with them. Since I was in elementary I've had social workers, I've always only really had 30 minutes with them & everything I had going on was never always said. I'm now in the 10th grade because I never had that much time with them. I just shut down and tell them there's nothing going on because I feel like it's a waste of time and I can't get everything out, also when I need them the most they're always busy. Because I started to shut down in middle school I was going through so much & I began to cut myself. I am now 16 in highschool and I still cut myself, Im now in highschool and developed anger issues. I get so angry and don't know how to control it because I feel like my social work doesn't have time. I just recently told her about me getting r*ped and the toxic/abuse household hold I'm in but I still push it to the side with her and don't talk about it. IMagine if I go through this or feel this way think about how other youth that's not speaking up feel. I feel like social workers sometimes don't have enough time to get to the bottom of the problem so I feel like it's a waste of time. Imagine how many youth feel this way! Also youth that have a certain healthcare is not able to get a social worker that is inexcusable. Any youth in any school should be able to access a social worker! The decrease in youth mental health and the caretaker is ridiculous! According to the NCS, the most prevalent mental illnesses among children were anxiety disorder (32 percent), behavior disorders (19 percent), mood disorders (14 percent) and substance use disorders (11 percent). People with medicaid cannot access treatment for their mental health, mental access for treatment for any insurance should be available because some people cannot afford other insurance. For DC children enrolled in medicaid managed healthcare organizations (MCOs), nearly all (88 percent) of those with a diagnosed mental health disorder did not receive treatment for it in fiscal year 2010. US Youth are mentally struggling. US Youth are screaming for help silently. And there's not enough social workers to hear our cries so I'm speaking of how US youth increase our social workers and decrease the rate of youth dying!

Thank you for listening to my testimony and hearing my concerns.

SPACEs in ACTION

Buenos días miembros del concejo

Mi nombre es Ana Coto soy hija, hermana, madre, amiga, mujer y soy parte de la comunidad en Washington DC.
Estoy en este pais hace 18 anos, soy separada tengo dos hijos varones ya mayores.
Cuando llegue a este pais llenos de eportunidades pude trabajar cuidando ninos que me gusta mucho, me llevo muchos anos hacer mi CDA pero lo logre y hace 4 anos trabajo en un centro donde puedo estar haciendo lo que me gusta, estar con los ninos, ensenarles las letras, colorear, cantar y muchs otras cosas mas.
Me gusta saber que soy parte de la buena crianza de los ninos que son el futuro del mundo
Soy una mujer que aprendi a ser independiente con dedicacion y mucha pasiencia gracias a esto estoy donde estoy y pude lograr lo que logre asta este momento, mi fe siempre esta conmigo ya que se que Dios esta siempre conmigo
La intervencion temprana Healthy Steps, Healty futures es muy importante para nuestras comunidades para nuestros hijos, sobrinos, nietos, vecinos pienso que deben continuar apoyando a mantener la financiación en dos de los programas exitosos de prevención e intervención temprana de DC
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Gracias, miembros del concejo, por escuchar mi testimonio.
Ana Coto

Testimony to the Committee on Health & Chairperson Christina Henderson
For the Budget Oversight Hearing of the Department of Health
Bailey McFadden
Youth Advocate, Young Women's Project
April 10, 2023

Hello Chairwomen Henderson and members of the Committee on Health. Thank you for the opportunity to testify today. My name is Bailey McFadden and I am a Ward 5 resident. I'm 15 years old and a sophomore at School Without Walls. I have been a Youth Health Peer Educator with the Young Women's Project since August 2022. YWP develops youth leaders and supports our work to solve community problems. I am testifying today to share the work that I've been doing as a peer health educator and to encourage you to restore funding to the Department of Health FY 2024 budget that will support sexual health education and condom distribution in high schools.

The Youth Health Educator Program (YHEP) is important because teenagers are more likely to reach out to their peers for sexual health education and resources. This program arms us with extensive education so that we can spread that knowledge into our communities. YHEP educators hit the ground running in person in 15 schools on 9.20.21 and have already reached 1000s of youth with vital information, distributed thousands of condoms and connected youth to school-based clinics for sexual health services. However, our work has been hindered. In 2021, DOH removed our school-based sexual health education grant ($213,000) from their budget. We were in year 2 of a 5 year grant. We testified to get it back in and Chairmen Gray said that he would – but he did not, which makes it much harder for us to provide these vital resources.

During my year of working with YWP, I helped develop and distribute our annual sexual health survey, which provides vital information to YWP and my school on the educational needs of the student population. I also distributed sexual health resources to ten or more students a week, while sharing education and answering questions. Overall, I corrected misinformation and broadened the knowledge of my peers on topics such as the laws in DC surrounding sexual health. Currently, I am conducting classroom presentations on birth control, to educate my classmates on their birth control options, and where to access them in DC.

We ask that Council allocate $300,000 within the Department of Health (DOH) HAHSTA budget to issue an RFP for a School-Based Sexual Health Education & Condom Distribution Program that would fund 2-3 organizations to collectively hire and train 165 youth (5 from each of 33 high schools) do one on one and classroom based health education, condom distribution, and connect youth to clinic services in all DCPS and DCPSC high schools with a collective reach of 10,000 youth. We also ask that the Committee allocates $100,000 to support DOH's work to

update and reopen the Wrap MC certification program and condom distribution efforts in DC public high schools, and that the committee direct DOH to resume annual collection and reporting of teen pregnancy data.

Please continue to support us in our mission to educate DC youth. Thank you for your time.

Hello,

My name is Leah Kanzer, I am a resident of ward 4 in DC. I'm extremely disappointed that DC health decided to close its Covid testing centers. I urge the DC Council Committee on Health to keep the COVID centers open until the end of the year because they provide crucial resources to protect DC residents.
According to the CDC, COVID-19 is the third leading cause of death in the United States, despite assertions that the pandemic is over. COVID infections and long COVID are still causing serious illness, disability, and death, which threaten our community's wellbeing.

I unfortunately have a few loved ones whose entire lives have changed due to long covid. They can no longer go to work, do their daily tasks, or spend time with community in the same ways due to their lower lung capacities, chronic pain and unpredictable symptoms. I am doing everything I can to keep my loved ones, with and without long covid, safe but I can only do so much.

The DC COVID Centers have helped to stop the spread by providing free masks and testing. Without these readily accessible resources, it will be difficult for myself and so many other DC residents to keep ourselves and our loved ones healthy. DC has been able to keep your Covid rates low due to these accessible tests and masks. Covid is not over, it is still hurting people across DC and the world.

Please keep the Covid Centers open until the end of the year to keep our people safe.

Thanks for your time,
Leah Kanzer

April 07, 2023

To the DC Council Committee on Health,

Good day, though in such depressing, dystopian times, it really doesn't feel like it. My name's Aodhán Connor-Farrell (first name pronounced like "ae-on") and I'm queer, disabled, low-income community neighbor from NoVA, which is on stolen indigenous Manahoac land, and an organizer who travels and works in solidarity with D.C. communities (which is on stolen indigenous Piscataway and Anacostan lands) in the fight for disability justice. To come before you to testify on a matter of keeping COVID Centers open and operating in D.C. is to speak on a monumental issue regarding accessibility to care, disability justice, and overall human life.

With COVID spreading unchecked, killing almost 400+ more people and 1,400+ new cases reported per day, affecting millions of lives with few treatment options, it's become, like other pandemics before, a public health issue that continues to escalate. We've seen how it's ravaged us, taken our loved ones, and makes us unsafe through the mishandling of the pandemic on all fronts. COVID disproportionately impacts Black, Indigenous, low-income, LGBTQIA+, immigrant, unhoused, elderly and disabled, and many more communities. Our demands are simple: to keep the COVID Centers open and accessible to us all.

Closing the COVID Centers in D.C. will make COVID testing inaccessible for our most vulnerable residents, which can easily lead to spikes in COVID transmissions in our community. During 2022, a clinical trial showed that lack of testing availability leads to increased risk of COVID transmission. If all testing centers close, this will escalate outbreaks leading to more hospitalizations, disablism from Long COVID, and deaths. Fewer testing options mean that it will be more difficult to track infections, hotspots, and overall transmissions in an ongoing pandemic that continues to breed new mutations of variants of the virus.
As of now, we've seen this D.C. government body axe COVID contact tracing programs last summer in July 2022 deeming them "no longer necessary", diminish accessibility, such as remote access, in public spaces with lifting and relaxing mask "requirements" of it being optional rather than required, which translates to "let's not mask and put people at risk". This includes spaces such as public transportation, healthcare facilities, school and workplace grounds, and more as super-spreader events continue to be on the rise following the very eugenist footsteps of D.C. and the CDC's relaxed recommendations and policies. And due to the continued cuts into SNAP Benefits, lack of rent control leading for violent evictions and homelessness, Medicare being under threat that will impact over 15 million people, as more and more have to apply for disability and other social security benefits just to survive on a bare minimum level, and that the Public Health Emergency Funding is at risk to being taken away this May that allows accessibility to free and affordable COVID care; it is egregious to think that cutting centers is a good idea. It's a devastatingly vile concept that contributes to the domino effect of further ableist violence under this capitalist government that will further traumatize people.

An extremely important tool in our arsenal is leaving our city's COVID Centers open and accessible to the public. The more testing centers and options remain available, the better we can protect our city and keep track of infections. In the long term, keeping COVID Centers open will prevent unnecessary transmissions and risky behaviors that put our disabled, marginalized, and immunocompromised community members at risk for hospitalization, death, and disablism that is Long COVID, ME/CFS, and more.
The recorded numbers and forgotten numbers; the very lives and humanity of every person who has passed or become disabled or further disabled, has reached levels that can be also described as genocidal; especially nationwide. This is not okay; bottom line, it's not okay. The collective grief is immeasurable and we need these solutions to keep at it to help us live. Mutual aid work and care webs among communities, especially all marginalized communities, have been the backbone and forefront of our survival during these three years in the on-going pandemic making sure we can still have access to our basic needs. It's not just that we are deserving of care and access- it's our right to have access to free testing, vaccinations, masks and other medical care, to safe environments like clean ventilated air, to be given accessibility and accommodations in work, school and healthcare settings. It's humane to care and give care, and it's inhumane to deny and take away that care.

I know that the current systems can never truly save disabled lives. It can never be in solidarity with the people. But while I still practice hope in standing with communities that are neighbors to me, and are just as part of my community, that doesn't stop us from continuing the work necessary and to demand for our livelihoods, to live, and not be disposed of by eugenist policies and institutions. It's really that simple: COVID is NOT over. In the words of Mia Mingus, I quote

"We will not trade disabled deaths for abled life. We will not allow disabled people to be disposable or the necessary collateral damage for the status quo. We will not look away from the mass illness and death that surrounds us or from a state machine that is more committed to churning out profit and privileged comfort with eugenic abandonment."

In solidarity with the people fighting back to live and thrive against ableist systems and institutions,

Aodhán Connor-Farrell

Testimony to the Committee on Health & Chairperson Christina Henderson
For the Performance Oversight Hearing of the Department of Health
Hanna Floyd
Youth Advocate, Young Women's Project
April 10, 2023

Hello, Chairperson Henderson and council members. I am Hanna Floyd and I am a resident of ward 8. I am a sophomore at Mckinley Technology High School. At the moment I enjoy painting and playing with my cat doja. In the future I want to work in the STEM field specifically, Computer Science. I started at the Young Women's Project (YWP) as a youth peer educator in 2022. YWP develops youth leaders and supports our work to solve community problems. I became a peer educator so that I could share important information on sexual health with my peers. I am testifying today so you are aware of our work and to encourage the restoration of funding to the DOH FY 2024 budget that will support sexual health education and condom distribution in high schools.

YWP gives us a chance to come together and learn about sexual health and share this information with our peers, who often lack accurate knowledge. As a youth educator I love that students can come to me and feel comfortable asking questions, and that I have the answers to help them. Additionally, we work in schools to distribute condoms and raise awareness of the school based clinics for sexual health services. In 2021, DOH removed our school-based sexual health education grant ($213,000) from the budget. We were in the 2nd year of a 5 year grant. We testified on the vital importance of continuing the grant funding and Chairman Gray said he would reinstate the funding – but he did not.

Being a sexual health educator taught me how important it is to be up to date with your health. For example, I learned that most youth were unaware that they could access clinics without their parents permission. I also educate my peers on how important consent is and to get tested in between partners. Currently, I am working on creating a virtual wellness center focused on reproductive health, pregnancy prevention, and general information about sexual services. The Sexual Health Wellness Center is critical because it gives youth access to resources that they may not know are available.

In my school, the distribution of condoms is either via our health teacher or from the nurse's office, which is not well known. We have health class for one semester, which then concludes the rest of our sexual health education. Sexual health resources are important to have at school to prevent not only pregnancies, but also transmission of a STI. Having these resources helps to lower the risk and elevate the opportunities for students to practice safer sex.

We are asking that the Committee allocate $300,000 within the DOH budget to the specific purpose of sex education, clinic referrals, and condom distribution in DCPS and Charter high schools with a goal of reaching 25 schools and 10,000 youth. Peer educators should be engaged as part of this work to increase effectiveness (since adults are not as effective in reaching youth through social media or text messages) and should be paid for their work. Thank you for your time and consideration.

TESTIMONY

Rodney Mackey, Graduate of Friendship Collegiate Academy - 2015
Bachelors in Health Science from Virginia State University - 2020
Masters in Occupational Therapy from University of St. Augustine
in Miami, Florida July 2023

To
DC Committee on Health
Budget Oversight for Department of Health Care Finance
April 10, 2023

Good morning, Chairperson Henderson and members of the committee. My name is Rodney Mackey and I graduated from Friendship Collegiate Academy in 2015, where I was in the Health Sciences Academy and had an internship at Sibley Hospital. I graduated from Virginia State University in 2020 with a Bachelors in Health Science and will complete my Masters in Occupational Therapy from the University of St. Augustine in Miami, Florida in July 2023. I am now working as a clinical assistant at Kaiser Permanente while completing my masters.

I have just learned about plans to lower the age for being a Certified Nursing Assistant (CNA) from 18 to 16. I seriously wish this opportunity had been available to me when I was in 11th and 12th grade in the Collegiate Health Sciences Academy. It was a disadvantage that I did not graduate with a CNA certification.

It would have been such so helpful to me to have this certification under my belt when I was in high school. I could have worked part time in high school and college. And, the certification would have allowed me to get a job faster after graduating from college. Even after I graduated from Virginia State University with a Bachelors degree I was prevented from working at many hospitals because I did not have my CNA certification.

Lowering the age from 18 to 16 will give many different youth who are interested in health care careers the chance to enhance their knowledge in the medical field. They will also have access to jobs while completing their high school and college degrees and will have increased practical experience. Thank you for enabling our students to work in jobs that prepare them for college and careers in health sciences. I support Friendship's position in urging the Council to act quickly to lower the age for CNA certifications from 18 to 16. Attached is the testimony from Friendship Public Charter School.

TESTIMONY
Dianne Harris, Director of Health Services
Friendship Public Charter School
To
DC Committee on Health
Budget Oversight for Department of Health Care Finance
April 10, 2023

Good morning, Chairperson Henderson, and members of the Committee, my name is Dianne Harris and I am Director of Health Services at Friendship Public Charter School (Friendship). Testifying with me is Rodney Mackey who was in the Friendship Collegiate Health Sciences Academy and graduated in 2015. We represent a 15-campus charter that serves 4,600 scholars in Washington, DC, including two high schools with nearly 900 students ages 14 to 18. At Friendship, our rigorous curriculum, exemplary instruction and deep commitment to student advancement have made it one of Washington, DC's top performing charter systems. The Friendship culture is driven by great educators, academic rigors that cultivate curiosity and confidence, and the belief that every child can achieve the highest standards.

One avenue to high standards is a successful high school training program that allows students to test careers that they want to pursue. High school employment in their chosen field enhances students' ability to enter selective colleges in pursuit of that discipline. Friendship is specifically interested in creating opportunities to work in entry level health care jobs as an introduction to future careers in health sciences. In addition to offering students work experience, these jobs offer much needed funds for college.

For example, certification and employment as a Certified Nursing Assistant (CNAs) while in high school can be a launching pad for careers in high demand,

high needs jobs in health care while also providing financial support to help the students get to and through college. We are talking with the University of the District of Columbia about developing a CNA training program at Friendship by spring 2024.

We seek your help with a problem that can be easily fixed and at no cost**.** The minimum age requirement for a CNA is 18. Newly trained CNAs are not eligible to take the certification test until they are 18, when many students have already graduated. The DC Coalition on Long Term Care has proposed amending the Health Occupations Regulations Act (HORA) to reduce the age requirement from 18 to 16 years of age. DC Health supports this change and is working on proposed amendments; their timetable is unclear. We would like this change made soon, so that we can pursue planning for a spring 2024 launch of our CAN training program.

By lowering the CAN age to 16, the Committee on Health enables our students to work in jobs that prepare them for college and careers in health sciences. The change will also address the direct care workforce shortage. Friendship urges the Council to act quickly to make this small but important change to the HORA.

Testimony Before the
Committee on Health
Council of the District of Columbia

Budget Oversight Hearing on
DC Department of Health

Uriyoán Colón-Ramos, Sc.D., M.P.A.
Associate Professor of Nutrition & Global Health
Milken Institute School of Public Health
George Washington University

March 10, 2023

Good morning Chairperson Henderson and members and staff of the Committee. My name is Uriyoán Colón-Ramos, faculty at the Milken Institute School of Public Health at George Washington University. The views expressed in this testimony are my own and do not necessarily reflect the views of GW.

My work focuses on identifying ways to eliminate health inequities by addressing dietary disparities. There is a growing body of evidence that suggests that sugary drink consumption, which is a known risk factor for health inequities, [1] is associated with avoidance of tap water, especially among low-income and minoritized groups, and driven by mistrust of tap water.[2] My research in DC found that we could increase confidence in and consumption of tap water via a low cost water filter, and we saw that as filtered tap water consumption increased, sugary drink consumption decreased among low income families of young children in the larger DC Metro area.[3]

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[1] Hu FB (2013) Resolved: there is sufficient scientific evidence that decreasing sugar-sweetened beverage consumption will reduce the prevalence of obesity and obesity-related diseases. Obesity Reviews: An Official Journal Of The International Association for the Study of Obesity 14, 606- 619. Malik VS, Hu FB (2022) The role of sugar-sweetened beverages in the global epidemics of obesity and chronic diseases. Nature Public Health Emergency Collection 28 (4):205-218. Singh GM, Micha R, Khatibzadeh S, Shi P, Lim S, Andrews KG, Engell RE, Ezzati M, Mozaffarian D, Global Burden of Diseases Nutrition and Chronic Diseases Expert Group (NutriCoDE) (2015). Global, regional, and national consumption of sugar-sweetened beverages, fruit juices, and milk: a systematic assessment of beverage intake in 187 countries. PLOS One 14(3).

[2] Onufrak SJ, Park S, Sharkey JR et al. (2014) The relationship of perceptions of tap water safety with intake of sugar-sweetened beverages and plain water among US adults. Public Health Nutrition 17, 179-185; Pierce G, Gonzalez SA (2016) Mistrust at the tap? Factors contributing to public drinking water mis(perception) across US households. Water Policy 19, 1-12; Huerta-Saenz L, Irigoyen M, Benavides J et al. (2012) Tap or bottled water: drinking preferences among urban minority children and adolescents. Journal of Community Health 37, 54-58; Rosinger AY, Patel AI, Weaks F (2022) Examining recent trends in the racial disparity gap in tap water consumption: NHANES 2011-2018. Public Health Nutrition 25, 207-213.

[3] Santillán-Vázquez C, Hernández L, Reese AC, Burgos-Gil R, Cleary SD, Rivera IM, Gittelsohn J, Edberg MC, Monge-Rojas R, Colón-Ramos U. How providing a low-cost water filter pitcher led Latino parents to reduce sugar-sweetened beverages and increase their water intake: explanatory qualitative results from the Water Up!@Home intervention trial. Public Health Nutr. 2022 Nov;25(11):3195-3203. doi: 10.1017/S1368980022001744. Epub 2022 Aug 19. PMID: 35983682. Use of a Water Filter at Home Reduces Sugary Drink Consumption among Parents and Toddlers in a Predominantly Hispanic Community: Results from the Water Up!@ Home Intervention Trial. Reese AC, Burgos-Gil R, Cleary SD, Lora K, Rivera I, Gittelsohn J, Seper S, Monge-Rojas R, Colón-Ramos U.J Acad

This represents an enormous "untapped" opportunity to tout safe tap water consumption and address diet-related chronic disease, with the additional benefits of reducing household expenditures on bottled beverages, [4] and decreasing pollution from single-use plastics, which are a substantial contributor to the District's waste stream.[5]

Further, when a mother chooses a sugary drink over water, this is a preference that has been heavily influenced over time by their experience with tap water, and reinforced over and over again by formal and informal communication and marketing in the communities, social systems and structures in which our families live and in which children grow up. Our research identified that reinforcing trust in tap water infrastructure could be a key driver of healthy beverage choice in DC.[6]

For this reason, I propose that the Committee:

(1) Provide funding to align all the messaging between DC Water, DC Health and DOEE. around the District's investments in water infrastructure, touting the benefits of drinking water for residents' health and the environment.
(2) Fund a pilot at DC Health to assess the return on investment of providing low-cost water filters for families participating in the WIC program, especially on diet behaviors, household spending and dollars saved from preventing diet-related chronic diseases in the future.
(3) Finally, the District should normalize tap water as the default beverage by providing appealing and accessible tap water infrastructure by requiring water-filling stations at all District facilities including schools, recreation centers, and libraries.

Together, these recommendations would achieve significant health benefits for children and families in the District of Columbia.

Thank you for the opportunity to testify and I welcome any questions you might have.

Nutr Diet. 2022 Jun 15:S2212-2672(22)00346-X. doi: 10.1016/j.jand.2022.06.006. Online ahead of print.PMID: 35714910

[4] Gorelick MH, Gould L, Nimmer M et al. (2011) Perceptions about water and increased use of bottled water in minority children. Archives Of Pediatrics & Adolescent Medicine 165, 928- 932.

[5] Anacostia Watershed Society, Demonstration of Trash Reduction Technologies in the Anacostia Watershed, October 2010, https://doee.dc.gov/sites/default/files/dc/sites/ddoe/publication/attachments/Nash_Run_TT_Final_Tech_Report_Entire.pdf

[6] Colon-Ramos U, Estrade M, Mui Y, Burgos-Gil R, Witting L, Gittelsohn J. Research Brief: Developing shared systems and policy strategies to sustain an Early Head Start healthy beverage program among Hispanic families of infants and toddlers in the Greater Washington DC area. Jan 2023. (Not published).

Good Morning/ Afternoon Councilmember Henderson and committee members. My name is Deja Williams. I am a Ward 4 DC native and advocate with SPACEs In Action, a member of the U3DC Coalition, Home Visiting Council, and Mary's Center Community Advisory Board Member. Today's testimony will focus on supporting the DC Healthy Steps Program and HomeVisiting for a strong, effective, and connected early childhood system in the District. My Values are family, community, and healthcare. These values matter to me because, as an organizer and advocate for families with babies from birth to three, the health of my community is a top priority to ensure DC families have a healthy start.

During Oversight hearings, I mentioned that while working with families in DC, financial insecurity and the need for access to healthcare and prevention and early intervention services are very real. Family support services available to DC residents at little or no cost, like Healthy Steps and Home Visiting, can be critical lifelines and an opportunity for families to thrive.

We appreciate the District's continued investment in Healthy Steps. The maintained funding for this program will continue to support families with various physical and behavioral health supports and services for themselves and their baby or toddler. We would like the council to maintain this funding in the FY'24 Budget.

Home visiting is another proven effective early childhood service. However, in the past, Home Visiting has yet to receive the appropriate funds to maintain the program. Cuts to Homevisitig in previous fiscal years has made it difficult for the families and the home visitor who rely on this funding. Many home visitors have expressed the need for higher pay. Low wages are causing home visitors to leave their roles for better pay. This causes disruptions with the families they serve because they must be placed with another home visitor. This does two things: it adds more to the Home Visitors' workload and means the family has to gain trust with this new person now. This happens more than it should and could be solved if we addressed the need for more investment in this workforce.

Homevisitors are crucial to the growth of our families in the District. Home Visiting leads to positive family outcomes and reduces child abuse and neglect. This service allows a holistic and preventive approach to support families, their health, and economic well-being. Home visitors support the most underrepresented communities, supporting Adults with disabilities with children and low-income families. These are the frontline workers in the family homes, providing direct assistance to the families. Home visitors show up in more ways than one for these families, and we must invest in them.

The council's next action should be an increase in funding for DC Health Home Visiting programs. We are asking for a $1.2 million increase. This investment will ensure that the Home Visitors receive appropriate funds to serve our community. We also support Medicaid reimbursement for Homevisiting and Healthy Steps program.

Thank you, Councilmember Henderson and committee members, for hearing my testimony. In addition to my testimony, 31 written testimonies will be submitted today from our SPACEs in Action leaders. Thank you for the opportunity to elevate community voices.

Diana Castillo
Testimonio para el Budget Hearing de DC Health
Lunes 10 de abril, 2023

Buenos días miembros del cónsul de DC y el comité de Salud, gracias por la oportunidad de narrar un poco de lo que he vivido en el programa de Nurse Family Partnership. Mi nombre es Diana Castillo. Tengo un año en el programa de NFP. Tengo un linfoma ubicado en el estómago en donde me comentaron que era tratable pero tendría que tomar medicamento por el resto de mi vida. Mientras recibía mi tercera quimioterapia, me di cuenta de que estaba embarazada de 4 meses y 3 días, dónde me preocupaba por mi enfermedad y mi embarazo. Cuando salí embarazada suspendieron la quimioterapia hasta después de 3 meses del parto para seguir en seguimiento del linfoma. Era mi primer embarazo, no sabia donde acudir o quien me podía apoyar con todo lo que necesitaba manejar. Por eso una de las terapeutas me conectó al programa de NFP. No tengo familia cercana y empecé con el programa con la enfermera Magy. Recibí el apoyo de Magy y me sentía bien porque estaba llena de miedos. Al recibir este apoyo me tranquilizo porque sabía que no estaba sola y que alguien más estaba conmigo durante este proceso.

En la primera cita Magy me comunicó que podía confiar en ella para apoyarme. Ella me dijo “tranquila, vamos a ver cómo van las cosas de la salud de tu pequeño y la tuya.” Me dijo que podía confiar en ella 24/7, sentí que tenía el respaldo de Magy. Mi primera preocupación era el idioma. No hablo el inglés y no sabía cómo iba a comunicarme con los doctores o con las enfermeras. Cuando estaba con citas médicas antes de que llegara Magy a veces no conocía los resultados de los exámenes que recibía, ya después con el apoyo de Magy, ella trataba de clarificar lo que no entendía y sentí que podía confiar en que tendría su apoyo para seguir acudiendo a estas citas de los doctores que me mantenían saludable a mi bebe y a mi.

Hasta el día del parto, hacíamos video chat para ver cómo iban las cosas con los doctores. En este punto he visto muchos cambios, Magy me ayuda a avanzar en todas las citas que necesito cuando el lenguaje es barrera. Ella me da mucha información acerca de la salud de mi bebe y la mía; por ejemplo me ha apoyado con saber que comidas empezar a darle ya que mi bebe está listo para incluir los alimentos y también llevar el seguimiento del tratamiento de oncología. Magy, me respaldó en ese entonces porque fue un choque fuerte. Fue una semana en donde tuve que cambiar medicamentos, hacer citas y llevar un estricto control de mi salud ya que estaba pasando por unos días muy difíciles. He tenido muchos cambios desde entonces, pero Magy ha estado a mi lado durante todo estos cambios y avances que resultaron después del parto. Estos días me va mucho mejor. Aún tengo síntomas, pero los he tratado con Magy a mi lado; era mi angelito de guardia que ha hecho tanto por nosotros y mi familia. Antes de llegar Magy no sabía ni qué hacer. En ese tiempo estaba tan confundida que no confiaba que iba a salir adelante con todo este proceso de mi enfermedad y mi embarazo. No se como agradecerle al programa y a la enfermera Magy por estar conmigo siempre y nunca dejarme rendir en esos momentos tan difíciles en mi vida. Ella más que una enfermera fue mi amiga, mi hermana, que siempre fue mi fuerza para seguir luchando.

Mamas primerizas aún enfermas y graves sin estos programas y apoyos estuviéramos desconectadas de los servicios de salud. No sabríamos qué hacer en esta situación, ni cómo manejar todos los cambios de salud. Se que no todos van a querer recibir este tipo de apoyo, pero les prometo que las personas como yo que reciban este apoyo están más conectadas a servicios de salud y por lo cual más saludable. Es importante que estos programas crezcan con la finalidad de ayudar a más mamás primerizas y romper el miedo que nos puede dar cuando nosotros nos damos cuenta que estamos embarazadas. Hoy en día es un reto llevar el programa de NFP a otros hogares pero es un desafío el cual los invito a enfrentar para asegurar que las familias como la mía puedan beneficiarse durante su primer

embarazo. Deberíamos aumentar espacios que sean más orientados para apoyar y concientizar a las mamás de las realidades o los procesos de que se lleva un embarazo normal o de alto riesgo. Gracias al apoyo que me han ofrecido hasta entonces estamos creciendo más allá de nuestros miedos y superando nuestras expectativas y todas las que desean lo mismo merecen recibirlo. Y espero contar con esa ayuda para fortalecer este programa de NFP que es importante para las mujeres latinas y estadounidenses. Gracias por escucharme.

Camila Perez
Community Health Worker / Home Visitor
Mary's Center for Maternal and Child Care, Inc.

Good morning Councilmember Henderson and committee members,

Thank you for the opportunity to testify today. My name is Camila Perez, and I am a Community Health Worker in the Home Visiting department at Mary's Center. As I've shared before, representation is important to me as I work to provide support to families that look like mine and rely on services and support like my family did. It is essential that DC continues to make sustainable investments into Home Visiting to make sure that the workforce can continue to have long-lasting positive impacts in the lives of our neighbors and families in DC. Home visitors, like childcare teachers, have been some of the most dedicated, yet underpaid professionals working with District families and children for years. The competitive labor market has driven many working for underfunded programs to seek higher-paying jobs in other industries.

Well-resourced and well-staffed Home Visiting programs that support families have a significant positive impact on our families with young children and their health outcomes. However, Fox 5 has recently reported that Mayor Bowser has proposed investing $750K for pickle ball courts, maintaining a $7.4M investment to install 342 new automated traffic cameras, and adding $13.3M to support the DMV's increased ticket processing and additional responsibilities. I understand that we want to encourage people to be safe, healthy and active outdoors, but if we're really invested in the health and well-being of residents, better distribution of these funds could improve outcomes for your constituents if they are poured into Social Support Programs that families can access. If the city wants to count on a return on investments in the FY24 budget, according to the National Home Visiting Resource Center, "HV Programs have a return on investment of $1.80 to $5.70 for every dollar spent on home visiting. This strong return on investment is consistent with established research on other types of early childhood interventions." Additionally, the costs associated with poor birth outcomes are high. In 2012, the Planning Council reported that the societal economic cost associated with preterm birth in the U.S. was at least $66,218 per preterm infant. We estimated the total maternal morbidity cost for all U.S. births in 2019 to be $32.3 billion from conception through the child's fifth birthday. This amounts to $8,624 in additional costs to society for each maternal–child pair. Home Visitors improve outcomes for families throughout the perinatal period, and investing in us is investing in DC residents. I would like you to understand that home-visiting programs positively impact the families we serve. By educating our families about child development and healthy family dynamics, we are improving the health outcomes of our community.

HV programs can have improved outcomes for our pts and their children because of the support and resources we provide them with. By ensuring that Home Visiting Programs are funded, and Home Visitors receive thriving wages, we can reduce the interruptions families face when working to access services. Home visiting is an investment in communities – and as councilmember Henderson says "your zip code should not determine your opportunity for success," so by continuing to invest in Home Visiting, we can support families and improve their health and well-being. We request that DC Health restore and increase investments by $1.2M so that FY23 cuts can be restored and $700K can go towards an increase in workforce retention.

THANK YOU.

Medicaid reimbursement funding can sustain home visiting programs long-term.

It is challenging to deliver Home Visiting services successfully when Home Visitors tend to have a high turnover rate due to low wages and high costs of living. Also, not being able to live in the community I serve is frustrating at times as it takes away from the time I can devote to families. These challenges lead to disrupted services to families and overburdens staff. For example, it is taking several months of

outreach to reengage a participant who expressed interest in continuing Home Visiting due to their Home Visitor's departure. Families want to be healthy and well but if the workforce is not supported more departures mean more difficulties in successfully engaging and supporting families with their health.

This total $1.5 million enhancement breaks down into → $1,200,000 for DC Health funding and $300,000 for CFSA funding.

Medicaid funding can sustain home visiting funding in the long-term

For every dollar spent on these efforts, at least $2.00 dollars in future spending is saved. Moreover, the costs associated with poor birth outcomes are high. In 2012, the Planning Council reported that the societal economic cost associated with preterm birth in the U.S. was at least $66,218 per infant born preterm.

We estimated total maternal morbidity costs for all U.S. births in 2019 to be $32.3 billion from conception through the child's fifth birthday. This amounts to $8,624 in additional costs to society for each maternal–child pair.

Maintain the $7.4M to install 342 new automated traffic cameras and add $13.3M to support DMV's increased ticket processing and adjudication responsibilities

Home visiting is cost effective.
Studies have found a return on investment of $1.80 to $5.70 for every dollar spent on home visiting. This strong return on investment is consistent with established research on other types of early childhood interventions.

Mom felt like she could safely explore and share the challenges she was facing with me. This is important because as mom progressed through her pregnancy, complications arose, and I had to provide health education on her gestational diabetes diagnosis. With my support we were able to reiterate the importance of managing her G.D. for her and her baby's health outcomes. When she first realized she needed to manage her G.D(as she was reluctant at first) to manage it because she had a bad experience the first time she learned of her diagnosis, and she did not like needles. Through our conversations, she realized it was vital for her to take ownership of her health during and beyond doctors' appointments that she had previously been ambivalent about. She shared that food insecurity was also making it difficult to make healthier choices. Because she was having a tough time navigating the WIC app, We worked to connect her to a food bank and reviewed the WIC-approved food list so she could self-manage her health better. The mom has been able to take steps in the right direction to make those necessary changes, and I see how proud she is of her efforts. I enjoy celebrating these small victories with her.

Children's National

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ChildrensNational.org

Council of the District of Columbia

Committee on Health

FY 2024 Budget Oversight Hearing:
Department of Health (DC Health)

Testimony of Andrea Boudreaux, PsyD, MPH, MA, FACHE

Children's National Hospital
Monday, April 10, 2023

Good morning, Chairwoman Henderson and members of the Committee, my name is Dr. Andrea Boudreaux, and I am the Executive Director of Children's School Services (CSS), an affiliate of Children's National Hospital. CSS is a school health organization comprised of dedicated health professionals, nurses, and health technicians who work diligently each day to provide the highest quality of health care services to students, families and the communities we serve with compassion, commitment, and sense of connection. For over 20 years, Children's School Services (CSS) has provided school health services for DC Public Schools (DCPS) and DC public charter schools. Thank you for the opportunity to present testimony at the DC Department of Health (DC Health) FY 2024 Budget Oversight Hearing.

First, thank you, Chairwoman Henderson, for your ongoing support to improve student health outcomes and for the introduction of B25-0026, Access to Emergency Albuterol and Glucagon Amendment Act of 2023, which will support student's access to life saving medications. We look forward to working with you and the Committee to move this legislation forward. Ensuring all health needs are being met is critical in maximizing the well-being, safety, and care coordination for students. With funding from DC Health, Children's School Services is a pillar in addressing the health needs of students and schools. Our school nurses' partner with the schools to ensure:

- students are immunized;
- students with asthma, diabetes, and emotional/behavioral health challenges are getting the care they need during the school day but are also connected to care they need to optimize their chronic illnesses;
- students with disabilities receive the care they need and have the equipment needed to provide that care; and
- students who are experiencing health related absences are getting support to access appropriate care.

We are testifying today because we are deeply concerned that the proposed budget does not include adequate funding for the expansion of school nursing services at additional school health services programs in public and public charter schools. As you may recall in the FY 23 budget, the Council approved $5.9 million for school nursing. Of that $5.9 million, only $1.4 million was recurring over the four years of the financial plan. Through the additional funding allocated in FY 23, we have been able to support comprehensive care delivery through care coordination, expand our innovative telemedicine program, and provide comprehensive oversight from the

administrative office. This proposed budget jeopardizes all of these initiatives. With the addition of new schools in the 2023-2024 school year, we will need even more resources, to continue to maintain our excellent care delivery.

As we mentioned during our Performance Oversight testimony in March, the national shortage of nurses is not one that we believe will resolve in the coming months as reported by the US Bureau of Labor Statistics. Over the past few months, we have partnered with DC Health to develop a new staffing model that will allow us to staff every school with dedicated team members. We thank DC Health for working collaboratively with us during this process. The proposed model will open the labor pool for additional candidates, allow nurses to practice at the top of their license, and support the community with career ladders and training opportunities for paraprofessionals. In the coming weeks, I will be in the community meeting with parents and principals to discuss the proposed model, how it will impact the daily staffing of the health suites, and most importantly, how each of the 90,000 students we serve daily were considered in this process.

As we look forward to the next school year, we believe there should be continued investment in telehealth and care coordination. We continue to partner with Children's National Mobile Unit and Children's National Telehealth, to break down barriers of social determinants and most importantly, get children access to the physicians and providers who can provide needed healthcare interventions. We are excited to report that Children's National has established a partnership with Howard University, the Colleges of Dentistry and Medicine, the Faculty Practice Plan to host "A Family Affair", where both child and parent can have access to providers, children will receive immunizations from Children's National, and Howard dentists will be onsite to provide dental screenings. Children's National is committed to supporting the needs of the community and will continue to lead the conversation in pediatric health innovation.

Children's School Services in collaboration with Children's National continues to be a safety net for so many families and communities in need. We thank DC Health for their emphasis on improving the health and wellbeing for children and adolescents in the District. However, we need continued investment to meet this goal. As the Committee considers additional funding for school nursing services, please consider that a continued commitment to addressing the health needs of students and schools can result in real improvements in promoting health equity and improving

health outcomes. Thank you for the opportunity to testify and I am happy to answer any questions you may have.

COMMITTEE ON HEALTH
BUDGET OVERSIGHT HEARING ON
the Department of Health
Wednesday, April 10, 2023, at 9:00 a.m.
Yasmina Konate Testimony

My name is Yasmina Konate, I am an 11th grader currently enrolled at Jackson-Reed High School and reside in Ward 4. I am affiliated with YWP which is the Young Women's Project, DCGC- the DC Girl Coalition, and BlackSwan Academy. Today I am testifying for consent at 16 years old.

I am testifying for Consent at 16. More specifically how it relates to healthcare. In DC, an individual must be 18 years of age or older to consent (with some exceptions) to the provision of medical services for themselves and face difficulties in accessing educational records, public benefits such as food stamps, government identification, and housing. D.C. law sets the age of legal consent for marriage at 16 years, making that the minimum marriageable age in the district. This comes with many complications such as those that I mentioned before. At 16 years old you are allowed to be married, but not allowed public benefits and medical services. This can be dangerous for 16 and 17-year-olds who may have children and are fleeing an environment of 16 and 17-year-olds who may not have a full-time parent or guardian. 16 and 17-year-olds without parents or guardians should be able to make their own doctor's appointments and have private conversations with their doctors. If 16 and 17-year-olds are old enough to get married, shouldn't they be old enough to schedule their own doctor's appointments? Youth who are not able to access healthcare because they do not have a parent or guardian with them have many health risks. These risk range from pregnancy to an unwell mental state. Common health services such as therapy are the medical services that could save a youth's life but instead, the medical services are being denied. Some ways the city could make sure youth don't have adult support without distrusting the youth is by asking them and making 3+ referral calls to legal adults. These adults can include teachers, principals, and even coaches. This will ensure that the youth is not lying about the guardianship status. This topic is important to me because affects people who are my age and it could affect people who attend my school and live in my community. Consent at 16 is important to me because it could potentially be the deciding factor in a youth's life.

Thank you council for reading my testimony, if you have any questions please feel free to follow up.

Children's National

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Council of the District of Columbia

Committee on Health

FY 2024 Budget Oversight Hearing:
Department of Health (DC Health)

Testimony of Andrea Boudreaux, PsyD, MPH, MA, FACHE

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- students with disabilities receive the care they need and have the equipment needed to provide that care; and
- students who are experiencing health related absences are getting support to access appropriate care.

We are testifying today because we are deeply concerned that the proposed budget does not include adequate funding for the expansion of school nursing services at additional school health services programs in public and public charter schools. As you may recall in the FY 23 budget, the Council approved $5.9 million for school nursing. Of that $5.9 million, the Committee on Health recommended an increased investment of $1.4 million over the four years of the financial plan. With the addition of new schools in the 2023-2024 school year, we will need even more resources, to continue to maintain our excellent care delivery.

As we mentioned during our Performance Oversight testimony in March, the national shortage of nurses is not one that we believe will resolve in the coming months as reported by the US Bureau of Labor Statistics. Over the past few months, we have partnered with DC Health to develop a new staffing model that will allow us to staff every school with dedicated team members. We thank DC Health for working collaboratively with us during this process. The proposed model will open the labor pool for additional candidates, allow nurses to practice at the top of their license, and support the community with career ladders and training opportunities for paraprofessionals. In the coming weeks, I will be in the community meeting with parents and principals to discuss the proposed model, how it will impact the daily staffing of the health suites, and most importantly, how each of the 90,000 students we serve daily were considered in this process.

As we look forward to the next school year, we continue to build trust in the community of teachers, parents, and students around the safety of immunizations, as well as the comprehensive care that can be provided between the health suite and community providers. We continue to partner with Children's National Mobile Unit and Children's National Telehealth, to break down barriers of social determinants and most importantly, get children access to the physicians and providers who can provide needed healthcare interventions. We are excited to report that Children's National has established a partnership with Howard University, the Colleges of Dentistry and Medicine, the Faculty Practice Plan to host "A Family Affair", where both child and parent can have access to providers, children will receive immunizations from Children's National, and Howard dentists will be onsite to provide dental screenings. Children's National is committed to supporting the needs of the community and will continue to lead the conversation in pediatric health innovation.

Children's School Services in collaboration with Children's National continues to be a safety net for so many families and communities in need. We thank DC Health for their emphasis on improving the health and wellbeing for children and adolescents in the District. However, we need continued investment to meet this goal. As the Committee considers additional funding for school nursing services, please consider that a continued commitment to addressing the health needs of students and schools can result in real improvements in promoting health equity and improving

health outcomes. Thank you for the opportunity to testify and I am happy to answer any questions you may have.

Testimony of
Kowshara Thomas, Executive Director, Joseph's House
Committee on Health and Human Services
Budget Oversight Hearings on Fiscal Year 2024, Department of Health
April 10, 2023

Good morning, Councilmember Henderson and committee members; thank you for this opportunity to testify before you today. My name is Kowshara Thomas. I am the Executive Director at Joseph's House. We have been operating in Adams Morgan since 1990 and serve the most vulnerable individuals in WDC, with the vast majority of our residents coming from Wards 5, 7, and 8. Last year, we served 20 residents and 25 former residents.

Residents arrive at Joseph's House with advanced HIV disease. About 90% of them have experienced chronic homelessness and a history of trauma, substance abuse, and mental illness. We provide our residents with safe housing and 24-hour nursing and personal care. We determine barriers to past HIV medication adherence, help them access benefits, address trauma and addictions, and find appropriate housing after discharge. We seek to bridge the wide health disparities of care our residents have received as unhoused individuals and people of color. As one of the only dedicated respite centers in DC, we provide a unique level of intensive and personal care that does not exist for our clients elsewhere.

We currently receive DC-appropriated funds through the Department of Health to provide transitional housing and support services for people with HIV/AIDS. We no longer receive funding from the Department of Health through the federal Ryan White Program. This has created a significant gap in our funding.

We currently don't receive funding to support our community members that reside outside of Joseph's House. Once a resident is discharged, we continue to support them in maintaining their health. Our social worker and nonmedical case management program are essential to effectively meet the needs of the vulnerable population that we work alongside. Most

individuals we work with face co-occurring concerns like substance use, mental health issues, and chronic and acute health conditions. These issues impact their health and housing stability and must be addressed, incorporating harm reduction principles and trauma-informed care. Outpatient case management services improve the quality of care for patients with complex illnesses. And through our social worker's ongoing case management support, we can support long-term health outcomes and housing stability.

For individuals who have experienced chronic homelessness, learning to live independently is a long-term process. Clients with complex psycho-social needs may always need support to maintain housing. This includes helping our community members through their annual housing recertification process, supporting them with activities of daily living, and addressing behaviors like hoarding and money mismanagement. We also connect them with behavioral health services, home health aides, food pantries, and other supports to ensure they have the resources in place to be successful while living independently.

As this Committee and DOH work together to continue strengthening the District's response to HIV/AIDS, we believe it is crucial to invest healthcare resources in Community Based Organizations like Joseph's House. With the funding support from DOH, Joseph's House has profoundly impacted the health of people living with HIV, an impact that can play a crucial role in helping the District reach the HIV goals outlined by Mayor Bowser.

I want to thank the Committee for your support, including $550,000 in last year's budget to support Joseph's House programs. Those funds support lifesaving programs, and we ask you to include $550k in your budget again this year. These funds support transitional housing and medical and nonmedical supportive services. Such investments will improve housing instability and their health and help our larger community to reduce the number of new HIV infections significantly, goals we know that we share with this Committee, the Council as a whole, and the administration.

Carolyn Babendreier
Healthy Start Supervisor
Mary's Center for Maternal and Child Care, Inc.

Hello, my name is Carolyn Babendreier. I am the supervisor for the Healthy Start Program at Mary's Center. I started out as a Community Health Worker and want to thank you all for the support that you have provided struggling families through the current investments in home visiting. I firmly believe, as I know you all do, that investing in families and the health and wellbeing of our children is most essential.

In my direct work with families as a home visitor I have seen how transformative these interventions can be for children and their whole family. However, insufficient funding and investment in Home Visiting is resulting in negative impacts on staff and a reduction of services; ultimately affecting the families on our caseloads. I have also experienced the challenges with providing consistent services through staffing departures and turnover due to DC Grants not facilitating thriving wages for the workforce. I see how unsustainable this is, even more now as a supervisor and hiring manager. This has been especially true since the pandemic where the need for support that families seek has increased and so too the burden on our home visitors; however, our home visitors do not receive the fiscal support that would ensure their long-term stability and success in the role. Our families and programs deserve long term stability which requires livable wages for our staff and sustainability options such as the Medicaid reimbursement you have heard of from some of my peers. Now is not the time to reduce investments that support family wellbeing. Now is the time to make sure families and children are able to access the resources and supports that ensure their wellbeing. **Our** community is only as strong and healthy as our neighboring families and children are.

My own team has been managing staff turnover for over a year while not being fully staffed. The staff that has remained in the role in the year and half of partial staffing have not received any increase in salaries since their time covering unfilled positions in the program. As a hiring manager we try to hire quality candidates who can quickly train and begin supporting families, but I have seen qualified wonderfully engaged and passionate candidates shy away from the position after hearing the maximum salary we can offer. This is not sustainable for our program participants. We lose on high quality candidates when we can't offer thriving wages. Participants lose on high quality support when our programs are undervalued and overburdened.

Home visiting is an investment in communities – a holistic, preventative approach to supporting families and their health, well-being, economic stability, etc. especially when some participants face more challenges. For this to continue, we need to be competitive in attracting candidates and incentivizing workers. We want qualified and passionate candidates to remain in the role long term so that they can focus on their work with families rather than be concerned for their own economic stability. How can Home Visitors expect to support families to get economically stable if they themselves are struggling to do the same with the wages these grants force us to offer? Our Home Visiting professionals should be able to support their families without worry. I am here among HV programs and partners asking that DC Health restore and increase HV investments of 500K restoring the FY23 funds that were cut and 700K for salary increases that will support workforce retention that decreases interruptions to families seeking care and support a total of of $1.2M. I also recommend that DC Health explore and implement a Medicaid reimbursement plan so that evidence based HV programs can bill for Home Visits that increases positive health outcomes for families. Lastly, I welcome Councilmember Henderson to

shadow one of our Home Visits so that you can see the impact of our program services and see what your investments can do when we are funded and resourced to support family health and wellbeing.

Thank you!

Testimony on FY2024 Budget
Before the Committee on Health
April 10, 2023

Good afternoon, Chairperson Henderson and members and staff of the Committee on Health. I am Charlene Flaherty, Director of Policy and Advocacy at Community of Hope, which is a Federally Qualified Health Center and provides homelessness prevention, short-term and rapid re-housing, and permanent supportive housing programs. In 2022, we worked to prevent and end homelessness for approximately 1,400 households, the majority of which were families.

I am here today to express Community of Hope's sincere gratitude for Mayor Bowser's commitment to and investment in health care services targeted to a demographic that forms the heart of and anchors our community – seniors. They are the grandparents, aunts, uncles and neighbors who serve as our wisdom figures. They carry the collective memory of our communities in their hearts, as they live on in the futures of our children.

This program was originally funded from January 1, 2019, to September 30, 2020, at which time funding was discontinued. Funding was restored in FY 2023. Despite challenges posed by the pandemic, 324 unique patients were seen during the period of December 1, 2018, to April 6, 2023.

Throughout the history of the program, we have been able to provide care to patients who would have otherwise been uninsured and had to forego this basic, necessary care. The need for the program, however, continues to grow as the number of eligible seniors grows and inflation eats into the pockets of those on fixed incomes.

Unfortunately, due to lack of care throughout their lives, many of the seniors who receive dental care at Community of Hope have lost some or all of their teeth and find it difficult to chew and eat. Eating without teeth or dentures may cause a number of health risks including weakened jaw bones and gums, and poor nutrition. As society looks for ways to help seniors remain in their homes safely, lack of basic dental care works against that goal.

And sadly, seniors lacking teeth often don't smile because they are embarrassed. Science has shown that the mere act of smiling can lift our mood, lower stress, boost our immune systems and possibly even prolong our lives. That may sound backwards, but neurologists explain that a smile spurs a chemical reaction in the brain, releasing hormones including dopamine and serotonin which are related to depression. Depression weakens our immune systems, while happiness has been shown to boost our body's resistance.[1] Good nutrition

[1] https://www.nbcnews.com/better/health/smiling-can-trick-your-brain-happiness-boost-your-health-ncna822591

and a smile, then, can make the difference between depression and isolation, and happiness and engagement.

Your support for the Senior Dental Program has made a tremendous impact in the lives of our patients and on the communities in which they live. Today, you will also hear testimony from Mr. Solomon Palmer who is a Community of Hope dental patient and a recipient of this investment. Mr. Palmer is just one of the hundreds who benefit from this vital program. I urge City Council to keep this funding intact in the FY 2024 budget.

Thank you, Chairperson Henderson, for your time and I am happy to answer any questions you have.

Commented [CF1]: I've left several messages for Mr. Palmer but am still working on connecting with him. I informed Dr. Karim of that.

Commented [CF2R1]: I connected with Mr. Palmer yesterday.

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Testimony Before the District of Columbia Council
Committee on Health
April 10, 2023

Public Hearing:
Budget Oversight Hearing
Department of Health

Leah Castelaz
Policy Attorney
Children's Law Center

Introduction

Good morning, Chairperson Henderson, and members of the Committee. My name is Leah Castelaz. I am a 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 Mayor's proposed budget for the Department of Health (DC Health). The District's behavioral health system encompasses many agencies beyond the Department of Behavioral Health (DBH). My testimony today will focus on DC Health's role in the behavioral health system and how key investments in the FY24 budget can support their work.

Over the past year, we have testified to the worsening behavioral health for both adults and youth.[1] While we must be responsive and take immediate action to respond to the current crisis, we must also invest in proactive and prevention strategies. To this end, we are asking for the following investments:

1. Maintain HealthySteps funding at its current level to continue expansion.
2. Increase funding for home visiting to support its workforce.
3. Add additional FTEs to increase the capacity of the Board of Social Work to administer licenses.

These investments support the current needs of District children and families as well as the long-term vision for the District – to have a behavioral health system that is both proactive and responsive.

Maintain funding for HealthySteps in the District

Since 2019, the Children's Law Center has advocated for the expansion of HealthySteps, an evidence-based national program model that provides infants and toddlers with social-emotional and development support by integrating child development specialists into primary care.[2] 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 supports and resources.

We know from our work that children have the best chance to avoid child maltreatment when their parents and caregivers are fully supported and equipped to meet their needs.[3] The first few years of a child's life typically are full of rapid change and development for the child and stress and uncertainty for the parent or caregiver putting

younger children at a higher risk of experiencing a strained parent-child relationship or some form of maltreatment.

Through screening, HealthySteps Specialists[4] can identify and provide support to those with postpartum depression and Family Services Coordinators[5] can give resources and specific care coordination. Screening mitigates the strain that undiagnosed and untreated mental health issues can put on the parent-child relationship. In FY22, Children's National, a HealthySteps provider, screened 252 children for developmental issues and screened 243 mothers for postpartum depression.[6]

There are soon to be ten HealthySteps in the District, six of which will be locally funded. This Council's major investments in HealthySteps has allowed the program to surpass the original goal laid out in the Birth-to-Three for All DC Amendment Act of 2018, further increasing the programs reach to children and families in the District.[7]

As we testified during performance oversight, behavioral health workforce shortages have impacted current HealthySteps sites from being able to reach full staffing.[8] We, therefore, ask this Committee to maintain the funding in the Mayor's proposed FY24 budget to allow more time for the current five locally funded HealthySteps sites to hire the needed staff as well as time for the soon to be selected sixth site to come onboard.[9] Looking beyond FY24, we hope HealthySteps will continue to expand to additional sites to serve more District children and families in a setting they already frequent. As we testified to earlier this month, continued expansion of HealthySteps can in part be

supported by the inclusion of HealthySteps in DHCF's ongoing rate study to help leverage federal Medicaid dollars and secure a more sustainable funding stream for the program.[10] Sustaining HealthySteps through Medicaid billing and reimbursement frees up local dollars to support expansion of HealthySteps as well as other early childhood and family-serving programs.

Investments in DC Health's Home Visiting Must Be Increased to Maintain and Expand the Workforce to Reach More District Families

Home visiting is another program supported by DC Health funding that improves the behavioral health systems proactive approach to prevent children and families from future negative outcomes. By developing meaningful relationship, home visitors help build a solid foundation for children's earliest years to create long term sufficiency and future success for both child and caregiver.[11]

During performance oversight, this Committee heard from many District residents who are currently or have participated in home visiting services about what an immense value this program has been to them and their children. Witnesses shared that home visitors help to build confidence and provide support navigating parenthood.[12] Home visitors decrease stress by breaking down barriers to resources, participating in goal setting and completion, and general support to caregivers who sometimes just need a listening ear.[13] When a parent is less stressed, they are better able to meet the needs of their child resulting in the healthiest outcomes for all.

Despite, the clear benefit of home visiting, this program experiences significant overturn of home visitors due to the programming being under resourced which results in high administrative burdens and low paying wages.[14] Home visiting grants have not been adjusted for inflation since 2019. Additionally, the grant amounts continue to fluctuate, which further puts a strain on an already struggling workforce.[15] As exhibited in performance oversight testimony and the recent *Voices from the Field* report the current level of funding is insufficient to truly support the workforce and increase services to families.[16] We are, therefore, asking this Committee to invest minimally $1.2 million in home visiting to sustain and grow the current workforce and ensure District children and families have consistent access to this valuable program.[17]

We also ask this Committee to support the pursuit of long-term sustainable funding for evidence-based home visiting programs in the District. As we testified at DHCF's budget oversight hearing, DHCF should establish the coverage and reimbursement of evidence-based home visiting under Medicaid.[18] After establishment of reimbursement, DHCF will need adequate financing to draw the federal match from Medicaid. We are, therefore, asking this Committee for up to an additional $450,000 to be invested into DHCF's budget to support Medicaid funding of evidenced-based home visiting once it is established for coverage and reimbursement. The utilization of Medicaid dollars will not only provide a more sustainable form of funding but will also

free up local dollars which can be used to increase access to more evidence-based home visiting programs and other services.

The Board of Social Work Needs Increased Capacity for the Licensing Administration

The District has been responsive to the upward trends of poor behavioral health of District children and families by making strategic investments to employ behavioral health professionals, such as licensed social workers. These investments mark a significant paradigm shift in understanding the centrality of behavioral health to community well-being. At the same time, this shift has revealed sizable workforce challenges. Community-based organizations (CBOs) and government alike are struggling to recruit and retain licensed clinicians amid the nationwide shortage of behavioral health care professionals.[19] For example, as of this February 2023, only 159 of 253 DC public and charter schools (63% percent) have a full-time CBO clinician providing services in school through the School Based Behavioral Health Expansion Program.[20] Our clients consistently report being unable to find providers offering the services they need, such as individual and family therapy, counseling, autism evaluations, and medication management appointments. If they do connect with a provider, the wait for an appointment is often prohibitively long.

One barrier to recruiting is the lack of capacity to process and administer licenses to licensed independent clinical social workers (LICSW) in an efficient and timely manner by the Board of Social Work, within the Health Regulation and Licensing

Administration (HRLA). Increasing the capacity of the Board of Social Work to process and administer licenses is needed to address the workforce issues that undermine the entire behavioral health system.

In FY23, this Council increased the capacity of HRLA by adding ten new licensing specialists. This funding, however, did not give permanent support to any of the three behavioral health Boards (Board of Social Work, The Board of Psychology and The Board of Professional Counseling).[21] HRLA, however, recognized that additional staff would be "beneficial" to these boards, as "these licensing processes are traditionally longer due to the various supervision periods needed prior to licensure."[22] Therefore, in FY23 the Board of Social Work was granted one temporary contractor, which improved processing time, particularly for Licensed Graduate Social Work (LGSW) and LICSW applications.[23] HRLA's performance oversight responses note that this additional staff helped with inquiry response, sorting and tracking down documents supporting applications, and communicating with applicants, ultimately "leading to greater customer satisfaction."[24]

Unfortunately, this year's proposed budget appears to cut 2.6 FTEs from the Health Professional Licensing Administration while at the same time increasing the budget line by $642,000. It is unclear how there is both an increase in a funding and a decrease in FTEs.[25] We fear without proper reconciliation we will be rolling back progress made in staffing capacity since last year. Therefore, we ask for at least one

additional dedicated FTE for the Board of Social work; in FY23, the cost of each FTE added by the Council totaled $93,421.84, which was split between salary ($77,722) and fringe ($15,699.84).

We urge this Committee to work with DC Health to ensure adequate staffing to process social work license applications in a timely manner. This is a practical complement to the suite of other workforce development goals in the FY24 budget, getting future social workers licensed and ready to serve. Ensuring the behavioral health workforce is strong and sustainable will improve the safety and well-being of people with behavioral health needs in our community.

Conclusion

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

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[1] Amber Rieke, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (February 1, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/02/Amber-Rieke_CLC_Performance-Oversight-Testimony_DBH_February-1-2023_SBBH_final-1.pdf; Sharra E. Greer, Children's Law Center, Testimony before the District of Columbia 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; Amber Rieke, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (February 16, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/02/Amber-Rieke_DHCF-Performance-Oversight_FINAL-2.16-and-2.17.pdf; Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (February 16, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/02/Leah-Castelaz_Testimony-Performance-Oversight_DHCF_FINAL.pdf; Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (March 2, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/03/LeahCastelaz_PerformanceOversightTestimony_CommitteeonHealth_DCHealth.pdf.

[2] Anne Cunningham, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (April 9, 2019), *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/07/DC-Health-FY2020-Budget-Hearing-Childrens-Law-Center-Testimony-FINAL-nj.pdf; Tami Weerasingha-Cote, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (February 20, 2020), *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/07/FINAL-Childrens-Law-Center-2020-Performance-Oversight-Testimony-for-DC-Health_0.pdf; Sharra E. Greer, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (March 19, 2021), *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/07/SGreer_Childrens-Law-Center-Testimony-for-March-19-2021-DC-Health-Oversight-Hearing_FINAL-1.pdf; Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (February 23, 2022), *available at:* https://childrenslawcenter.org/wp-content/uploads/2022/02/LCastelaz_Childrens-Law-Center-Testimony-for-Fe.-23-2022-DC-Health-Oversight-Hearing_Final-Exhibit-A.pdf; Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (March 2, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/03/LeahCastelaz_PerformanceOversightTestimony_CommitteeonHealth_DCHealth.pdf. *See also* ZERO to THREE, *HealthySteps, available at:* https://www.healthysteps.org/.

[3] Centers for Disease Control and Prevention, Supporting Parents to Help Children Thrive, *available at:* https://www.cdc.gov/childrensmentalhealth/features/supporting-parents.html; American Psychological Association, Parents and Caregivers Are Essential to Children's Healthy Development, *available at:* https://www.apa.org/pi/families/resources/parents-caregivers; Child Welfare Information Gateway, Protective Factors Approaches in Child Welfare, Issues Briefs March 2020, *available at:* https://www.childwelfare.gov/pubpdfs/protective_factors.pdf.

[4] HealthySteps Specialists can deliver clinic-based mental health visits with families to address critical needs in areas such as maternal depression, grief and loss, and child behavior management. Specialists can also answer questions about behavioral health as well as facilitate the development of attachment, self-regulation skills, and family resiliency. Early Childhood Innovation Network, Innovation Spotlight: HealthySteps DC, May 2019, ECIN Newsletter, *available at:* https://www.ecin.org/newsletter-may-2019.

[5] Family Service Coordinators provide dedicated case management and care coordination for families through the support of DC residents with lived experience navigating systems. Early Childhood Innovation Network, Innovation Spotlight: HealthySteps DC, May 2019, ECIN Newsletter, *available at:* https://www.ecin.org/newsletter-may-2019.

[6] Kimberly Brooks, Children's National Hospital, Testimony before the District of Columbia Committee on Health regarding the Department of Health Performance Oversight, (March 2, 2023), *available at:* https://www.youtube.com/watch?v=SvGJ7GMoFuk.

[7] DC Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[8] Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (March 2, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/03/LeahCastelaz_PerformanceOversightTestimony_CommitteeonHealth_DCHealth.pdf.

[9] FY24 DC Health Budget Oversight Pre-hearing Responses, response to Q13, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAIiPdhYtacABxBTKEvacWWa/FY%202024%20Budget/DOH/Agency%20Responses?dl=0&preview=FY24+DC+Health+Budget+Oversight+Questions_final040623.docx&subfolder_nav_tracking=1.

[10] Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (April 5, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/04/L-Castelaz_Testimony-before-DC-Council-Committee-on-Health_DHCF_4.5.23_FINAL.pdf.

[11] Center for the Study of Social Policy, Strengthening Families, *available at:* https://cssp.org/ourwork/project/strengthening-families/; Center for the Study of Social Policy, Strengthening Families Through Home Visiting, *available at:* https://cssp.org/resource/sf-through-home-visiting/; DC Action, DC Home Visiting Council, *available at:* https://www.wearedcaction.org/our-initiatives/homevisiting#:~:text=Home%20visiting%20helps%20parents%20deepen,to%20meet%20their%20child's%20needs; James H. Duffee, et. al., *Early Childhood Home Visiting,* American Academy of Pediatrics, Volume 140, Issue 3, September 2017, *available at:* https://publications.aap.org/pediatrics/article/140/3/e20172150/38307/Early-Childhood-Home-Visiting?autologincheck=redirected.

[12] Home visitors provide a safe and judgement free space where both generation, parent, and child, feel supported simultaneously. *See* District of Columbia Council Committee on Health, Performance Oversight of the Department of Health, (March 2, 2023), *available at:* https://www.youtube.com/watch?v=SvGJ7GMoFuk.

[13] Center for the Study of Social Policy, Strengthening Families, *available at:* https://cssp.org/ourwork/project/strengthening-families/; Center for the Study of Social Policy, Strengthening Families Through Home Visiting, *available at:* https://cssp.org/resource/sf-through-home-visiting/; DC Action, DC Home Visiting Council, *available at:* https://www.wearedcaction.org/our-initiatives/homevisiting#:~:text=Home%20visiting%20helps%20parents%20deepen,to%20meet%20their%20child's%20needs.

[14] Significant overturn of the workforce is particularly problematic in a program that relies on the consistent long-term development of relationships. *See* District of Columbia Home Visiting Council, *Voices from the Field: The Experiences of the District's Home Visitors,* 2021, *available at:* https://www.wearedcaction.org/standardizing-wages-boosting-funding-and-streamlining-reporting-will-strengthen-home-visiting.

[15] In FY21 there was a budget reduction for home visiting, and in FY22 DC redirected funds from other programs to maintain home visiting grantee awards. However, in FY23 grantees once again saw a reduction in their awards. *See* FY22 DC Health Performance Oversight Responses, response to Q43, *available at:* https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAIiPdhYtacABxBTKEvacWWa/FY%202024%20Budget/DOH/Agency%20Responses?dl=0&preview=FY24+DC+Health+Budget+Oversight+Questions_final040623.docx&subfolder_nav_tracking=1.

[16] *See* District of Columbia Council Committee on Health, Performance Oversight of the Department of Health, (March 2, 2023), *available at:* https://www.youtube.com/watch?v=SvGJ7GMoFuk; District of Columbia Home Visiting Council, *Voices from the Field: The Experiences of the District's Home Visitors,* 2021, *available at:* http://www.dchomevisiting.org/uploads/1/1/9/0/119003017/home_visitors_experience_report-final_english.pdf; and DC Action, *Standardizing Wages, Boosting Funding, and Streamlining Reporting Will Strengthen the Home Visiting Profession,* 2023, *available at:* https://www.wearedcaction.org/standardizing-wages-boosting-funding-and-streamlining-reporting-will-strengthen-home-visiting.

[17] In FY22 performance oversight responses DC Health reported a cut of $275,485 to the home visiting programs in the FY23 budget. *See* FY22 DC Health Performance Oversight Responses, response to Q43, *available at:* https://www.dropbox.com/sh/z6g48dc4tq8528u/AAD22w6Zyc_AgEBb4FUDfa56a/COH%20Performance%20Oversight/DC%20Health/Agency%20Responses/CHA?dl=0&preview=FY22+Performance+Oversight-

CHA-Q27-62.docx&subfolder_nav_tracking=1. Grantees reported that this was in fact an even larger cut of $500,000. However, in DC Health's budget oversight pre-hearing questions, the agency reported no change in funding between FY23 and FY22 except a decrease of $150,000 to the First-Time Mother's home visiting program. *See* FY24 DC Health Budget Oversight Pre-hearing Responses, response to Q14, *available at:*https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAIiPdhYtacABxBTKEvacWWa/FY%202024%20Budget/DOH/Agency%20Responses?dl=0&preview=FY24+DC+Health+Budget+Oversight+Questions_final040623.docx&subfolder_nav_tracking=1. Therefore, we are unsure the true extent of DC Health's budget for home visiting and what is needed to at minimum to ensure the FY24 budget is the same as FY23 budget. Importantly, home visiting is in need of a greater investment. Home visiting grants have not bee adjusted for inflation since 2019 and home visitors report low wages as one of the main reasons, they leave the job. We believe the minimum investment of $1.2 million will restore any funds that need to be restored to the FY24 budget as well as provide a much-needed increase to this program to support higher wages for home visitors. We do encourage this Committee to seek clarity on the budget of DC Health's home visiting program and to help understand how to ensure consistency and stability across fiscal years.

[18] Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (April 5, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/04/L-Castelaz_Testimony-before-DC-Council-Committee-on-Health_DHCF_4.5.23_FINAL.pdf.

[19] The National Council for Mental Wellbeing, Behavioral Health Workforce is a National Crisis: Immediate Policy Actions for States, *available at:* https://www.thenationalcouncil.org/wpcontent/uploads/2022/01/Behavioral-Health-Workforce-is-a-National-Crisis.pdf; USA Facts, Over one-third of Americans live in areas lacking mental health professional, June 9, 2021, *available at:* https://usafacts.org/articles/over-one-third-of-americans-live-in-areas-lacking-mental-healthprofessionals/; and Health Resources and Services Administration (HRSA) Health Workforce, Behavioral Health Workforce Projections, 2017-2030, *available at:* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf.

[20] Materials shared at Department of Behavioral Health's Coordinating Council on School Behavioral Health meeting, February 2023, on file with the Children's Law Center.

[21] FY22 DC Health Performance Oversight Responses, response to Q109, *available at:* https://www.dropbox.com/sh/z6g48dc4tq8528u/AACbEsbUqhrQkJaoKUux7UO2a/COH%20Performance%20Oversight/DC%20Health/Agency%20Responses/HRLA?dl=0&preview=FY22+Performance+Oversight-HRLA+Q98-121.docx&subfolder_nav_tracking=1.

[22] *Id.*

[23] *Id.*

[24] *Id.*

[25] Mayor's Proposed FY 2024 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Department of Health, Table HC0-4, line 4200, (March 22, 2023), available at: https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/rl_cfsa_chapter_2024m1.pdf.

Jules Plumadore

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Jules Plumadore is the Founder and Senior Consultant of Goldfeather Consulting, a network of peer-identified consultants offering mental health training and technical assistance that is both evidence-based and experience-tested. Goldfeather consultants have contributed to national conversations on mental health and bring lived experience as well as professional expertise on subjects including hoarding and cluttering challenges, peer workforce development, community crisis response, language change, and more.

Jules draws on his own lived experience of mental health challenges as well as his leadership in community-based mental health. Having worked in high-profile community-based roles at every professional level, from part-time Peer Responder to Executive Director, Jules' unique insights into mental health and workplace culture have helped to spark conversation and create change at organizations like the San Francisco Public Library system, Zuckerberg San Francisco General Hospital Psychiatric Emergency Services, the Institute on Aging, and the California Institute of Integral Studies.

Jules is an internationally-recognized peer expert in supports for hoarding and cluttering. An original member of the Mental Health Association of San Francisco's innovative Peer Response Team, Jules has been a featured presenter at the International Conference on Hoarding and Cluttering; shared his expertise with periodicals including the New York Times and Al Jazeera America; and contributed to groundbreaking research with UCSF on peer-led supports for hoarding and cluttering. He has trained hundreds of Bay Area supportive housing staff members on harm reduction practices for hoarding and cluttering, was part of the first team of Buried in Treasures skill-building group facilitators on the West Coast, and is a member of the Institute for Challenging Disorganization (ICD).

Jules works collaboratively with other values-aligned trainers, consultants, and community partners to make Goldfeather Consulting a catalyst for transformative change in mental health.

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Work History

Goldfeather Consulting
Oakland, CA

Senior Consultant **10/20 - Present**

Summary

» I'm the founder of a consulting network providing person-centered, evidence-based training and technical assistance on topics related to mental health and wellness through the lens of social justice.

Achievements

» Develop and deliver original-content trainings and webinars on hoarding and cluttering supports and services; peer workforce development; community crisis response without police intervention; and other subjects relevant to behavioral health

» Offer technical assistance on behavioral health topics to nonprofits, universities, and government entities

» Provide ongoing consultation to the California Mental Health Services Authority (CalMHSA) for the development of a statewide Peer Support Specialist certification exam

Peers Envisioning and Engaging in Recovery Services (PEERS)
Oakland, CA

Interim Executive Director **4/20 – 9/20**

Summary

» I served as Interim Executive Director for a community-based mental health nonprofit run by and for a diverse coalition of people with shared experience of mental health conditions.

Achievements

» Identified opportunities for growth and oversaw long-range organizational planning, change management. fundraising, and capacity building

» Established and maintained relationships with community leaders, partner organizations, and funders

PEERS
Oakland, CA

Community Engagement and Development Director **1/20 – 4/20**

Summary

» I led strategic planning initiatives to expand unrestricted funding opportunities and broaden the organization's reach to program participants, donors, and community partner organizations.

Achievements

» Designed, supervised, and managed outreach strategy for a hoarding and cluttering program centered around the Buried in Treasures skill-building group

» Crafted marketing and communications strategies to improve community outreach and expand the organization's reach

» Established measurement-based practices to evaluate outcomes in outreach, training, and fundraising activities

» Developed a fee-for-service training program, including curriculum and training materials, and managed Scopes of Work for service delivery to community partners

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PEERS
San Francisco, CA

Senior Programs Manager **2/19 – 12/19**

Summary

» I supervised and managed a team of 7 and oversaw programs including outreach and engagement, data collection and reporting, communications, and the Lift Every Voice & Speak (LEVS) mental health advocacy speakers bureau

Achievements

» Oversaw all aspects of community programs, including budget development and tracking; event coordination; vendor relations; data collection, reporting, and quality assurance; and outreach and engagement strategy and implementation

» Developed an original, evidence-based speakers bureau curriculum for the LEVS program, including a train-the-trainer process, a Facilitator's Guide, and a Speakers Manual

» Updated and standardized internal policies and procedures for participant accessibility and equitable staff recruitment, hiring, and retention

Mental Health Association of San Francisco (MHASF)
San Francisco, CA

Training and Community Engagement Manager **8/15 – 2/19**

Summary

» I developed, marketed, booked, and delivered original trainings to government agencies, secondary and post-secondary schools, and over 50 public and private sector organizations, and coordinated conferences and community events.

Achievements

» Supervised the peer arm of the 3-year Help for Hoarding study in collaboration with UCSF, which demonstrated that peer-led support groups for hoarding and cluttering are therapeutically equivalent to clinician-led groups

» Co-authored a toolkit on peer workforce development, including best practices for recruiting, hiring, and retaining peer-identified employees and integrating them into an existing team

» Co-led fundraising and grantwriting initiatives resulting in over $10 million

» Oversaw volunteer recruitment, onboarding, supervision, and retention

» Co-coordinated annual Tools for Change and International Hoarding and Cluttering conferences, including managing event logistics, speaker recruitment, communications, marketing, and registration.

MHASF
San Francisco, CA

SOLVE Program Manager **8/13 – 7/15**

Summary

» I supervised the Sharing Our Lives, Voices, and Experiences (SOLVE) mental health advocacy speakers bureau with over 75 speakers.

Achievements

» Collaborated with K-12 and post-secondary educators to ensure voices of lived experience are represented in their curricula, resulting in speaker placements at Berkeley and Galileo High Schools, the MFT and Summer Bridge programs at the California Institute of Integral Studies, and the Community Health program at San Francisco State University

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Certifications

- Organizational Leadership in Diversity, Equity, and Inclusion (Rice University, 2023)
- Level I Certificate of Study in ADHD (Institute for Challenging Disorganization, 2019)
- Level I Certificate of Study in Time Management/Productivity (Institute for Challenging Disorganization, 2019)
- Foundation Certificate in Chronic Disorganization (Institute for Challenging Disorganization, 2019)

Publications

- "Randomised clinical trial of community-based peer-led and psychologist-led group treatment for hoarding disorder," *BJPsychOpen Press*, Vol. 4, Issue 4, July 2018, pp. 285 – 293
- "Contributions of self-criticism and shame to hoarding," Psychiatry Research, Vol. 262, 2018, pp. 488-493
- "How is hoarding related to trauma? A detailed examination on different aspects of hoarding and age when hoarding started," *Journal of Obsessive-Compulsive and Related Disorders*.,Vol. 16, 2018, pp. 81-87

- Good afternoon Councilmembers, and thank you for this opportunity to testify.

- My name is Shavonne Healy and I am a Registered Dental Hygienist in DC and MD with more than 20 years of experience. My testimony relates to the worsening oral health crisis in D.C. and what the Council can do to address it.

- Poor oral health affects all aspects of our community, from financial well-being to healthcare systems, and even our ability to thrive and communicate with others. Oral diseases, including tooth decay, remain widespread in D.C., especially in school-aged children.

- I work in a Medicaid clinic and see many patients, including children, who suffer from a lack of access to preventive oral health care.

- Just recently, for example, I had a 2-year-old African American, child with cavities in all twenty of his baby teeth. Cavities like these are highly preventable through access to oral health care, such as dental hygiene education and routine preventive oral health care provided by hygienists!

- But the D.C. Code severely restricts hygienists' ability to perform this care, requiring a dentist examination before a hygienist can provide preventive care to a patient. This disproportionately harms Black and Brown communities.

- These communities of color face **serious** inequities in both oral health outcomes and access to care. There are 7 times more dentists per capita in Ward 2 than in Anacostia, restricting access, and patients of color are more likely to have tooth extractions and less likely to have received preventive oral healthcare in the last year.[1] Only a quarter of dentists in D.C. accept Medicaid,[2] which covers nearly 300,000 District residents,[3] the vast majority of whom are non-white.[4]

- Because very few dentists practice in Anacostia, or in schools, long term care facilities, or federally qualified health centers, hygienists cannot practice in these settings either, because they must be supervised by dentists, and therefore cannot give patients the critical preventive care needed.

- So what can the Council do? The most important thing you can do is modernize the Code to clear the way for dental hygienists to provide desperately needed preventive care without requiring a dentist to examine the patient first, a practice known as Direct Access.[5]

- Most states allow this. In fact, D.C. is one of only **9** states that do not, a group that includes Louisiana, Mississippi, and Alabama. In contrast, direct access is a recognized best practice and has been shown to be safe and effective not only in places like California, but also in our own backyard in Virginia and Maryland.[6]

- Direct Access to dental hygiene is predicted to reduce the cost of oral health care for students receiving care at a school by as much as 42% .[7] But these cost reductions are based on no dentist being present and prior examinations not being required. In other words the savings require direct access. Additionally, more independence for hygienists is associated with a reduction in patients visiting emergency rooms for preventable dental issues, and states with the most hygienist independence saw nearly 50 percent fewer preventable ED visits in urban areas, compared to states with the least.[8] Additionally, fewer patients have to have teeth removed in states with direct access.[9] This can reduce costs through preventing costly, invasive, and permanent procedures.

- This Council has the opportunity to modernize hygienists' scope of practice laws this year, and, in doing so, both address inequities in health and save the public money by reducing costs to public programs like Medicaid. Thank you for the opportunity to speak, and I look forward to working together on this issue.

Citations

1. Department of Health databases demonstrate worsening oral healthcare disparities. To reach this data, navigate from the BRFSS landing page to "Health and Well-being" then select the drop-down menu labeled "step 2" and select either "teeth extracted any - age 65" or "visited dentist". *District of Columbia BRFSS*, D.C. Dep't of Health, https://dataviz1.dc.gov/t/OCTO/views/DCHEALTH-CPPE-BRFSS/Eula?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3Aembed=yes&%3Atoolbar=no (last visited Feb. 14, 2023).
2. Nicoleta Serban et al., *Assessment of Dentist Participation in Public Insurance Programs for Children in the US*, 5 JAMA Network Open 1 (2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794118 (Finding only 25 percent of dentists in D.C. accept Medicaid.).
3. *D.C. Department of Healthcare Finance,* Monthly Medicaid and Alliance Enrollment Reports (2023),https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports.
4. Kaiser Family Foundation, *Distribution of the Nonelderly with Medicaid by Race/Ethnicity* (2021) https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/.
5. *Direct Access*, Amer. Dental Hygienists' Ass'n, https://www.adha.org/direct-access (listing the 42 states that allow direct access).

6. Steve Turner et al., *The Risks and Benefits of Direct Access*. British Dental J. Team (2015), https://doi.org/10.1038/bdjteam.2014.25 (finding cost savings from direct access)
7. Howard Bailit et al., *Financial Feasibility of a Model School-Based Dental Program in Different States*, 123 Pub. Health Rep. 761 (2008).
8. Marvellous Akinlotan et al., *Dental Hygienists' Scope of Practice Regulations and Preventable Non-traumatic Dental Emergency Department Visits: A Cross-sectional Study of 10 U.S. States,* Comty. Dentistry & Oral Epidemiology (2023), https://doi.org/10.1111/cdoe.12737 (finding that states with more expansive dental hygienist scopes of practice have lower rates of preventable dental emergency care).
9. Margaret Langlier et al., *Expanded Scopes Of Practice For Dental Hygienists Associated With Improved Oral Health Outcomes For Adults*, 35 HealthAffairs 2207 (2016) https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0807.

For additional information, please contact me for the letter a colleague and I wrote to the Board of Dentistry regarding their current bill proposal language, which would modify the practice of dental hygiene. I may be reached at Contact@AHigherLearning.com.

Good afternoon,

My name is Rachel, and I am a resident of Ward 4. I apologize for the delay in submitting my written testimony, but I hope it will still be considered. I'm writing today regarding the closure of the DC COVID centers, which is removing a safety net for our most vulnerable and marginalized residents.

The reasons cited for closing the centers included a drop in COVID-19 cases, high vaccination uptake, and an increase in the availability of vaccines and testing kits for at-home use. **But without the COVID centers, many will not be able to afford these resources, which in turn could drive community spread and lead to an undercount of diagnosable cases.**

Case counts are lower now than they were earlier this year, but they are still high at baseline according to wastewater data. The baseline lows keep climbing higher and higher, so ever since Omicron hit a year ago, we are seeing increasingly higher levels that are not going back down. If our residents don't have tools such as free masks and testing to curb transmission, this number could continue to climb.

In addition, an estimated 99% of DC residents have received the first dose of the primary vaccine series, and the DC COVID centers have been instrumental in this success. However, less than a third (31.5%) of residents have received the updated bivalent vaccine, which provides better protection against severe infection from the dominant COVID-19 strain, Omicron. The CDC currently recommends the bivalent booster for everyone 6 months and older.

Furthermore, even though there has been an increase in the availability of vaccines and testing kits, they are not financially accessible for many. An at-home rapid test can cost up to $12 or more for just 1 test, and a single PCR test can cost $129. Drug companies are suggesting that the average price for vaccines after commercialization will be $110 to $130 per dose without insurance. Not everyone can afford these prices, which will discourage testing and vaccine uptake. We're already losing support from the Federal Government; the end of the Public Health Emergency in May means private insurers will no longer be required to pay for eight home tests every month, and the Government provides only four rapid tests per residential household, period. But FDA recommendations state that individuals should rapid test two to three times (depending on symptoms) to avoid a false negative test result. The COVID centers made that realistic for us, but now those recommendations will be much harder to follow. The end of the Public Health Emergency also means millions will lose health insurance under Medicaid, and uninsured people may not have

free access to vaccines, or they may face complicated and time-consuming paperwork.

These are just some of many reasons why there is a continued need for the COVID centers. According to the CDC, COVID-19 is the third-leading cause of death in the United States despite assertions that the pandemic is over. COVID-19 infections and Long COVID are still causing serious illness, disability, and death, which threaten the future of our community's health and prosperity. The centers are expensive, but our residents' wellbeing is worth the cost—especially because we now know reinfection increases the likelihood of negative health outcomes.

Respectfully, I ask that the COVID centers be reopened or that an alternative means of distributing these COVID-19 resources be established (for example, via DC public libraries).

Thank you for hearing my spoken testimony today. I was very nervous because I've never testified for anything before, but this issue is incredibly important to me because it impacts the entire DC community.

Sincerely,
Rachel Unger

FACTSHEET

MARCH 2023

alzimpact.org

Race, Ethnicity, and Alzheimer's

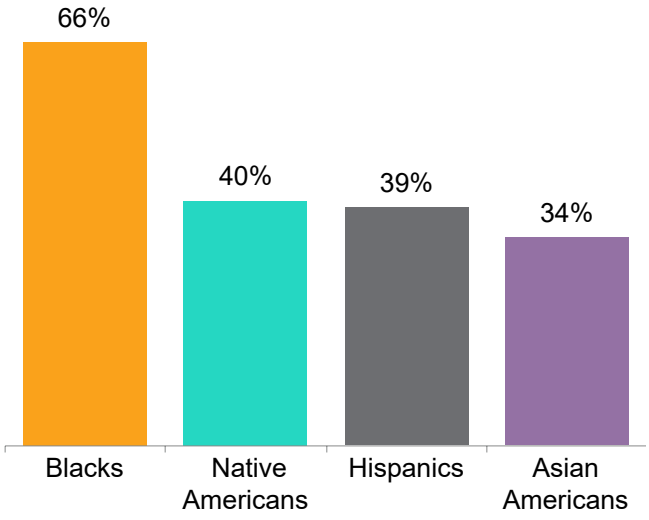
The burden of Alzheimer's is not equally shared — Blacks and Hispanics are at higher risk.

- Of the 6.7 million people in the United States with Alzheimer's, a majority are White. However, combined evidence from available studies shows that Blacks and Hispanics are at higher risk.
- Black Americans are about two times more likely than Whites to have Alzheimer's and other dementias.
- Hispanics are about one and one-half times more likely than Whites to have Alzheimer's and other dementias.

In addition to having higher risk, non-White populations experience barriers when accessing dementia care.

- Two-thirds of Blacks believe that it is harder for them to get excellent care for Alzheimer's, as do 40% of Native Americans and 39% of Hispanics.
- Less than half of Blacks and Native Americans feel confident they have access to providers who understand their ethnic or racial backgrounds.
- Additionally, 62% of Blacks believe that medical research is biased against people of color. This belief is also held by more than a third of Asian Americans, Hispanics and Native Americans.

Percentage of Adults Who Believe Their Race/Ethnicity Will Affect the Quality of Dementia Care



In addition to these barriers, Blacks and Hispanics are less likely than Whites to have a diagnosis of dementia despite being at higher risk for the condition.

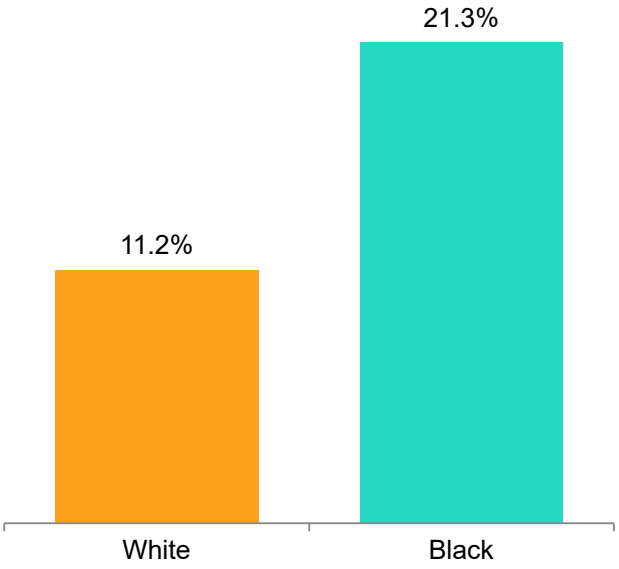
- While Blacks are about two times more likely than Whites to have Alzheimer's and other dementias, they are only 34 percent more likely to have a diagnosis.
- Hispanics are about one and one-half times more likely than Whites to have Alzheimer's and other dementias, but they are only 18 percent more likely to be diagnosed.

When they are diagnosed, Blacks and Hispanics are typically diagnosed in the later stages of the disease when they are more cognitively and physically impaired — and therefore in need of more medical care.

- As a result, Blacks and Hispanics diagnosed with Alzheimer's use substantially more health care services — and incur substantially higher costs for those services, especially for hospital care — than Whites with Alzheimer's.
- In 2019, average per-person Medicare payments for Blacks with Alzheimer's and other dementias were 25% higher than those for Whites with Alzheimer's and other dementias. Medicare payments for Hispanics with Alzheimer's and other dementias were 8% higher than those for their White counterparts.

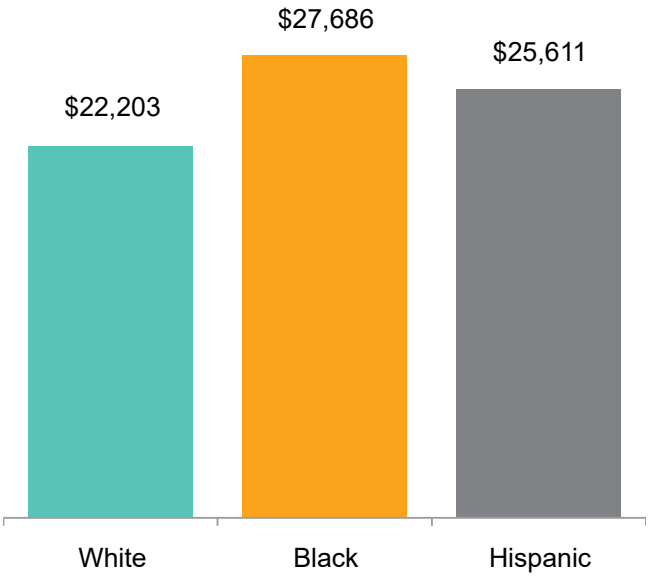
Proportion of Americans Aged 71 and Older with Alzheimer's and Other Dementias

Aging, Demographics, And Memory Study (ADAMS)



Total Average Annual Medicare Spending per Beneficiary 65 and Older with a Dementia Diagnosis, 2019

(in 2022 dollars)



Genetic factors do not account for the greater prevalence of — or the greater risk for developing — Alzheimer's.

- High blood pressure and diabetes — suspected risk factors for Alzheimer's and other dementias — are more prevalent in the Black community. These conditions, among others, may contribute to the greater prevalence of Alzheimer's.
- The differences in prevalence are also likely explained by disparities produced by the historic and continued marginalization of Black and Hispanic people — disparities in life experiences, socioeconomic indicators, and ultimately health conditions.
- Some studies suggest that after adjusting for health and socioeconomic risk factors, no differences in Alzheimer's prevalence exist.

Testimony for The Committee on Health

April 10, 2023

Submitted By Kiaira Wilkerson

Family Support Worker / Home Visitor

Mary's Center for Maternal and Child Care, Inc.

to Councilmember Henderson

Good morning, Chairwoman Henderson and members of the Committee on Health. Thank you for the opportunity to speak to you all as you conduct this budget oversight hearing for DC Health. Thank you for the current investments you've made to support DC families in navigating parenthood, without it I would not have the chance to support families in the ways that I am able to. My name is Kiaira Wilkerson and have been a Home Visitor at Mary's Center for about a year. I am here to talk about my experience as a Home Visitor, the impacts of our programs on families to urge the council to invest $1.2M to restore the Fiscal Year 2023 budget cut and increase DC Health Home Visiting grants that support stronger workforce retention. I am here to recommend DC Health explore and implement Medicaid Reimbursement opportunities for Evidence Based Home Visiting programs. Throughout the rest of my testimony, I will demonstrate how this request will not only continue to support families but will increase their positive outcomes and experiences.

In my time as a Home Visitor, I've been a cheerleader and advocate for the participants in my caseload. For instance, I have worked closely with a young mother and daughter. That is, it. That is all they have; they are here in the United States alone with no other support. There have been times when the mother has sat on the phone for close to two hours sharing tears and worries with me on how she would be able to provide her daughter with her basic needs. The trust that it takes to share your fears at

one of a mother's most vulnerable time is almost impossible to imagine. Our program and more importantly my relationship with this mother allowed me to contribute to the success that I now see in her. I now sit on the phone with this mother and discuss how her days at work go. This mother now sleeps peacefully at night knowing how she will feed her daughter tomorrow. This mother now can share the same resources and hope with the striving mothers of her community. As a home visitor, experiences and stories like this one I shared are what keeps me engaged in the work I do. The outcome and change to my participants lives inspire me and aid me to not only stay in the work that I do but to advocate for it at times like this. I don't know what the future will hold, I do know that I will continue to be a support to my community. DC has a chance to invest in Home Visiting to make sure that Home Visitors are incentivized to stay in their roles long term. Individuals are truly impacted by the support they receive from Home Visitors, but if we are not investing in the family support system providing these resources who will they go to access support and care?

In conclusion, we've explored some truths from my home visitor experience and the impact it has on a family. This one example may not demonstrate the full work the mom or I did, and I hope you can see the potential of what Home Visitors can do when they support a family. Despite all the obstacles I've shared, I still feel that we can go far to improve family wellbeing in the city. I would like to be a part of that work and insist that DC Health make the necessary investments that will uplift me and the Home Visiting Workforce. It would be great to receive DC Health's support to succeed in my role as I become a better cheerleader for families looking to achieve their personal and family goals. It is important that DC Health restores and increases investments into HV of $1.2M, 500K to restore what was cut in FY23 and Increase grants by 700K to increase salaries for the workforce. Medicaid reimbursement is an option DC Health should explore and implement so programs that support families have stable durable funding streams. To close this conversation, I urge councilmembers to consider not only my story but the impact my work has on our neighbors when thinking about increasing the investments Home Visitors need.

Intro:

- Purpose: Highlighting my personal experience in the work, and empathize the urgency of why we should invest in family support systems

    - Families without FSW's forced me to quickly train to catch families sooner.
    - Express how families have been impacted by under resourced supports
    - If we do have these resources, a family can benefit and strive with our support and go further
- Who am I and my Values
    - Recent Graduate from College. First Job right out of school. Was a manager in retail space through college.
    - I knew I would be in the social support field knowing that it is an under resourced environment
        - I'm the middle child of 5 siblings. My family didn't have the resources that others may have had. I grew up and benefitted from programs that revolve around the same goal of educating and uplifting families in their well-being.
    - Many individuals are leaving the field of their choosing because the salaries aren't enough
    - What their passionate about should fulfil their needs.

Body:

- For a lot of participants the resources are around them but as first time parents they don't always have the support to access them
    - Examples to share on this will be on the body of the draft
- As a home visitor I get to be the bridge and cheerleader for the families to succeed in their role as parents.

Conclusion:

- Salary
    - Home visitors, like child care teachers, have been some of the most dedicated, yet underpaid professionals working with District families and children for years. The competitive labor market has driven many working for underfunded programs to seek higher-paying jobs in other industries.
- Demanding that DC Health restore and increase investments into HV of $1.2M, 500K to restore what was cut in FY23 and Increase grants by 700K to increase salaries for the workforce.
- Medicaid reimbursement is an option DC Health should explore and implement so that programs that support families have stable durable funding sources.

https://docs.google.com/document/d/1KAGOAHZk-D2OEaJHzprlNefojyavmDOKWxjRgTJVFnQ/edit?usp=sharing

I've had the chance to not only work with them but get to know them on a level that many individuals won't or haven't seen. I am building trust with a family so that they can be vulnerable enough to ask for what they need and confront challenges head on. As a home visitor I've had the opportunity to offer resources and support to a number of my families. Families that I meet with have experienced and carry trauma that has progressed over the years, in addition to this they face hardships that they must try to tackle. I have had the chance to introduce and promote resources and personal encouragement that have led families to successes and opportunities that may not have been presented to them without our established relationship.

D.C. Council Committee on Health: Department of Health Budget Hearing
Monday, April 10, 2023
Testimony by Ashley Matejka,
Director of Community Wellness at Latin American Youth Center

Thank you, Councilmember Henderson and members of the Committee on Health, for allowing me to speak with you today. My name is Ashley Matejka and I am the Director of Community Wellness at Latin American Youth Center or LAYC. LAYC is in ward 1 and has been an important part of the District and region for over 50 years. We serve over 4,000 youth and families annually and operate programs in the District, and Prince George's and Montgomery Counties. LAYC is a proud member of the Fair Budget Coalition and we work in partnership for an equitable DC.

LAYC's COVID-19 relief and education efforts have served residents from youth to adults in the Washington, DC metro area by disseminating COVID-19 information and personal protective equipment, hosting COVID-19 vaccine clinics, and collaborating with partner organizations in wards 4, 5, 7, & 8. LAYC COVID relief also includes the distribution of shelf-stable food to youth and families experiencing food insecurity. Over 1600 bags of shelf-stable food have been distributed from October 2022 to present.

As we transition out of the public health emergency, LAYC continues to be a trusted source for health education and resources for DC youth. LAYC's efforts have evolved from a sole focus on COVID-19 to chronic diseases impacting the youth in our community. This includes disseminating information through outreach events and social media, hosting educational workshops, and linking youth to healthcare services as needed.

I believe in the wide-ranging work of the Fair Budget Coalition as I work to improve health literacy within our community. We expect the DC DOH Advancing Health Literacy grant to be refunded for FY24 to continue LAYC's efforts to ensure that DC youth have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and their families.

Thank you for your time. I am happy to answer any questions you may have.

Ashley Matejka
Director of Community Wellness

Latin American Youth Center
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Statement of Carrie Stoltzfus, Executive Director, Food & Friends, before the DC Council Budget Oversight Hearing: Committee on Health meeting
with the Department of Health
April 10, 2023

Good morning Chairperson Henderson and members of the Committee. I am Carrie Stoltzfus, the Executive Director of Food & Friends. Thank you for your support of our mission to improve the lives and health of DC residents living with serious illnesses such as cancer, kidney failure, HIV/AIDS, and others that limit their ability to provide their own nourishment. We are also grateful for our partnership with Dr. Lewis and the staff of DC Health.

I'm here today to report on a reduction of $25,000 in the FY24 budget for Food & Friends, to ask for the cut funding to be restored, and to respectfully ask for an increase in our support. Last year we home-delivered nearly 800,000 medically tailored meals free of charge to nearly 2,500 District residents, a nearly 30% increase from the prior year. We are hearing time and again from our health care partners that patients are returning to care with pandemic-delayed diagnoses of severe-illnesses, putting more people in need of Food & Friends than ever before, at a time when higher food and housing costs are already debilitating.

Therefore, in the FY24 budget, we request a $310,000 increase to our Community Health Administration grant to care for our neighbors. These funds will help us keep pace with increased need and provide an additional 55,000 meals. We do not make this request lightly. The majority of Food & Friends budget comes from philanthropy and health care partnerships, and for each dollar we receive from the District, we raise about $6.50 from other sources. But our support from DC Health and the Council remains key to our ability to carry out this important work.

In addition to being good stewards of your money, we also reduce the cost of healthcare. Those living with complex health condition who receive medically tailored meals and medical nutrition therapy experience 50% fewer inpatient admissions and 70% fewer emergency department visits than those not enrolled in such a program. A recent Tufts study estimates that if all US eligible patients received access to meals with nutrition standards such as ours, in just the first year over **1.5 million hospitalizations could be avoided for a net cost savings of $13.6 billion.**[i] One of the neighbors we are proud to serve, Aimee, will tell you first-hand about the difference our services make to her via separate testimony.

More so than ever in the past few years, we've been proud to work alongside those in our city who are making a difference for those who are nutritionally vulnerable. We enthusiastically support the requests of all members of the Fair Food for All DC Coalition, which I have attached to my written testimony. DC would not be the city that we are without these providers.

Food & Friends will continue to meet the challenges of feeding those who are medically vulnerable, we appreciate the Council's support of our mission and we look forward to a continued partnership. Thank you.

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[i] Hager K, Cudhea FP, Wong JB, et al. Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US. JAMA Netw Open. 2022;5(10):e2236898. doi:10.1001/jamanetworkopen.2022.36898

Client Story

AIMEE BERENSON IS A CHANGEMAKER WHO REFERRED PEOPLE LIVING WITH HIV/AIDS TO FOOD & FRIENDS IN THE 90'S, TODAY SHE COUNTS ON OUR DELIVERIES HERSELF

Aimee Berenson is a one-of-a-kind lawyer and Washingtonian. She spent decades working on landmark legislation to protect persons living with HIV/AIDS, and she was one of the best. But if you met her, she would not boast about that. In her younger days, she was a fearless, outspoken legal advocate. At the very beginning of the epidemic in the 1980s, Aimee worked with GMHC (formerly Gay Men's Health Crisis). She held a key leadership role at the AIDS Action Council from 1993 to 2001, and even advised member organization Whitman Walker Health. Aimee's story and the origins of Food & Friends are intertwined.

Today, she lives in Northwest D.C., in an early century row-house with Max, her beautiful white Maine Coon cat, a gift from a good friend. She is living with major heart and respiratory disease and receiving medically tailored meals and nutrition counseling from Food & Friends. We had the honor of spending a winter afternoon with her and Max, and hearing some of her stories.

Aimee exudes humility, though if you ask her enough questions, you will discover that her life story and career are worthy of a best-seller. Aimee says, "looking back, if you have some skills and talents, you want to use them to help the kind of people who can't afford the help they need."

In those days, it was common for people living with AIDS to be illegally evicted from their homes, abandoned by their families, and left homeless. Aimee had seen the devastation this caused firsthand in the subway tunnels and avenues of New York City. The suffering she witnessed inspired the fierceness she used to pursue justice. She began in a small office in the city with three other attorneys, and they worked side by side in a small, rented room on one big plastic table.

Aimee had found a cause she was passionate about and a way to use her gifts; she informed her work through interviews with people living with HIV/AIDS. She patiently learned about their hopes and fears and uncovered the extreme inequities they experienced. She then used their stories to directly translate their voices into groundbreaking legal memos, which she would write and help advance through the legislature.

Aimee led the way in setting up a series of meetings with Henry Cisneros, the 10th Secretary of Housing and Urban Development (HUD) who worked in the administration of President Bill Clinton. The goal was to enable Mr. Cisneros to directly hear the voices of people living with HIV/AIDS, so they could explain the barriers they had to housing to him, and why they so desperately needed support and legal protection.

She authored reports for Secretary Cisneros in favor of the creation of an internal HIV/AIDS office at HUD to coordinate its AIDS housing programs. It was 1994. At the time, AIDS was the leading cause of death for all Americans ages 25 to 44. The most important HUD program making grants to local communities, States, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families was in serious jeopardy of being eliminated. Aimee and her colleagues stopped that from happening.

Aimee speaking at an HIV/AIDS conference in the early 1990s; and meeting with Vice President Al Gore. Aimee later worked with President Joe Biden on health policy when he was a Senator.

In 1990, there were only $75 million in grants per year for AIDS housing projects. By the end of 1994, thanks to the work of Aimee and her colleagues, the United States Congress and the United States Senate voted to increase the funding to $186 million. In response to the meetings Aimee and her team of activists organized, Mr. Cisneros determined that HUD would move forward to launch the new HIV/AIDS office dedicated to improving the planning and implementation of these vital programs. Aimee and her colleagues on the National AIDS Steering Committee had won.

"I took joy in kicking down the doors for people with HIV/AIDS to tell their own stories. Secretary Cisneros trusted me to draft legislation and testify to translate the needs people were having into programs and funding. He was right on board," recalls Aimee. Mr. Cisneros would go on to have a recurring meeting with Aimee and a cadre of AIDS activists once a month on Saturday's. Aimee felt like it was her job to make sure the legislative documents she was drafting originated from the voices of the individuals being impacted.

Thousands of people living with HIV/AIDS would keep their homes thanks to this work. The median survival period for those diagnosed with AIDS at the time was still only about two and a half years. This gave them a chance to live and die in dignity in their own homes, even if they had been removed from their jobs and lost their livelihoods.

Andrew Cuomo was the assistant secretary of HUD at the time. Aimee's colleague Keith Cylar took him into the subway tunnels to show him where people living with HIV/AIDS were living. He questioned Keith for doing this work alone and told Aimee it was dangerous and wanted them

to stop. Aimee responded, "how else do you expect us to advocate for these men and make their voices heard, sir?"

An old photo in her living room shows her standing poised, with a cascade of jet-black hair, at a podium speaking at the National AIDS Housing Conference in June of 1997. She told the audience, "You have the power to affect change, you can speak for yourself, you can advocate."

Aimee remembers the devastation caused in the days when AIDS was referred to as "GRID," an acronym that stood for "gay-related immune deficiency." She remembers when Haitian Americans were the targets of discrimination after the U.S. Centers for Disease Control hastily listed Haitians as one of the four "high-risk" groups for AIDS. Americans of Haitian descent were removed from their jobs and had their applications for mortgages or college admissions denied. Aimee took on many discrimination cases like this, and she and her team were able to win every case that came before them with few exceptions.

Aimee was born with some congenital health conditions and had open heart surgery when she was just a kid, but despite the health barriers she faced, she became a hero for those she served. She is 5 feet tall, but her presence is grand. She radiates purpose.

Though she has serious chronic health issues, everything about her demonstrates resilience, confidence, and bravery. During her career, she became a visible legal advocate for the rights of persons living with HIV/AIDS. She served as a recurring voice of advocacy in national publications like the New York Times, The Chicago Tribune, and the LA Times. She worked on a breadth of groundbreaking legislation during her legal career including key cases for gay rights, marriage equality, health privacy, and housing protections.

Aimee also recalls referring individuals with HIV/AIDS to Food & Friends to receive meals during her time working as an attorney in partnership with community-based organizations serving persons living with HIV/AIDS in D.C. in the 1990s. She never expected that one day she would be receiving medically tailored meals and nutritional support from Food & Friends herself.

"You never know when you are going to be the one who needs help. It is especially important to help places like Food & Friends who serve populations with specific needs. You may turn around and be the person with one of those needs someday."

The medically tailored meals Aimee receives thanks to caring donors and volunteers are essential for her. They are also especially helpful because she is prone to seizures, so being able to microwave something is much safer than using the gas stove.

"My ability to go shopping and cook for myself is severely limited. If you do not have sufficient body fat it leads to heart failure, so this is a vital service for me. It is also not only about receiving the meals, but also having the support of a registered dietitian." Aimee especially enjoys working with her registered dietitian Nicole Merryman from Food & Friends.

The work of Food & Friends is much more than providing healthy food. We are neighbors helping neighbors. Thanks to our supporters, we will continue this important work and lift the voices of those we serve. It is our honor to serve Aimee Berenson, and 4,899 others this year, who count on our continued support.

FOOD & FRIENDS®

Delivering hope, one meal at a time®

Our work in the District of Columbia

Who we are:

Since 1988, we are the only community-based organization in the D.C. region providing home-delivered Medically Tailored Meals and Medical Nutrition Therapy to our neighbors living with serious illnesses that limit their ability to provide nourishment for themselves.

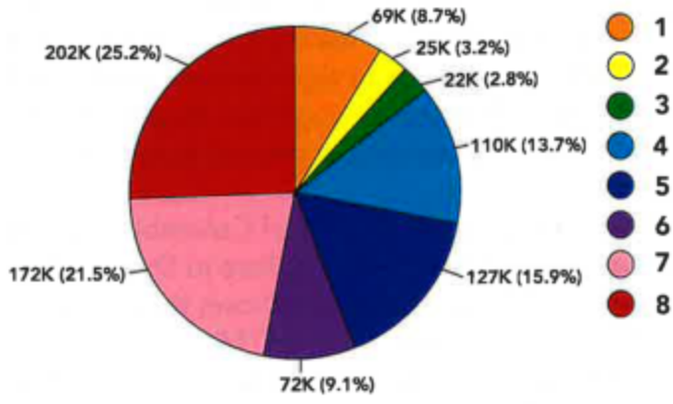
What we do:

With the help of thousands of volunteers, Food & Friends prepares and delivers nutritionally tailored, delicious meals directly to our neighbors' homes. Our Registered Dietitians and professional chefs work closely to provide individualized services to our clients.

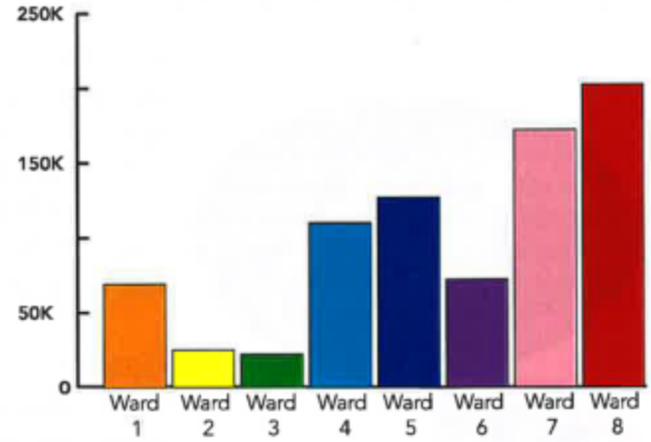
Who we serve:

Food & Friends provides Medically Tailored Meals, groceries, and Medical Nutrition Therapy to people living with life-challenging illnesses. All meals and services are free-of-charge to the client. Recognizing that clients with children often share their food with their kids, Food & Friends also provides services to dependents and caregivers in the household, ensuring the parent can focus on getting well.

Total Meals Delivered:



Total Clients Served:



Food & Friends is built on a simple premise: anyone can get sick, and everyone can help.

In FY22, Food & Friends home-delivered 799,244 Medically Tailored Meals to 2,449 primary clients in the District of Columbia. In 2022, our clients had a range of illnesses including cancer, diabetes, renal disease, HIV/AIDS, maternal health concerns, heart disease and other serious illnesses.

799,244
meals delivered to D.C. residents

2,449
clients live in D.C.

705
nutrition encounters with our registered dietitians

330
volunteers live in D.C.

61%
of all households served have income less than $1500/month

Connect

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219 Riggs Road NE
Washington, DC 20011

Phone (202) 269-6836
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publicgrants@foodandfriends.org

www.foodandfriends.org
United Way #8429
CFC#52114

FOOD & FRIENDS®

Delivering hope, one meal at a time®

Impact in the District of Columbia

Lower Cost of Care:

Proper food and nutrition helps increase absorption of medication, reduces side effects, and helps patients maintain a healthy body weight. As a member of the national Food is Medicine Coalition (FIMC), we adhere to rigorous nationwide nutrition and quality standards and uniquely employ Medical Nutrition Therapy through our Registered Dietitians, personalizing each client's nutrition needs and encouraging lifelong improved nutrition.

According to the District of Columbia Department of Health, serious illnesses such as diabetes cost an estimated $346 million dollars in D.C. each year for the approximately 52,000 residents with diabetes or prediabetes. Research shows that people living with complex health conditions and enrolled in Medically Tailored Meal (MTM) programs experience 50% fewer inpatient admissions and 70% fewer emergency department visits than similar patients not enrolled in an MTM program.[i] Just published national research shows that if all U.S. eligible patients received access to MTMs with nutrition standards such as ours, in just the first year of service 1,594,000 hospitalizations could be avoided for a net cost savings of $13.6 billion.[ii]

Equity:

Our Medically Tailored Meals and Medical Nutrition Therapy are free to clients and their families, and we work tirelessly to ensure that no eligible client is turned away. Over 61% of our client households have income of less than $1500 per month - we immediately address inequitable social determinants of health such as healthcare access and food security.

Healthier Communities:

We believe in the power of compassion and the importance of neighbors helping neighbors, so we create opportunities for impactful and fulfilling volunteer service that helps our sick neighbors and builds a healthier community for all. MTMs have been associated with reduced depressive symptoms and fewer dilemmas between paying for either food, healthcare or prescriptions.[iii] Our Client survey shows that 71% of our clients report improved mental health, 80% report improved quality of life, 80% report they are better able to follow doctors' orders and over 93% of our clients reported that they learned to eat better for their health condition after talking with our dietitians.

Need for increased support:

Food & Friends saw a 29% increase in need in the District in 2022, likely due to pandemic-delayed diagnosis of severe illnesses and due to rampant food insecurity from inflation and a volatile job market. To achieve our mission, we stitch together Federal, State and local public funds, private contributions and reimbursements from partnerships with Medicaid managed care plans. By supporting Food & Friends' services, the District of Columbia engages in a true public-private partnership that benefits the most vulnerable citizens and helps to build a healthier, more economically vibrant community.

i. Seth A. Berkowitz et al, Meal Delivery Programs Reduce the Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries, HEALTH AFFAIRS, (2018).
ii. Hager K, Cudhea FP, Wong JB, et al. Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US. JAMA Network Open. 2022;5(10):e2236898. doi:10.1001/jamanetworkopen.2022.36898
iii. Tapper EB, Baki J, Nikirk S, Hummel S, Asrani SK, Lok AS. Medically tailored meals for the management of symptomatic ascites: the SALTYFOOD pilot randomized clinical trial. Gastroenterology Report 2020;8(6):453-456. DOI: 10.1093/gastro/goaa059.

Fair Food for All DC Coalition
FY24 Budget Update and Call to Action

Food insecurity remains a major challenge in the District of Columbia. 145,000 of our residents rely on the SNAP Program, and just weeks ago, these households saw a dramatic reduction in those benefits as Federal emergency allotments came to an end. We cannot risk a dual 'hunger cliff' with the retreat of public benefits alongside insufficient funding for vital local food access programs at a time of growing food costs. We ask for the Council's support in protecting the important and laudable investments made in the Mayor's FY24 proposed budget and harnessing the additional resources needed to ensure critical programs can meet the fundamental needs of DC residents for healthy, dignified food in the year ahead. The Fair Food for All DC Coalition is comprised of respected local organizations with deep expertise in food access and food security programming. The below tables reflect recent and proposed funding levels for our essential programs and partnerships with DC Government. The combined efforts of these programs can be fully funded with an additional investment of **$2,305,000**. On page two, we detail necessary investments in already-passed local legislation and system-wide initiatives previously supported by the DC Council.

Produce Plus (FRESHFARM)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$1,200,000	$1,401,934	$1,500,000	$1,290,000	$1,960,000	**$670,000**

Home-Delivered Meals (Food & Friends)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$825,000	$825,000	$1,025,000	$1,000,000	$1,335,000	**$335,000**

Commodity Supplemental Food Program (Capital Area Food Bank)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$410,000	$309,232	$410,000	$410,000	$460,000	**$50,000**

Distribution Efforts (Capital Area Food Bank)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$1,000,000	$500,000	$0	$750,000	**$750,000**

The Well at Oxon Run (DC Greens)

FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$500,000	**$500,000**

Joyful Food Markets (Martha's Table)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$1,500,934	$1,825,000	$1,825,000	$1,825,000	$1,825,000	**$0**

Healthy Corners (DC Central Kitchen)

FY21 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY24 Need**	Funding Gap
$500,000	$750,000	$750,000	$600,000	$600,000	**$0**

Produce Rx (DC Greens)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$250,000	$250,000	$500,000	$500,000	$500,000	**$0**

CAPITAL AREA FOOD BANK · d.c. central kitchen · dcgreens · D.C. Hunger Solutions · FOOD & FRIENDS "Delivering hope, one meal at a time" · FRESHFARM "nourishing our food future" · Martha's Table

Additional Requests in Support of Critical Legislative and Local Initiatives

Fully funding the local costs of No Senior Hungry

FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$1,580,000	**$1,580,000**

Advancing the implementation of the Good Food Purchasing Program (GFPP)

FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$677,000	**$677,000**

Fully funding Give SNAP a Raise

FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$51.9M	**$51.9M**

With your support, DC's innovative homegrown hunger solutions and powerful legislative efforts can have a transformative impact in reducing food insecurity and addressing deep-rooted health disparities. Thank you for your continued partnership and leadership in the fight against hunger and chronic disease in our community.

Testimony before the Committee on Health

Oversight Hearing on the Department of Health

Janet A. Phoenix, MD, MPH, MS

Assistant Research Professor

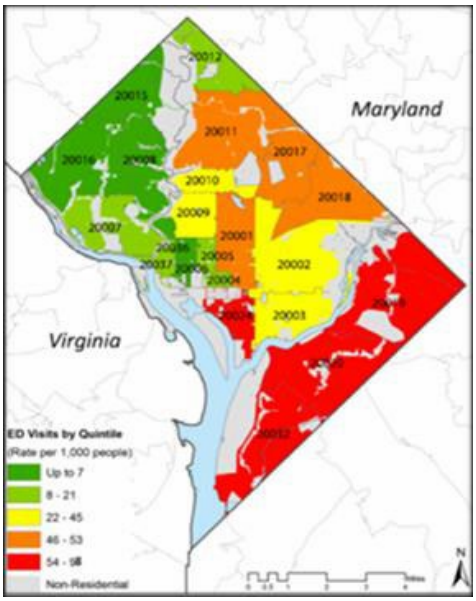
George Washington University Milken Institute of Public Health

Presented Monday, April 10, 2023

Good morning, Chairperson Henderson and members of the Committee of Health. My name is Dr. Janet Phoenix. I am an Assistant Research Professor at the Milken Institute School of Public Health at George Washington University and a physician by training. I also chair the DC Asthma Coalition. I am presenting this testimony regarding budgetary and data needs related to health outcomes for DC residents affected by social determinants of health.

Because so many children in DC were adversely affected by childhood asthma and lead poisoning, a group of organizations joined together to create the Campaign to Reduce Lead Exposure and Asthma which launched last year. This campaign has met with and will continue to meet with many of you to advocate for improved conditions to reduce the numbers of DC residents exposed to lead and suffering from asthma.

Wards 5, 7 and 8 have some of the highest rates of asthma emergency room visits and hospitalizations. I have included below a map of rates of hospital and emergency room visits for children in DC. Neighborhoods with higher rates are highlighted in red and neighborhoods with lower rates in green.



Source: Asthma Surveillance in DC Emergency Departments and Hospitals. Children's National. December 14, 2017.

This data was provided to me by Children's National. Similar data probably exists for adults in DC, but I have been unable to obtain them. The last data on asthma for DC residents that the Department of Health prepared was released in 2016 and was based on 2013 data.

Children living in SE Washington are 23 times more likely to be hospitalized or in the ER for their asthma than children living in Ward 3. Traffic corridors that run through Wards 5, 7 and 8 are a contributing factor to the pattern of ER visits and hospitalizations as are housing conditions. Many children live in housing that is poorly maintained exposing them to mold and pest infestations. Are there similar patterns for adults? Is proximity to traffic associated with adult asthma as well as childhood asthma? These are questions I would like DC Health to explore.

Right now, the responsibility for programs, grants, and partnerships for conditions like asthma and lead poisoning are housed in the Chronic Diseases Division. Many city and state health departments have a division that focuses specifically on Environmental Health but there is no such entity within the DC Department of Health; there is no section of the organization tasked directly with addressing environmental determinants of health.

For chronic diseases like asthma, there is a need to provide evidence linking sources of exposure to asthma allergens and irritants to outbreaks of disease. While

there is clear ecological evidence of an association between traffic corridors like 295 and New York Avenue to high rates of emergency room visits and hospitalizations for asthma and some causal links that have emerged from data in other jurisdictions, little has been done to explore these associations here in DC.

The proposed budget contains increased support for the Center for Policy, Planning and Evaluation with increases for epidemiological support for the agency. Cancer and Chronic Disease Prevention fare less well with a decrease in this years' budget compared to last fiscal year.

It would be logical to focus more on chronic diseases like asthma, linking sources of exposure like traffic related air pollutants and housing. This would require at least level funding for chronic disease and prevention and potentially additional funding might be needed. I also recommend that there be cooperative efforts with the Department of Health Care Finance, so that Medicaid data could be used for some of these analyses. This would require additional support for both the Chronic Diseases Division and the Center Policy, Planning and Evaluation.

The Center for Policy Planning and Evaluation may need additional resources are needed to ensure the DC Health has access to recent data on asthma from sources like the American Hospital Association and Children's National so that this data can be analyzed and regularly made available to the public. Our lead and asthma campaign has had to rely upon outdated information as we advocate for policies to address lead exposure and asthma. This has undermined our effectiveness.

It is understandable that during the pandemic, the priorities of DC Health needed to focus on infectious disease treatment and prevention. But 7 years is too long to wait to have accurate data on the extent of a prevalent condition like asthma which affects so many DC residents.

Children's National has used data from their Asthma registry to overlay housing code inspection data with multifamily housing where children with asthma live in a searchable database. They are to be applauded for this effort, but they do not have adequate resources to sustain this effort over time and the data is limited to childhood asthma. We should not have to rely solely on private entities for collection of health outcomes data for DC residents. It is not unreasonable to ask

city agencies to take the lead in collecting, analyzing and publishing current data on asthma for DC residents.

Lastly, partnerships between the Department of Health and other agencies are needed (such as the Department of Health Care Finance to receive and analyze Medicaid data and the Department of Buildings to inform housing inspections in housing where children with asthma reside). This cooperation between agencies in the administration can lead to more effective program administration and implementation of laws and regulations designed to protect the health of DC residents and to improve the environment of these vulnerable populations.

These relationships are needed to inform decisions being made by agencies responsible for regulating conditions that impact health. A roadmap for identifying and describing the nature of these relationships could be guided by a working group. I have attached a recommendation we made last year to the Health Committee for the formation of such a Working Group. Suggested participants for such a Working Group are attached as an Appendix.

Thank you for the opportunity to testify.

Suggested Working Group Participant Categories

- **Governmental agencies**

  DOEE, DHCD, DOB, DCHA, DOH, DHCF, OAG

- **Non-governmental Advocacy Organizations**

  NAACP-DC, Empower DC, Children's Law Center, DC Appleseed, Sierra Club, Interfaith Power & Light, WIN, DC Asthma Coalition, Caracen, DC Healthy Housing Collaborative

- **People directly affected.**

- **Health Care Providers**

  Children's National, Unity, Amerihealth, Medstar Georgetown Community Pediatrics, DC Chapter of the American Academy of Pediatrics

- **Representatives**

    - Individuals and groups that work directly with affected communities and/or represent their communities.
- **Community Leaders**
-
    - **Tier 1:** Formal/Official
        - People who are elected or hold titles in their respective communities.
            - E.g., ANC Leaders, DC Asthma Coalition, DC Healthy Housing Collaborative,
    - **Tier 2:** Informal
            - DC Environmental Justice Coalition, Ward 7 Health Alliance, Attendees of DCHA Board of Commissioner's Meetings

- **People with Substantive Expertise in Healthy Housings**
    - e.g., Rodham Institute, Other Researchers in Academic Institutions, Green and Healthy Homes Initiative, National Center for Healthy Housing

- **Property Owners/Managers**

  e.g., Lincoln-Westmoreland, WC Smith

- **Affordable Housing Developers/Advocates**

  Coalition for Nonprofit Housing Development

- **Remediation Professionals**

  Yachad, Rebuilding Together, Habitat for Humanity

- **Philanthropic Community**

  e.g., Cafritz, Greater Washington Community Foundation

Testimony for The Committee on Health

April 10, 2023

Submitted By Jennifer Vega

Family Support Worker / Home Visitor

Mary's Center for Maternal and Child Care, Inc.

to Councilmember Henderson

Good morning councilmember and committee chairs, thank you for the opportunity to testify. I am Jennifer, a Nurse home visitor with Nurse Family Partnership.

I am here to propose investments that will work towards familial wellbeing and healthy life outcomes. Also, explore the Medicaid reimbursement options to fund and sustain Home Visiting Programs.

As a healthcare professional, I know that prevention is much more effective to support families than to provide treatment to a magnified issue or symptom.

For example, while working at a Hospital, someone came in postpartum in critical condition because she was bleeding out due to an infection. It could have been prevented if she had been connected to a service or support like NFP. As a home visitor with the ability to do a limited medical assessment, we were able to get someone else seen early with her OB and prevent escalation and severity of symptoms. (Connect to the Medicaid Reimbursement item, because of the positive medical outcomes because of NFP's preventative approach)

Another example is a family I worked with regarding their child's development by completing developmental activities, the mother was able to connect the dad to some of the activities for the child. Since then, the mother and father have strengthened the relationship dynamic between the parents and their child. The mother reports having a stronger connection to the child with the dad, as well as strengthening the connection to the father as well.

Women and children's health has always been a focus in my life and being a Nurse Home Visitor I get to have an immense impact on the families. Many participants express gratitude for being someone they

can talk to about the journey of parenthood and on top of being a listening ear, I get to provide resources, advice, insight, and educate them on the challenges they face. This support makes the parents feel like they're not alone and that they have support.

These 2 stories I provided are just a couple of the countless stories NFP has positively impacted families and communities worldwide.

In more than 40 other States, NFP, and other evidence-based home visiting programs, are funded through a mix of both private and public dollars. At least 37 states cover evidence-based home visiting programs, including NFP through the Medicaid program and that list is growing. While rates and payment structures vary depending on the methodology used, we know that leveraging Medicaid dollars to support evidence-based home visiting is cost effective.

Home visiting is an investment in communities – a holistic, preventative approach to supporting families and their health, well-being, economic stability, etc especially when some participants face more challenges

I fully support all the other asks presented to Council on Home Visiting and look forward to your increased investments to ensure a thriving landscape for families to benefit from.

Good morning councilmember and committee chairs, thank you for the opportunity to testify. I am Jennifer, a Nurse home visitor with Nurse Family Partnership.

I am here to propose investments that will work towards familial wellbeing and healthy life outcomes. Also, explore the Medicaid reimbursement options to fund and sustain Home Visiting Programs.

As a healthcare professional, I know that prevention is much more effective to support families than to provide treatment to a magnified issue or symptom.

- For example, while working at a Hospital, someone came in postpartum in critical condition because she was bleeding out due to an infection. It could have been prevented if she had been connected to a service or support like NFP. As a home visitor with the ability to do a limited medical assessment, we were able to get someone else seen early with her OB and prevent escalation and severity of symptoms. (Connect to the Medicaid Reimbursement item, because of the positive medical outcomes because of NFP's preventative approach)
- Another example is a family I worked with regarding their child's development by completing developmental activities, the mother was able to connect the dad to some of the activities for the child. Since then, the mother and father have strengthened the relationship dynamic between the parents and their child. The mother reports having a stronger connection to the child with the dad, as well as strengthening the connection to the father as well.
- Women and children's health has always been a focus in my life and being a Nurse Home Visitor I get to have an immense impact on the families.
    - Many participants express gratitude for being someone they can talk to about the journey of parenthood and on top of being a listening ear, I get to provide resources,

advice, insight, and educate them on the challenges they face. This support makes the parents feel like they're not alone and that they have support.

- These 2 stories I provided are just a couple of the countless stories NFP has positively impacted families and communities worldwide.
- In more than 40 other States, NFP, and other evidence-based home visiting programs, are funded through a mix of both private and public dollars. At least 37 states cover evidence-based home visiting programs, including NFP through the Medicaid program and that list is growing. While rates and payment structures vary depending on the methodology used, we know that leveraging Medicaid dollars to support evidence-based home visiting is cost effective.
- **Home visiting is an investment in communities** – a holistic, preventative approach to supporting families and their health, well-being, economic stability, etc especially when some participants face more challenges
    - I fully support all the other asks presented to Council on Home Visiting and look forward to your increased investments to ensure a thriving landscape for families to benefit from.

- Intro:
- Gratitude for the time to testify and the resources that they've already poured into our programs.
- Purpose is to persuade and call to action the council to make the investments that will work towards familial wellbeing and healthy life outcomes. Also, explore the Medicaid reimbursement options to fund and sustain Home Visiting Programs.
- Prevention is much more effective to support families than to provide treatment to a magnified issue or symptom.
- Working in the hospital – quick fixes when things are going bad – What does a prevention strategy look like? Home Visiting is setting up for things to look well long term.
- The priority of providing support to families that educate on their children's developmental milestones and resources that improve outcomes when necessary.

Body:

- Professional experiences supporting families navigating health concerns as an NFP Nurse Home Visitor.
- For example, while working at a Hospital, someone came in postpartum in critical condition because she was bleeding out due to an infection. It could have been prevented if she had been connected to a service or support like NFP. As a home visitor with the ability to do a limited medical assessment, we were able to get someone else seen early with her OB and prevent escalation and severity of symptoms. (Connect to the Medicaid Reimbursement item, because of the positive medical outcomes because of NFP's preventative approach)

- By doing all of the developmental activities, the mother was able to connect the dad to some of the activities for the child. Since then, the mother and father have strengthened the relationship dynamic between the parents and their child. The mother reports having a stronger connection to the child with the dad, as well as strengthening the connection to the father as well.
- Women and children's health has always been a focus in my life and being a Nurse Home Visitor I get to have an immense impact on the families. Knowing that I'm here for them judgement free is really nice to see.
    - Many participants express gratitude for being someone they can talk to about the journey of parenthood and on top of being a listening ear, I get to provide resources, advice, insight, education on the challenges they face. This support makes the parents feel like they're not alone and that they have support. (Connect to the holistic preventative approach line at the conclusion)

Conclusion:

- Communicate how impactful our programs are to the community
- In more than 40 other States, NFP, and other evidence-based home visiting programs, are funded through a mix of both private and public dollars. At least 37 states cover evidence-based home visiting programs, including NFP through the Medicaid program and that list is growing. While rates and payment structures vary depending on the methodology used, we know that leveraging Medicaid dollars to support evidence-based home visiting is cost effective.
    - Funding NFP and other evidenced based home visiting programs through Medicaid is not only cost-effective it also promotes better coordination of care and services for pregnant persons and babies who are enrolled in Managed Care.
    - For every dollar spent on Home Visiting efforts, at least $2.00 dollars in future spending is saved. Moreover, the costs associated with poor birth outcomes are high. In 2012, the Planning Council reported that the societal economic cost associated with preterm birth in the U.S. was at least $66,218 per infant born preterm .
- **Home visiting is an investment in communities** – a holistic, preventative approach to supporting families and their health, well-being, economic stability, etc especially when some participants face more challenges
    - I fully support all the other asks presented to Council on Home Visiting and look forward to your increased investments to ensure a thriving landscape for families to benefit from.

Fair Food for All DC Coalition
FY24 Budget Update and Call to Action

Food insecurity remains a major challenge in the District of Columbia. 145,000 of our residents rely on the SNAP Program, and just weeks ago, these households saw a dramatic reduction in those benefits as Federal emergency allotments came to an end. We cannot risk a dual 'hunger cliff' with the retreat of public benefits alongside insufficient funding for vital local food access programs at a time of growing food costs. We ask for the Council's support in protecting the important and laudable investments made in the Mayor's FY24 proposed budget and harnessing the additional resources needed to ensure critical programs can meet the fundamental needs of DC residents for healthy, dignified food in the year ahead. The Fair Food for All DC Coalition is comprised of respected local organizations with deep expertise in food access and food security programming. The below tables reflect recent and proposed funding levels for our essential programs and partnerships with DC Government. The combined efforts of these programs can be fully funded with an additional investment of **$2,485,000**. On page two, we detail necessary investments in already-passed local legislation and system-wide initiatives previously supported by the DC Council.

Produce Plus (FRESHFARM)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$1,200,000	$1,401,934	$1,500,000	$1,290,000	$1,960,000	**$670,000**

Home-Delivered Meals (Food & Friends)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$825,000	$825,000	$1,025,000	$820,000	$1,335,000	**$515,000**

Commodity Supplemental Food Program (Capital Area Food Bank)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$410,000	$309,232	$410,000	$410,000	$460,000	**$50,000**

Distribution Efforts (Capital Area Food Bank)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$1,000,000	$500,000	$0	$750,000	**$750,000**

The Well at Oxon Run (DC Greens)

FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$500,000	**$500,000**

Joyful Food Markets (Martha's Table)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$1,500,934	$1,825,000	$1,825,000	$1,825,000	$1,825,000	**$0**

Healthy Corners (DC Central Kitchen)

FY21 Budget	FY21 Budget	FY22 Budget	FY23 Draft Budget	**FY24 Need**	Funding Gap
$500,000	$750,000	$750,000	$600,000	$600,000	**$0**

Produce Rx (DC Greens)

FY21 Budget	FY22 Budget	FY23 Budget	FY24 Draft Budget	**FY24 Need**	Funding Gap
$250,000	$250,000	$500,000	$500,000	$500,000	**$0**

Additional Requests in Support of Critical Legislative and Local Initiatives

Fully funding the local costs of No Senior Hungry

FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$1,580,000	**$1,580,000**

Advancing the implementation of the Good Food Purchasing Program (GFPP)

FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$677,000	**$677,000**

Fully funding Give SNAP a Raise

FY24 Draft Budget	**FY24 Need**	Funding Gap
$0	$51.9M	**$51.9M**

With your support, DC's innovative homegrown hunger solutions and powerful legislative efforts can have a transformative impact in reducing food insecurity and addressing deep-rooted health disparities. Thank you for your continued partnership and leadership in the fight against hunger and chronic disease in our community.

Testimony of Karen Doyne
1706 19th Street NW, Washington DC 20009
DC City Council Committee on Health — Budget Hearing
April 10, 2023

Good morning, Committee Chair Henderson and Members of the City Council:

My name is Karen Doyne. I am a 40-year resident of Ward 2 and a small-business owner. I'm also a passionate advocate for those suffering from Alzheimer's Disease, which took the lives of my father and my grandmother.

I'm here today to urge the Committee to restore the $170,000 that was previously appropriated to implement the Dementia Training for Direct Care Workers Act. Under the Act, passed in 2020 by the Council and signed by Mayor Bowser, the District established important new training standards regarding dementia for all direct care workers in nursing homes, assisted living, adult day care and home care settings. Yet, nearly three years after its passage, this law has yet to be implemented and the Mayor has not included it in her FY 2024 budget.

Direct care workers are the largest segment of the workforce providing day-to-day care for people living with Alzheimer's and other dementias. We are seeing major growth in the sheer number of these workers because of growing demand: In DC, the number of direct care workers needed will grow by 25 percent between 2020 and 2030. It is critical that these front-line workers understand how best to care for people living with dementia. But unfortunately, existing training programs do a poor job of equipping them to do so.

Under DC's new law, those who work extensively with dementia patients must go through at least 8 hours of specialized training – certainly not an unreasonable burden given the gravity of their responsibilities and the unique needs of people with dementia. The law also requires the development of standardized training programs and certification of workers who have completed the training.

Based on the statistics, I stand a good chance of someday suffering from Alzheimer's. So do many of the people taking part in this hearing today. Some 10,000 District residents are already living with Alzheimer's and that number is growing. Among the Baby Boom generation, like me, nearly half of us who reach age 85 will get Alzheimer's, and we will die either from it or with it.

As you may know, there are also other risk factors for Alzheimer's that affect a large part of DC's population, namely people of color: Studies have shown that Black older adults are about twice as likely to have Alzheimer's than White older adults; a disproportionate risk for Latinos is evident as well.

So, it is not a theoretical exercise when I ask each of you to imagine yourself, your spouse, your parent or another loved one suffering from Alzheimer's; and relying on the services of direct care workers. (Chances are, you will be in this situation sooner or later.) Or, when I ask you to imagine how you would feel if those workers caring for you or your loved one were poorly prepared to help you deal with the difficult and heartbreaking challenges posed by dementia.

Please restore funding for the Dementia Training for Direct Care Workers Act, to help make sure the growing population of District residents living with Alzheimer's have access to the quality care every one of them needs and deserves.

Testimony for The Committee on Facilities and Family Services

April 10, 2023

Submitted By Felix Hernandez

Advocacy and Fatherhood Program Manager

Mary's Center for Maternal and Child Care, Inc.

to

Councilmember Janeese Lewis-George

Good morning, Chairperson Henderson and members of the Committee on Child Family Services Agency. Thank you for the opportunity to speak to you all as you conduct this budget oversight hearing for the Department of Health Care Finance. I am Felix Eduardo H. and am the Advocacy and Fatherhood Program Manager at Mary's Center and am a member of the Home Visiting Council. I am here to share some considerations and feedback that focus on Home Visiting. Specifically, we are here seeking an investment increase of $300,000 for CFSA for workforce retention.

Many of our neighbors in DC have not been able to access home visitor support and services primarily because the health care and support workforce is seeing an incredibly steep turnover rate, something that the pandemic has magnified greatly. For Home Visitors the primary factor and driver of this trend is due to the high administrative burden coupled with a salary that does not adequately compensate them for the impact and services they deliver. The interruptions to our services due to low wages have a negative impact on the demographics we hope to partner with and support. From October 2021 to May 2022, we had only 1 Home Visitor because when the first 2 two people we offered the job to rejected the salary we were able to offer based on the funding limitations of our grants. Many participants have shared that they've had to work two jobs to make ends meet. I've also had many home visitors share the same. The Grants DC offers for Home Visiting programs directly impacts the salary amounts we can offer. Many of the challenges participants confront are usually about housing, food, job security and family

wellbeing and in the last couple of years, I've heard Home Visitors share that they're also navigating the same. We need stronger investments for a stable healthy workforce.

Recently, the mayor is set to invest $750K to refurbish 4 tennis courts into Pickleball courts and a $20M in increases to New Police Recruit Sign on bonuses from 20K-25K. I'm sharing this with you as we consider the modest invest we're requesting for HV. I invite this committee to make sure prevention services like Home Visiting have abundant resources to make thriving wages possible. The work of prevention can positively improve community safety and wellbeing. I'm observing policing intervention strategies get more resources and attention and would like us to consider how stronger abundant investments into prevention should be where we pour the bulk of our efforts towards. I am confident that this committee can find resources to increase our Home Visiting Grants and ensure a thriving workforce and even higher thriving community of parents and families we partner with. I am confident that prevention is where we can ensure our community is safe and healthy. As others have said, a healthy and safe society is made of healthy and safe individuals.

To conclude we suggest that DC Health together with CFSA join in strengthening Home Visiting Grants by increasing DC Health Home Visiting grants to restore and increase investments by $1.2M so that the $500K FY23 cut can be restored and $700K can go towards an increase in workforce retention. By ensuring that Home Visiting Programs receive bold investments, and Home Visitors receive thriving wages, we can reduce the interruptions families face when working to access home visiting services that support their holistic wellbeing. Thank you for your time.

HUMANE RESCUE ALLIANCE

Animals. People. Community.

April 10, 2023

Honorable Members of the Committee on Health
Council of the District of Columbia
1350 Pennsylvania Avenue, NW
Washington, DC 20004

RE: **Humane Rescue Alliance Testimony – DC Health FY24 Budget Oversight Hearing – Animal Services Funding**

Madam Chair and members of the Committee, my name is Lisa LaFontaine and I'm the Chief Executive Officer of the Humane Rescue Alliance. I'm grateful for this chance to testify, and to emphasize our commitment to providing DC residents with the best possible animal services program.

Since our legacy organization the Washington Humane Society was founded over 150 years ago, we have served as the city's protector of animals, and have advocated for their wellbeing. Over the decades, we've become the most trusted community resource for those who care for animals of all species. When the city decided to contract out its animal control services in 1980, we were selected as the provider, a role we have fulfilled now for 43 years.

Our responsibilities, and the community's needs for service, have expanded continuously as animals have become valued family members of DC residents. Last year, demand for our services reached its peak; in 2022, our Animal Control Officers responded to over 19,500 calls for help, the largest call volume in the history of holding the contract. We reunited more than 1,200 lost pets with their families and rescued nearly 2,000 wild animals who were in distress. And, we provided over 36,000 routine preventative vaccinations to DC pets, which is a critical component of our city's public health program.

We were pleased to extend our partnership with DC Health in March, as we signed a contract to provide services through September 30th, 2024. But, we have recently learned that the DC Health budget for FY2024 contains a $3 million reduction to the animal services contract. Given that we just executed a contract, which was approved by the Council on March 11, we are not sure what to make of this reduction.

Hopefully it is an oversight that will be fixed but if not, this would be devastating to the program, representing less than half of what DC Health agreed to provide for 2024 services.
As I'd mentioned, calls from DC residents who need our help have never been higher. The community's need for services such as investigating animal bites and housing lost pets are unlikely to decrease. Last year, when the Council removed $1 million for the contract, DC Health had to reprogram funding to continue the animal control contract at the appropriate level. At that time, everyone recognized that a decrease in funding for the animal services contract hurts District humans and animals alike.

Our service is a 24-hour, 365 day-a-year initiative. Each day we are responding to calls for help with pets who have been hit by cars, sick or injured wild animals and dog bites. We intervene with high-risk rabies-exposed animals, a disease that is 100% fatal to nonvaccinated people and animals. We investigate every reported dog bite to determine the circumstance and the health of the animals involved. Any cuts to this program will have unacceptable public safety risks.
In short, if this omission isn't corrected – or if there are any reductions in the contract – it would be impossible for HRA to continue to serve as the animal care and control provider for the District. We simply can't operate at an unsafe level of service – it wouldn't align with our mission but even more importantly, the residents of the District rely on these services throughout all wards and neighborhoods of our city.

While we are optimistic that this was an error and that the District intends to honor its contract, we respectfully seek assurance that DC Health will program funding to comply with the terms of the contract we have already signed, and the Council has already approved, for FY24.
On a related issue, during last month's performance oversight hearings, you expressed understandable concern about the delay in finding a solution to replace the District's aging Animal Care and Control Facility at 1201 New York Ave, NE.

As the operators of the current program and that facility, I can attest to the desperate need for a space that fully meets the community's animal sheltering needs. In the nation's capital facility, we should have an animal shelter that is best-in-class, and that can be an accessible, safe, and welcoming place for animals and people alike. We've met with our colleagues in the DC government and we are committed to finding a solution with them. In fact, we have proposed using a building we already own – and that the community already patronizes – at 15 Oglethorpe Street, NW, and we are preparing a proposal for our partners' consideration.

Thanks so much for your time. I am happy to answer any questions and would welcome the opportunity to meet with you and your Committee staff on any issues related to this program.

Lisa LaFontaine
Chief Executive Officer

GOLDFEATHER CONSULTING FEE SCHEDULE – 2023

HOURLY CONSULTATION RATES

Tiers	Topics	Fee
Tier 1: Nonprofit Organizations (budget <$1 million)	• Hoarding and cluttering community-based program design • Integrating and supporting peer employees in an existing workforce • Peer certification, professional development, and career path planning • Developing transitional age youth/LGBTQ+ supports for hoarding and cluttering challenges • Crisis response implementation • Additional topics upon request	$75/hr
Tier 2: Nonprofit Organizations (budget >$1 million)	• Hoarding and cluttering community-based program design • Integrating and supporting peer employees in an existing workforce • Peer certification, professional development, and career path planning • Developing transitional age youth/LGBTQ+ supports for hoarding and cluttering challenges • Crisis response implementation • Additional topics upon request	$100/hr
Tier 3: • Private sector businesses • Universities • Government agencies	• Hoarding and cluttering community-based program design • Supporting organizational wellness and staff mental health • Crisis response implementation • Additional topics upon request	$135/hr

jplumadore@gowithgoldfeather.com
510-309-3470

goldfeather CONSULTING

TRAINING CREATION & DELIVERY FEES[1]

Tiers	Qualified Clients	Half-Day (3 hours)	Full-Day (6+ hours)
Tier 1	Nonprofit organizations (budget <$1 million)	$1000	$1750
Tier 2	Nonprofit Organizations (budget >$1 million)	$1500	$2250
Tier 3	• Private sector businesses • Universities • Government agencies	$2000	$3500

SPEAKERS' FEES[2]

Tiers	Qualified Clients	Per hour
Tier 1	Nonprofit organizations (budget <$1 million)	$100
Tier 2	Nonprofit Organizations (budget >$1 million)	$200
Tier 2	• Private sector businesses • Universities • Government agencies	$300

[1]Includes pre-training consultation meeting, training development, travel costs within the San Francisco Bay Area, and 1 training delivery. Additional deliveries of a previously delivered training will be assessed at a 40% discount. Travel outside the Bay Area will be assessed at 2023 IRS standard rates. Contractor retains the rights to the training.

[2] Speakers' fees are prorated at training rates for the appropriate tier; for example, a 30-minute speaking engagement at a community-based nonprofit organization would be $150 per speaker, and $300 per speaker for a private sector business.

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510-309-3470

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

To: The Honorable Christina Henderson, Chair, DC Council Committee on Health
Members of the Committee on Health
From: Patricia Quinn, VP of Policy and Partnerships, DC Primary Care Association
Re: Budget Oversight Hearing for DC Department of Health
Date: April 10, 2023

The DC Primary Care Association (DCPCA) works to build a healthier DC by sustaining community health centers, transforming care delivery, and advancing racial and health equity. Our strategic focus areas include:

- Value-based care and contracting
- HIT innovation for health centers and community based providers
- Cross-continuum stakeholder relationships
- Equity-oriented programs and innovations
- Health center infrastructure and operations support

Our collaborators in this work include community health centers, serving almost 200,000 patients in every ward of the city. Our members serve District residents most impacted by inequity—95% of health center patients are racial or ethnic minority, 88% have incomes below 200% of the federal poverty level, and 37% are best served in a language other than English. Health centers are at the nexus of efforts to rewrite DC's story of health inequity, and we are grateful for the partnership we have forged over decades with the DC Department of Health. That partnership has only strengthened through the crucible of the COVID pandemic. We appreciate the opportunity to provide testimony regarding the budget of DC Health.

We all learned the importance of a robust public health system through the course of the three-year COVID-19 public health emergency. DC Health's focus on health and wellness promotion, promoting health equity, and public health systems enhancement requires aggressive funding if we are to address the persistent inequity along race/ethnicity lines that has impacted individual and community well-being in the District.

<u>Workforce</u>

DCPCA, like other healthcare organizations throughout the District and nationally, is gravely concerned for the state of the healthcare workforce. In 2022 and 2023, DC Health convened the Mayor's Healthcare Workforce Task Force to identify viable pathways to meet health workforce needs in the short and long term. The task force has specific draft recommendations across six critical workforce areas:

- Strengthening recruitment and retention
- Increasing District resident employment in healthcare occupations
- Improving opportunities for advancement in health careers within the District
- Enhancing access to high-quality allied health training programs
- Retention of DC health professional students post-graduation

- Development of a health careers pipeline strategy

Draft recommendations for licensing, payment, reducing provider burdens, building public trust, eliminating barriers to entry, defining career pathways, tuition support, and youth exposure and immersion opportunities should all be adopted if we hope to ensure residents' access to high quality health care. We look forward to working with DC Health to operationalize the task force recommendations, and we support robust DC Health investment in innovations that show promise for improving access and outcomes.

We encourage the department to continue to fund staffing to support more streamlined licensing procedures.

Home Visiting

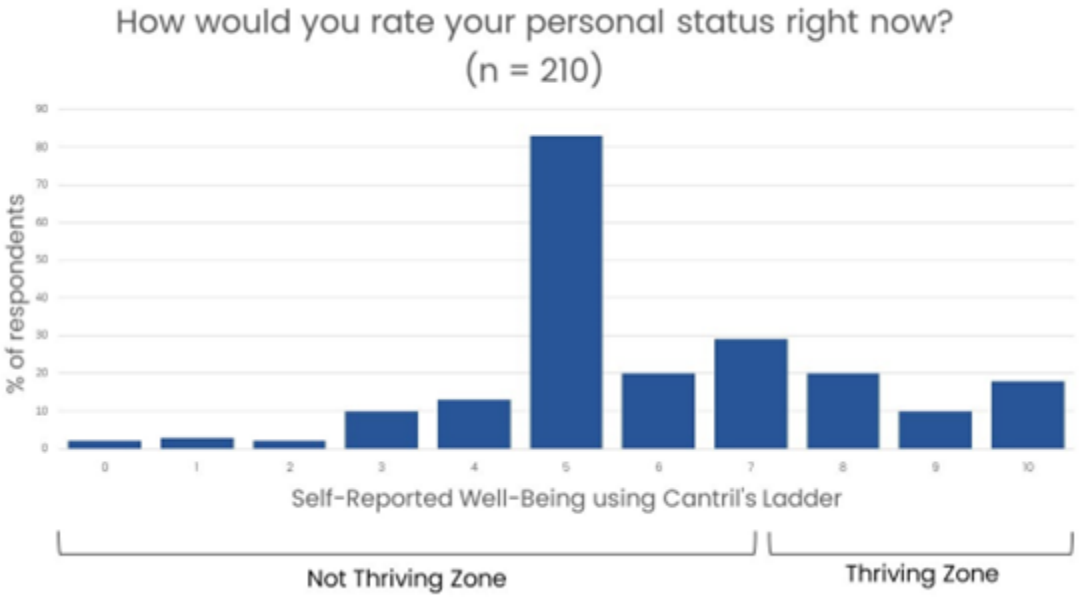
DCPCA supports our community health centers' call for full funding for home visiting services, and for the exploration of sustainable funding through Medicaid. As the District confronts a perfect storm of increasing need for behavioral health services and decreasing access to clinical care, we must amplify sources of support that, while not a replacement for clinical care, do help families to cope with challenges, build connections, and strengthen capacity.

In 2022, the DC Network for Expectant and Parenting Teens (DC NEXT!), a coalition facilitated by DCPCA, conducted a first of its kind Wellbeing Survey of youth in Washington D.C. This report presents emergent findings and policy actions for consideration developed from survey data, deep-dive interviews with young parents in the District and focus groups and dialogues with service providers and youth.

Emergent Findings:

Key Finding #1: Most young parents (63%) reported that they are not thriving, highlighting systems barriers related to housing instability, inadequate access to employment, childcare, and transportation that stand between young parents and the futures they yearn to create.
Key Finding #2: A subset of young parents in DC are facing severe challenges including frequent hunger, frequent housing insecurity, poor mental health, and social isolation.
Key Finding #3: Overall, young parents in DC feel confident and motivated in their parenting role.

Figure 1. Past analyses of data from surveys utilizing the Cantril's Ladder have had varied approaches in grouping respondents based on their self-reported life satisfaction. Consistent with a majority of published survey analyses, we have chosen to denote all respondents who self-report their well-being as a 7 and above as "thriving," and all others as "not thriving." Using this classification, 63% of our survey respondents self-reported they were "not thriving."



Teen pregnancy across the US and in the District of Columbia has dramatically declined over the last decade. Despite an almost 20% reduction in teen births between 2019 and 2021, 265 teen mothers under the age of 20 gave birth in the District of Columbia in 2021. We estimate that at any given time in DC, at least 800 teen mothers and young fathers are endeavoring to care for their children, continue their education, and find meaningful work in the hopes that their families can thrive.

For decades, policymakers and public health officials have focused on preventing teen pregnancy and teen births as keys to anti-poverty strategies, sometimes identifying teen parent families as the cause of family and community instability. But our data–quantitative and qualitative–tells a different story. The young parents we surveyed and interviewed show us that there is nothing inevitable about bad outcomes for teen parents and their children. If we change our response to teen parents, if we drop the stigma and instead raise our expectations and see the powerful, critical opportunity to redirect teens newly committed to succeed, we can change the outcomes for young parents and their children.

Recommendations:

1. Make teen parents the top priority in the District's investments in effective two-generation income, education, and workforce strategies that impact not only teen parents' own trajectory, but also that of the young children they parent.

2. Develop and fund a **teen parent system of care** tailored to meet the needs of adolescent parents and their children including:
    - Robust pathways/roadmap to educational attainment and career opportunities
    - High quality childcare
    - Affordable, convenient transportation
    - Housing for young parents who lack family options
    - Access to healthy food, particularly through WIC and SNAP
    - Mental health support and navigation assistance

3. Support the efforts of DC NEXT! to promote high quality, youth-centered services that recognize teen parents' commitment and capitalize on their new motivation to achieve.

DC Health, through its home visiting investments, management of the WIC program, and several other healthy food programs play an important role in building the system of care we envision for young parents. Food programs are particularly critical as the additional SNAP benefits offered during the pandemic sunset. Additionally, through its Office of Health Equity, DC Health spotlights the social and structural drivers of health inequity in the District. Young parents are disproportionately impacted by such drivers and should be a key priority in upstream efforts to improve health and well-being.

We appreciate the relationship we have with Dr. Lewis and other staff with the Department of Health. We collaborate with the Community Health Administration in the Chronic Disease management area working to reduce and prevent the incidence of heart disease, diabetes, and cancer. We work with the Primary Care Office in the promotion of the Health Professionals Loan Repayment Program. We have worked very closely with the HEPRA administration and the Health and Medical Coalition during COVID and will continue to prepare our heath care providers for any emergency incidents. We recommend the continued funding of these critical functions and the important work of the Department.

Subject: Testimony for Department of Health Budget Oversight Hearing, April 10th, 2023
Date: Wednesday, April 5, 2023 at 9:28:48 PM Eastern Daylight Time
From: Em Aufuldish
To: Strange, Ashley (Council)

Hello
Councilmember Christina Henderson,

My
name is Em Aufuldish. I am a resident of ward 2, and I am submitting testimony regarding the DC Health decision to close all DC COVID centers on March 31st.

I
understand that the decision was announced as "permanent", however, I ask that you advocate for funding to maintain at least one COVID center in each quadrant of DC. While open, the COVID centers provided crucial resources to protect DC residents.

According
to the CDC, COVID-19 is the third leading cause of death in the United States, despite assertions that the pandemic is over. COVID infections and long COVID are still causing serious illness, disability, and death, which threaten our community's health and
prosperity.

Clinical
studies have shown that availability of tests and masks is instrumental to reducing community spread.
The DC COVID Centers accomplished this by providing resources that would otherwise be out of reach for uninsured DC residents. **The centers are worth every penny because of the lives they save and economic productivity they preserve.**

Please
reconsider the decision to close all the centers, and reopen at least four centers to keep our community safe.

Thank
you for your time,

Em
Aufuldish (she/they)
Ward
2 resident

Testimony for The Committee on Health

April 10, 2023

Submitted By Camila Perez

Family Support Worker / Home Visitor

Mary's Center for Maternal and Child Care, Inc.

to Councilmember Henderson

Good morning, Councilmember Henderson and committee members,

Thank you for the opportunity to testify today. My name is Camila Perez, and I am a Community Health Worker in the Home Visiting department at Mary's Center. As I've shared before, representation is important to me as I work to provide support to families that look like mine and rely on services and support like my family did. It is essential that DC continues to make sustainable investments into Home Visiting to make sure that the workforce can continue to have long-lasting positive impacts in the lives of our neighbors and families in DC. Home visitors, like childcare teachers, have been some of the most dedicated, yet underpaid professionals working with District families and children for years. The competitive labor market has driven many working for underfunded programs to seek higher-paying jobs in other industries.

Well-resourced and well-staffed Home Visiting programs that support families have a significant positive impact on our families with young children and their health outcomes. However, Fox 5 has recently reported that Mayor Bowser has proposed investing $750K for pickle ball courts, maintaining a $7.4M investment to install 342 new automated traffic cameras, and adding $13.3M to support the DMV's increased ticket processing and additional responsibilities. I understand that we want to encourage people to be safe, healthy and active outdoors, but if we're really invested in the health and well-being of residents, better distribution of these funds could improve outcomes for your constituents if they are poured into Social Support Programs that families can access. If the city wants to count on a return on investments in the FY24 budget, according to the National Home Visiting Resource Center, "HV Programs have a return on investment of $1.80 to $5.70 for every dollar spent on home visiting. This strong return on investment is consistent with established research on other types of early childhood interventions." Additionally, the costs associated with poor birth outcomes are high. In 2012, the Planning Council reported that the societal economic cost associated with preterm birth in the U.S. was at least $66,218 per preterm infant. We estimated the total maternal morbidity cost for all U.S. births in 2019 to be $32.3 billion from conception through the child's fifth birthday. This amounts to $8,624 in additional

costs to society for each maternal–child pair. Home Visitors improve outcomes for families throughout the perinatal period, and investing in us is investing in DC residents. I would like you to understand that home-visiting programs positively impact the families we serve. By educating our families about child development and healthy family dynamics, we are improving the health outcomes of our community.

HV programs can have improved outcomes for our pts and their children because of the support and resources we provide them with. By ensuring that Home Visiting Programs are funded, and Home Visitors receive thriving wages, we can reduce the interruptions families face when working to access services. Home visiting is an investment in communities – and as councilmember Henderson says "your zip code should not determine your opportunity for success," so by continuing to invest in Home Visiting, we can support families and improve their health and well-being. We request that DC Health restore and increase investments by $1.2M so that FY23 cuts can be restored and $700K can go towards an increase in workforce retention.

THANK YOU.

Testimony of Sarah Barclay Hoffman
***Policy Director*, Early Childhood Innovation Network**

Budget Oversight Hearing: Department of Health
Committee on Health
Council of the District of Columbia

April 10, 2023

Good morning Chairwoman Henderson, and members of the Committee. My name is Sarah Barclay Hoffman, and I am the Policy Director of the Early Childhood Innovation Network (ECIN). ECIN is a local collaborative that promotes resilience in families and children from pregnancy through age 5 in Washington, DC.[1] ECIN joins community and clinical expertise to develop innovative multigenerational programs in health and education settings. We work to advance systemic changes that will eliminate health disparities that impact children and families in our most under-resourced communities. We are also members of the Under 3 DC Coalition. Thank you for the opportunity to submit testimony regarding the DC Department of Health (DC Health) FY24 proposed budget. Today, my testimony focuses on HealthySteps and home visiting, and the critical need to invest in upstream promotion and prevention interventions for the District's young children and their families.

HealthySteps: Maintain Funding at Current (FY23) Levels

HealthySteps is a national evidence-based program that strengthens parenting skills and improves child development outcomes. HealthySteps is integrated into pediatric primary care practices and in DC, incorporates a licensed mental health clinician and care coordinator, who provide care to families with infants and toddlers. This extends the impact of the pediatricians' office, and capitalizes on the high rate of well child visits in the District. Program components include team-based well-child visits; child development, positive parenting, and parent-child relationship guidance; providing early learning resources; screening that includes assessment of child development, social-emotional skills, and behavioral functioning, in addition to family protective/risk factors and social determinants of health; connection to community resources through targeted referrals (e. g., to early intervention, community-based behavioral health agencies) and warm hand-offs; and increased integrated mental health support for families, particularly for parents. Investments from DC Health and DC Council provide support to Children's National and Unity for HealthySteps sites in Wards 7 and 8, and another site to-be-determined with appropriated FY23 funding.

Evidence shows that HealthySteps improves child and caregiver outcomes, such as decreasing unsafe sleep practices and harsh punishment practices, and increasing attendance at well-child visits. Research also shows that HealthySteps is highly cost-effective.[2] A recent evaluation of HealthySteps sites throughout the country showed that the HealthySteps program has the potential to avert significant

[1] For more information on the Early Childhood Innovation Network, see: https://www.ecin.org/
[2] 8 ZERO to THREE. (2021, June 3). HealthySteps Outcomes Summary. HealthySteps. https://www.healthysteps.org/resource/healthysteps-outcomes-summary/

healthcare spending in maternal depression services, child emergency room utilization, and many other areas.[3]

Children's National, in collaboration with Georgetown University and ECIN, recently conducted a qualitative quality improvement study of the HealthySteps program in Washington, DC. The following local data indicate that HealthySteps plays a crucial role in pediatric primary care. Preliminary results include:[4] 1) HealthySteps offers specialized services that clinicians in pediatric primary care often do not have time or expertise to provide; 2) Child development is closely related to caregiver mental health; and 3) The "one-stop-shop" point-of-care model is a critical component of HealthySteps and supports families receiving timely services for both themselves and their young children, where and when they most need them. Providers and staff shared the following impacts:

- "Particularly I've found it [HealthySteps] really helpful for those with suspected or confirmed postpartum depression…" Clinic Staff
- "It benefited them [families] by knowing that they had someone that was going to be a advocate for them, their rights and the concerns, and they knew that I was going to be there. It wasn't a, as I mentioned, it wasn't a one touch thing. So they, once those were developed, the families had faith and had belief, and being able to get connected to services and/or opportunities as a result of being referred to [HealthySteps]." HealthySteps Staff
- "I think one of the big benefits is that they can get services for themselves and for their children, all in one place. So, it sort of provides a one-stop shop for parents and children, especially for parents and children who have issues/needs around behavioral and or mental health services. So, I think the benefit is that they can get what they need in a convenient way." HealthySteps Staff
- "The advantage of having the Healthy Steps integrated model there to be able to touch a family right there and then, as opposed to families going, leaving, and not getting the services that they need." HealthySteps Staff
- "The hardest part of behavioral health is people often don't follow through with referrals for many reasons, including barriers that we place on our end of the health care system. And so any same day services, I think, are a benefit to the family, because it means we're catching them while they're here, and while they're ready to get some help and some interventions." Clinic Staff

We commend Mayor Bowser and DC Health for continuing to prioritize HealthySteps in the proposed FY24 budget, and strongly support the FY24 budget proposal to maintain current investments and funding at FY23 levels so that this critical and effective evidence-based model can continue to have a transformative effect on the District's youngest residents and their families.

[3] Buchholz, M., Burnett, B., Margolis, K. L., Millar, A., & Talmi, A. (2018). Early childhood behavioral health integration activities and HealthySteps: Sustaining practice, averting costs. Clinical Practice in Pediatric Psychology, 6(2), 140–151. https://doi.org/10.1037/cpp0000239

[4] Preliminary data collected by Children's National, ECIN, and Georgetown University.

Home Visiting: Increase Funding to Ensure Sustainability of the Workforce

ECIN also strongly supports home visiting as a critical strategy in developing healthy and thriving families in the District. A robust evidence base undergirds home visiting, and utilizing a strengths-based approach, home visitors work collaboratively with families to improve outcomes. Studies also demonstrate the cost effectiveness of this strategy.[5]

However, low compensation for home visitors has led to high turnover, which negatively impacts the programs, and ultimately, the children and families. We ask the Committee to invest an additional $1.2 million in DC Health's budget so that home visiting programs can supplement wages and sustain the current workforce. Given that inflation rates have not been adjusted since 2019 and no new investment has been made in home visiting over the past two fiscal years, a $1.2 million investment will address workforce retention challenges and ultimately provide families with more stable, high-quality support.

ECIN appreciates Mayor Bowser and DC Health's work to support the HealthySteps and home visiting programs and continuing to invest in children and families. We look forward to continued collaboration. Thank you again for the opportunity to testify today and I welcome any questions the Committee may have.

[5] For more information on Home visiting, visit: https://nhvrc.org/about-home-visiting/why-home-visiting/

Testimony of Nisa Hussain
Program Manager of Early Childhood, DC Action
Department of Health
Committee on Health: Budget Oversight Hearing
Fiscal Year 2024
Council of the District of Columbia

Good morning Chairwoman Henderson and members of the Committee on Health. Thank you for the opportunity to address the Council as it conducts this budget oversight hearing for the Department of Health. My name is Nisa Hussain and I am the Early Childhood Program Manager for DC Action, Chair of the DC Home Visiting Council, member of the Under 3 DC Coalition, member of the Fair Budget Coalition, and Ward 1 resident.

DC Action uses research, data, and a racial equity lens to break down barriers that stand in the way of all kids reaching their full potential. Our collaborative advocacy initiatives bring the power of young people and all residents to raise their voices to create change. Through our signature coalitions, Under 3 DC and the DC Home Visiting Council, we empower families and communities. We are also the home of DC KIDS COUNT, an online resource that tracks key indicators of child and youth well-being.

Today, my remarks will focus on home visiting and DC Health's early childhood home visiting programs, which the agency both funds directly and through MIECHV funding. Specifically, DC Health administers the Healthy Families America, Parents as Teachers, and Nurse Family Partnership programs at Mary's Center, the Mothers Rising program at Mamatoto Village, the Healthy Families America program at Community of Hope, and the Parenting Support Program at Georgetown University. DC Health also receives some funding from CFSA for the administration of the Parents as Teachers program at Mary's Center, which I will address in my testimony at the CFSA budget hearing.

I would like to focus my testimony on the importance of deeper investments in home visiting programs in the FY24 proposed budget and ask for an increase of $1.2 million to the current home visiting grants at DC Health. This $1.2 million accounts for the $700,000 enhancement we are seeking for programs to raise home visitor wages and adjust for inflation, and for the

$500,000 we are seeking to restore from the cuts to Mary's Center's Healthy Families America program funding in FY23.

We are grateful for Chairperson Henderson's and the rest of DC Council's past support of home visiting programs over the years. We are also grateful for DC Health's continued partnership on the Home Visiting Council. We hope that the DC Council, the Mayor's administration, and the agencies can all work together to ensure home visiting programs receive sufficient funding to continue upholding these critical programs that support families in the District.

Home visiting is a preventative, two-generation early childhood strategy.

Home visiting is an evidence-based service delivery strategy that supports expectant parents, new parents, and families with young children. The service pairs a family with a trained professional or home visitor to assess the family's needs, guide them towards their goals, and offer resources for a healthy pregnancy or safe environment for a young child's development. These services use a two-generation model and a holistic, public health approach to support the entire family and ultimately, the rest of the family's community. Research has shown home visiting to reduce child abuse and neglect, improve maternal and child health outcomes, increase school readiness, and improve family economic self-sufficency. Home visiting programs in DC focus on families with low-incomes and many participants also face several risk factors.

In particular, DC Health home visiting programs serve populations with specific challenges. For example, Georgetown University's Parenting Support Programs focuses on caretakers with intellectual disabilities. Mamatoto Village's Mothers Rising program provides expectant individuals with wraparound care and services during the perinatal period, focusing on Black mothers who are Medicaid-eligible. Mary's Center's Healthy Families America program supports pregnant and postpartum families identified with high social or medical risks. Community of Hope's Parents as Teachers program provides family-well being services and offers referrals for migrant patients in DC who need prenatal care at their center.

In 2022, DC's 17 home visiting programs served a total of 1,374 families and out of that total, DC Health-funded health programs served 768 of those families. These are programs that allocate time, attention, and care for families that are navigating challenge after challenge. Home visiting is a unique, effective service that reaches the District's families that want and need the extra support the most in their parenting journey.

If the District wants to reach families, connect them to the network of services they may benefit from, and provide them care during the critical years of pregnancy and early childhood, then home visiting is a tried and tested approach to utilize.

Home visiting programs face the risk of losing a dedicated workforce of home visitors.

Home visitors work hard to guide expectant parents and families towards self-sufficiency and stability. They take time to get to know the families they work with, build a level of trust, and offer tailored support to the family to reach their goals. Whether it involves delivering basic supplies like diapers or food, walking them through rental assistance and paperwork, providing educational resources for the young children, or coaching them through positive parenting practices–home visitors are committed to the families they work with.

However, home visitors in DC have been leaving the workforce for higher paying jobs and as a result, services to those families are disrupted.

The average salary for DC home visitors is $44,000. Despite the fact that the DC home visiting workforce is highly educated, with 80% holding a bachelor's degree or higher, the low pay prevents many home visitors from being able to afford to live in the communities where they work. Some home visitors are forced to take on a second job. As is the case with similar industries, the home visiting workforce is also made up of primarily women and people of color. These roles are often underpaid, despite the critical labor they provide for the community.

When home visitors are forced to quit their roles to find higher-paying jobs to support their own families, the meaningful relationships they build with participants are cut short. Additionally, when a home visitor leaves, either the program cannot operate at peak capacity without full staff or the remaining home visitors are overburdened with increased workloads to fill in the gaps.

Home visiting programs need additional funding to raise home visitor salaries to address turnover. Home visitors deserve the recognition and pay for the invaluable services they provide. Without a strong, compensated workforce, programs are unable to serve at the best of their ability and families will be the ones who feel those impacts.

Long-term investments will stabilize the home visiting field and allow programs to sustainably support families over time

Home visiting is one of several key strategies to support the District’s efforts to produce positive health outcomes. While home visiting may not be the one single solution for every family, it can be one of many effective approaches within a robust system of care to support families during the perinatal, postpartum, and early childhood period of time. Families, especially families dealing with compounded challenges and risk factors, deserve the option to choose from support that meets them where they are at. Home visiting is uniquely positioned to support families in a holistic and individualized way. And due to the trusted relationships that home

visitors build with the families, they are able to successfully connect these families to other vital health services and community-based supports the District offers.

However, home visiting programs cannot continue to provide the highest quality care and reach as many families as they need to if they are underfunded, short-staffed, and underinvested in.

Home visiting programs need more funding to address the risk of losing valuable staff and lowering participant retention. Home visitors deserve higher wages to be able to afford to live in the District and continue working in the roles they love to do without needing a second job. Families deserve uninterrupted, quality home visiting services. Additionally, home visiting grants have remained at flat funding since 2019 and need to be adjusted for inflation, which has risen exponentially in recent years. Programs have been working hard since the start of the pandemic to meet the needs and resources of families who have been hit hard over the past three years. An increase of $700,000 would enable programs to raise home visitor salaries and catch up with inflation rates. Additionally, we are seeking $500,000 to restore the local funds that were cut in FY23. This $1.2 million increase will stabilize the local home visiting programs and allow them to address these current workforce challenges.

Additionally, we would like to ask for continued support for Mary's Center's Nurse-Family Partnership program for First-Time Mothers. We would like clarification around the program's funding in the FY24 budget, since we did not see renewal listed for this grant. If it has been cut, we request the $150,000 to be restored. DC Health's Perinatal and Infant Health division names home visiting as the primary approach to reducing infant mortality and perinatal health disparities, so we hope that this program can be restored.

As mentioned at the hearings for the Department of Health Care Finance, we are also seeking support for Medicaid reimbursement as a funding mechanism for home visiting programs. Leveraging Medicaid to fund home visiting programs is a cost-effective, coordinated strategy to support pregnant families who are already enrolled in Medicaid or managed care. If coverage and reimbursement can be established to fund evidence-based home visiting programs, DC has the option to ensure home visiting programs have sustained funding for the long-term.

With deeper investments in the FY24 budget and the possibility to expand streams of funding by leveraging Medicaid dollars, DC has the option to stabilize the home visiting field and create a stronger, more sustainable funding structure.

Despite the demonstrated positive outcomes of home visiting, the workforce continues to struggle to receive adequate investments in their programs. The yearly effort to tirelessly advocate for modest funding increases takes time and effort from the dedicated home visiting teams, programs, and families who share their experiences at public hearings. We are hopeful that in this budget season, the District will prioritize these critical services as they examine the

bigger picture and what it means to support our families and youngest residents to thrive. If we want to see positive family outcomes, we need to invest for the long-term. With a stronger, stabilized home visiting workforce and industry, the District has a chance to work towards that vision.

Sources

https://nhvrc.org/about-home-visiting/why-home-visiting/

https://developingchild.harvard.edu/science/key-concepts/toxic-stress/

https://www.cdc.gov/ncbddd/childdevelopment/early-brain-development.html

https://www.acf.hhs.gov/sites/default/files/documents/opre/home_visiting_outreach_july2022.pdf

https://www.maryscenter.org/social-services/family-support-programs/home-visiting/

https://www.wearedcaction.org/standardizing-wages-boosting-funding-and-streamlining-reporting-will-strengthen-home-visiting

https://www.thefamilyplacedc.org/hippy-home-visiting#:~:text=In%202011%2C%20The%20Family%20Place%20began%20its%20HIPPY,HIPPY%20instructor%20visits%20the%20home%20for%20one%20hour.

https://www.cflsdc.org/parenting

COUNCIL OF THE DISTRICT OF COLUMBIA
COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH – BUDGET OVERSIGHT HEARING

on

Department of Behavioral Health

taking place on

Thursday, March 30, 2023

Preliminary Notes (submitted April 6, 2023)
regarding Forthcoming Written Testimony yet to be submitted, from
Hilary Kacser, Public Witnesses

(she/her/hers; last name: "KACK-sir")
SAG-AFTRA Actor, Educator, Advocate
DisordeRThePlay.blogspot.com *"Disord*R*, The Play,"* about Pakrat Patty, the self-identified Hoarder
who comes out of the Clutter closet, uses humor to
educate about Mental Health, Stop Stigma, & Advocate Recovery.
Opening keynote: http://mentalhealthsf.org/joinus-18th-conference-on-hoarding-cluttering/

Committee on Health Chair At-Large Councilmember Christina Henderson and Committee Councilmember Zachary Parker, Committee Councilmembers, Committee Legislative Staff and Councilmember Christina Henderson Staff,

Thank you very much for your attention to us public witnesses and for this opportunity to testify before you at the Thursday, March 30, 2023, Committee on Health Budget Oversight Hearing on the Department of Behavioral Health.

In the District of Columbia, an estimated over 40,000 District residents struggle with the American Psychiatric Association diagnosis defined in 2013 as "hoarding disorder." (This testimony will refer to the diagnosis alternatively, such as HD, as collecting behavior, hoarding and clutter, or HC, in the effort to stop shame and stigma often directed or implicit toward this health condition. Shame and stigma are barriers to getting help for this serious behavioral health condition and public health challenge.)

The following preliminary notes relate to your April 6, 2023, Government Witness testimony presented by Dr. Barbara Bazron, Director of the Department of the Behavioral Health.

1. Does DBH have anyone working on HD?

2. Does DBH have any mandate to address HD?

3. Does DBH ask about clutter in home living spaces as part of intake screening?

4. If not, what would it take for DBH to add such a question to intake screening?

5. Do DBH CSA's ask about clutter in home living spaces as part of intake screening?

6. If not, what would it take for DBH to have CSA's add such a question to behavioral health care intake screening?

Surely adding a question about clutter in home living spaces to intake screening costs precious little. Wouldn't uncovering a vast, masked area of behavioral health unmet need be cost effective?

Department of Aging and Community Living is apparently devoting some resources to helping residents clean out their homes, in collaboration with Adult Protective Services. While this is perhaps better than nothing, especially in extreme cases of public safety hazard to self and others, people should not get that to that extreme point in the first place. DBH should not let people get to that point. APS is extreme, crisis, triage intervention, sometimes resulting in people – who should instead be out patiend ehavioral health care consumers – ending up in long term nursing care.

Again as to price tag and budget oversight, long term nursing care and putting out of their home an individual living in the District cannot be cost effective. This extreme intervention should be prevented before its need arises.

- We should have early intervention.

- Intervention should be trauma informed and should include behavioral health care.

Where is the early intervention?

Where is DBH in this scenario?

This is a challenging area, but that is no reason to ignore it. HD cuts across race, socio-economic, age, ethnic, gender orientation. We only need see the unhoused individual barely able to push their two shopping cars brimming over to appreciate that having too many possessions is not a health condition limited to those people with access to considerable means.

Early intervention is key.

Let's start this conversation.

Something must be done. With a relatively small amount of money, we could get the co-author of an evidence based approach, published in a scientific journal, who is also a training expert, to come to DC for a week and train stakeholders – including our our well developed cohort of DBH Consumer and Family Affairs Certified Peer Specialists.

Julian Plumadore supervised the peer arm of the 3-year "Help for Hoarding" study in collaboration with the University of California San Francisco, which demonstrated that peer-led support groups for hoarding and cluttering are therapeutically equivalent to clinician-led groups. Plumadore co-authored a peer workforce development toolkit including best practices for recruiting, hiring, and retaining peer-identified employees and integrating them into an existing team, and oversaw volunteer recruitment, onboarding, supervision, and retention.

Plumadore can provide training and ongoing consultation for the peer professional development component of an HC program in DC. Training, targeted towards peers who could actually be doing field work, benefits anyone involved, especially Program Managers/Clinical Coordinators, who should plan to attend, both to know what information a peer is receiving, and also to fill in any gaps in their own knowledge base about hoarding and cluttering services and supports.

Your investment of the fee of $17,500 + travel and lodging at 2023 IRS rates for a 5-day DC DBH training is provides extreme value to District residents in the form of evidence based, effective results that help people recover from HD. Full week of training includes technical support on establishing the DC Peer Response Team. Community Engagement and Development Director of Peers Envisioning & Engaging in Recovery Services (PEERS https://peersnet.org), Julian Plumadore promotes innovative peer-based wellness strategies and creates culturally rich, community based mental health programs that honor diverse experiences to eliminate stigma and discrimination.

Plumadore is even happy to follow up with DC DBH for up to one free hour of virtual consultation to answer any questions and explore next steps.

Talk about value return on investment.

Thank you again to the Committee and Chair At-Large Councilmember Christina Henderson for this opportunity.

Some data points:

"Randomised Clinical Trial of Community-Based Peer-Led and Psychologist-Led Group Treatment for Hoarding Disorder" – 2018 scientifically reviewed, academic journal study, published by Cambridge University Press, describes evidence based effectiveness of program co-authored by Julian Plumadore.
Abstract: https://www.cambridge.org/core/journals/bjpsych-open/article/randomised-clinical-trial-of-communitybased-peerled-and-psychologistled-group-treatment-for-hoarding-disorder/5804DDCE80DB0294AC378B6280CFB413
Full article: https://www.cambridge.org/core/services/aop-cambridge-core/content/view/5804DDCE80DB0294AC378B6280CFB413/S2056472418000303a.pdf/randomised_clinical_trial_of_communitybased_peerled_and_psychologistled_group_treatment_for_hoarding_disorder.pdf
Article concludes: "**Peer-led groups were as effective as psychologist-led groups**, providing a novel treatment avenue for individuals without access to mental health professionals."
Co-author Plumadore is available to train DC stakeholders, as outlined above, as well as in **attached support materials about Mr. Plumadore**.)

"Hoarding is a Serious Disorder — And it's Only Getting Worse" – ***The Washington Post***, states six percent of people struggle with HD – that equals over 40,000 District residents – plus countless additional friends, family, neighbors, and service providers affected by relationships with people living with Collecting Behaviors. http://www.washingtonpost.com/national/health-science/hoarding-is-serious-disorder--and-its-only-getting-worse-in-the-us

"**1 dead in Hillcrest Heights house fire" –** tragic civilian death in Hillcrest house fire involved **"excessive storage conditions"** according to Alan C. Doubleday, Assistant Fire Chief, Prince George's County. (Helpful language demonstrates the Fire Chief's person centered sensitivity to challenges experienced by people living with this diagnosis.) http://wtop.com/prince-georges-county/2017/09/1-dead-fire-hillcrest-heights

"HOARDING: A Dangerous Secret" – Metropolitan Washington Council of Governments In 2006 – almost two decades ago – described HC issues region wide in a 75 page report http://www1.mwcog.org/uploads/committee-documents/tVhbWVY20061106110151.pdf

Diagnostic and Statistical Manual of Mental Disorders – 5th Edition (**DSM-5,** American Psychiatric Association, 2013) defines Hoarding Disorder (HD) and Clinical Assessment for Hoarding Disorder. https://hoarding.iocdf.org/professionals/diagnosing-hoarding-disorder/
https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t29/

American Psychiatric Association Expert Q&A: Hoarding Disorder
https://www.psychiatry.org/patients-families/hoarding-disorder/expert-q-and-a
https://www.psychiatry.org/patients-families/hoarding-disorder/what-is-hoarding-disorder

"When talking a person who hoards, focus on safety rather than the clutter. Be empathetic. Match the person's language. If they call it hoarding, then you can call it hoarding." – National Fire Protection Association (NFPA) https://www.nfpa.org/-/media/Files/Public-Education/Resources/Safety-tip-sheets/HoardingTipSheet.ashx
"Many fire departments are experiencing serious fires, injuries, and deaths as the result of compulsive hoarding behavior." – **NFPA** https://www.nfpa.org/Public-Education/Fire-causes-and-risks/Behavioral-risks/Hoarding

Let's not let it get that far.

How much longer must we wait for DBH to address this challenge, and with early intervention? Let it not be until more extreme urgency arises.

The District can be pro-active and progressive with effective, evidence based, early intervention by engaging our existing certified peer specialists to provide sensitive and trauma-informed response services, respecting individual autonomy and rights, for community members in the District suffering from HD. DBH must provide training about Hoarding Disorder and thereby begin the effort to address HD. This training not only helps District residents living with Hoarding Disorder, but, in addition, de-stigmatizing HD also opens up people's acceptance of talking about Mental Health and substance use conditions – across the spectrum, including even our terrible opioid crisis and rising rate of suicide – facilitating a thriving recovery-oriented system.

Thank you for the opportunity to share with you.

Please advise how we can allocate funds to bring evidence based, effective training protocol to the District.

With thanks, wishing you and all our community members District wide
Peace, good health, & justice,

~~Hilary

April 10, 2023

Geoff Gilbert
Beloved Community Incubator
Legal and Technical Assistance Director

Testimony before the Committee on Health
Re: DC Health Regulation of Home Kitchens & Vending Carts

My name is Geoff Gilbert and I am the Legal and Technical Assistance Director at Beloved Community Incubator. I organize with street vendors part of Vendors United // Vendedores Unidos.

We ask that the Committee on Health ensure that the Department of Health has all of the resources and support it needs in order to implement the Street Vendor Advancement Amendment Act of 2023, which the Council passed earlier this week, in a way that is fair and accessible for all vendors.

To the best of our knowledge, DC Health currently employs only 11 inspectors for all restaurants, commercial kitchens and home kitchens throughout the District. For decades street vendors have been required to seek approval of the menu of food they are able to sell as part of the license application process before a food vendor is able to begin operations. Historically, DC Health has only allowed street vendors to sell half smokes and hot dogs. DC Health has long had the authority to inspect and create regulation for the production and sale of food from home kitchens and from street vending carts, yet it has chosen over and over again not to do so. Rather than promoting safe food practices in home kitchens and at street vending carts, DC Health has chosen to narrowly restrict the type of food that can be prepared and sold from home kitchens and street vending carts. These regulatory choices have kept street vendors trapped in the formal economy and subject to police violence, as vendors have been denied the opportunity to obtain licenses to prepare the food that their customers demand from their home kitchens and street vending carts.[1]

The Street Vendor Advancement Amendment Act of 2023 permits street vendors to prepare and sell all pre-packaged cooked foods and whole or pre-packaged cut fruit from home kitchens and street vending carts, and directs DC Health to develop regulations that support street vendors to do so in a safe manner. DC is a culturally vibrant city and food vendors have long sold many

[1] See “Where the Sidewalk Ends Part II: A Vision for Decriminalizing and Investing in Street Vendors,” Beloved Community Incubator (October 2022), https://www.belovedcommunityincubator.org/vending-decrim.

different types of food in addition to hot dogs and half smokes, including soul food, Caribbean food and Latin American food from many countries, primarily El Salvador and Mexico. Many vendors also sell fresh cut fruit. This food is deeply desired by the community - food street vendors rely on repeat customers and word-of-mouth marketing in order to make a living.

It is incredibly important that DC Health reverse its historic practice of placing unfair burdens on street vendors that keep vendors trapped in the informal economy. We are excited to work with the Committee on Health and DC Health in order to ensure that DC Health develops regulatory rules for home kitchens and street vending carts that are fair and accessible for vendors.

Sincerely,

Geoffrey Gilbert

Geoff Gilbert
Beloved Community Incubator
Legal and Technical Assistance Director

Comments on the
DC Health FY24 Budget Oversight
For the Committee on Health
April 10, 2023

On behalf of the Coalition for Nonprofit Equity, a coalition of approximately 1,000 DC nonprofits advocating for full funding and implementation of the Nonprofit Fair Compensation Act of 2020, I submit the following comments on the Mayor's proposed FY24 budget for DC Health as the Coalition Consultant. Members of the Coalition share a common goal of ensuring all DC residents have access to the vital community-based services and supports they need to not only survive, but thrive, and that community-based providers are treated fairly for their services. This law is an important step in right-sizing and adequately compensating nonprofit partners for their "actual costs" of doing business in DC.

FY24 Proposed Budget

The Mayor proposes a 2.8% increase to the overall budget of DC Health for FY24, from $283.9 million to $292 million. However, as a coalition advancing equity, proposed reductions to the Family Health Bureau and the AIDS Drug Assistance Program (ADAP), concern the Coalition as we continue to advocate for full implementation and funding of the Nonprofit Fair Compensation Act of 2020.

The Mayor's proposed FY24 budget not only suggests steep cuts in social service contract and grant programs, but fails to be transparent about the continued lack of funding for nonprofits' costs in administering their government contracts and grants. Fiscal Year 2024 is the third year of implementation for the Nonprofit Fair Compensation Act of 2020, and should attach to all contracts and grants to eligible nonprofit awardees for contracts and grants valued up to $10 million. With the steep proposed reductions to the District's many social services office and agency budgets, effectively compensating nonprofits for their actual costs may come at the unfortunate expense of even *fewer* services, which is the antithesis of the intent of the law. This is certainly not what District residents, still recovering from the effects of three years of the COVID pandemic, need.

Notwithstanding DBH's proposed budget increase, budget reductions in important programs within the agency and across the government concern the Coalition, and we share with the Committee that the Executive noted to the Coalition that some agencies and offices may have more budget flexibility than others, and if so, they could reprogram/reallocate funding to meet nonprofits' true indirect costs (until all agencies are properly funded). We urge Councilmembers to adjust agency budgets as able to allow for adequate funding to nonprofit partners in FY24. Further, during the FY24 budget hearing process, it is important to ask agencies and offices **to be transparent about whether and how they pay fully for indirect costs** and how are they training and implementing the law in their own contract and grant processes currently.

District Government Commitments on Law's Implementation

The District government provided certain acknowledgements and commitments to the Coalition for Nonprofit Equity with respect to assessing the costs of fully implementing the law in meetings in 2022-2023. These acknowledgements and commitments include:

- Acknowledging the initial cost analysis missteps when the law was being considered that caused "significant delay" in the law's implementation;
- Scheduling Listening Sessions in March and April 2023 to hear from nonprofits about their experiences working with the government, and asking for Coalition assistance;
- Building out a database of contract awards to nonprofits across agencies and offices and tracking what indirect cost rates they already have to understand costs and gaps. However, as creation may take into summer 2023, the government noted it will not be prepared to assess the costs of the law in time for proper budgeting for FY24 based on this tool; and
- Creation and distribution of a survey to understand additional "complicating factors" such as stipulations on federal pass-through funds.

Nonprofit Funding Proposal

What the government has *not* promised, however, was ensuring *funding* for the law. DC's nonprofits have subsidized the District government for too long, and the Nonprofit Fair Compensation Act of 2020 passed to finally and fully compensate nonprofit service providers for their work providing District residents DC-government services. Unfortunately, the Mayor's proposed FY24 budget fails to ensure that the law's requirement that grants valued at up to $10 million in FY24 will include additional funding for nonprofit service providers. To right this financial inequity, we propose funding two pots at $10 million ($20 million, total) to directly fund indirect costs on FY24 contract and grants and for nonprofit providers. The Coalition understands the financial challenges in the magnitude of the ask, but notes the proposal is based on similar work in New York City by their Human Services Council.

This proposal would work in tandem while the District is developing its database and assessing contracts and grant costs. Some nonprofits already receive some, if not *all*, of their allowable indirect costs in their DC contracts and grants, while others have gaps to be addressed with ongoing negotiations and fund-adjustments. Two general pots for indirect costs could help assess the magnitude *in concert with* the more detailed work the Executive is doing, *while also ensuring* that nonprofits can receive at least *some* indirect cost funding for contracts and grants in FY24; as we know, the Mayor has not specifically provided additional funding for those costs in accordance with the law this fiscal year or proposed in FY24.

In the first year of NYC's program, they allocated $40 million, which was a significant underinvestment. The following year the allocation increased to $190 million. The District's nonprofit contract and grant sector is smaller than NYC's, and as discussed, some nonprofits already receive some or all of their indirect rate, so the proposed pots of funds are meant to address the lingering inequity for those nonprofits who have remained under resourced, even as they provided essential and critical services to District residents throughout three years of a pandemic, let alone in the years that preceded COVID.

In NYC, funding was allocated to their Deputy Mayor for Human Services as well as the Deputy Mayor for Contracts, who jointly administered the indirect cost funds. Here, while outside of the purview of this Committee, the Coalition notes the District could site grant funding with the Mayor's Office of Community Affairs, and contract funding within the Office of Contracting and Procurement, or similarly to NYC, within the Deputy Mayors.

Coalition Recommendations for Law's Implementation

Irrespective of development and funding of the proposed indirect cost funds pots advocated for above, the Coalition requests DC Health work with the Executive Office of the Mayor (EOM) and the Office of Contracting and Procurement to ensure that grant officers and contract administrations throughout the agency are trained on the Nonprofit Fair Compensation Act of 2020 and urges DC Health to participate with their cost survey and database under development.

While outside of the realm of DC Health specifically, the Coalition also notes that the Executive and Council should consider annual adjustment to nonprofit service provider contracts and grants to account for inflation and cost-of-living increases. We also suggest the Council consider introducing legislation establishing an ombudsperson for nonprofits to assist with the implementation of the Nonprofit Fair Compensation Act of 2020. Having a dedicated advocate for nonprofits, large and small, could increase awareness and consistency of application of the law within the government and throughout the nonprofit sector.

Thanks for the opportunity to provide these comments.

Council of the District of Columbia

Committee on Health

Councilmember Christina Henderson, Chairperson

Budget Hearing on:

Department of Health

April 10, 2023

Testimony of:

Micaela Deming

Policy Director

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Introduction

Hello, my name is Micaela Deming and I am the Policy Director for the DC Coalition Against Domestic Violence (DCCADV). DCCADV is the federally-recognized statewide coalition of domestic violence service providers in the District of Columbia and includes domestic violence (DV) specific housing providers, counseling and case management services, legal services, and culturally specific organizations serving: African; Latinx; Asian and Pacific Islander; Immigrant; LGBTQ; teens and youth; and survivors who are Deaf and Deaf/Blind. We stand in solidarity with the Fair Budget Coalition, which has fully incorporated our budget platform as community safety and housing demands.

Intimate partner violence continues to be a significant public safety and public health concern for DC residents of all ages. These dedicated service providers work tirelessly to address the epidemic of domestic violence across all eight wards of the District. I am here today to inform the Committee on Health about survivors of domestic violence, the providers who serve them, and how that work relates to the Department of Health.

One in three women and one in four men have experienced domestic violence (DV) in their lifetime[1], which leads to disastrous effects for the victims, their families, and their communities. We also know that 39% of women and 25.5% of men living in DC have experienced sexual violence, physical violence, stalking, or a combination thereof perpetrated by an intimate partner.[2] Taking a closer look at domestic violence fatalities in DC, in 2020, there were 18 domestic violence homicides. In 67% of these DV homicides, the victim died by gunshot. Between 2016-2020, there were 68 domestic violence homicides. 51% of these fatalities involved shootings. According to the Domestic Violence Fatality Review Board 2022 Annual Report, addressing domestic violence homicides that were committed during calendar year 2021, 20 people over the age of 15 were killed

[1] M.C. Black et al., Ctrs. for Disease Control & Prevention, *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* 2 (2011), https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

[2] S.G. Smith, et al., *The National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report* 144 (2017), https://www.cdc.gov/violenceprevention/pdf/nisvs-statereportbook.pdf.

in domestic violence fatalities. One child was killed, bringing the total domestic violence fatalities identified to 21.

Department of Health Partnership

Domestic and sexual violence are a major public health concern. There is myriad data showing the devasting prevalence and impacts of this violence, especially on the District's youth. Young women and girls between the ages of 16-24 are at the greatest risk for experiencing dating violence[3] and relationship abuse[4]. Nationally, more than half of cisgender women and men who have been physically or sexually abused or stalked by a dating partner first experienced abuse between the ages of 11-24.[5] To transform our culture and end intimate partner violence, strategies that increase resiliency and reduce risk factors are paramount. As noted by DC Health in their recent Community Health Needs Assessment, injury and violence prevention is one area in which the District has seen the health indicators getting worse.[6] We recognize that the work to reduce and prevent violence does not happen overnight. DC Health has made an important commitment by recognizing dating and sexual violence as a public health issue.

We are grateful to work with DC Health and our community-based partners to address this prevalence through the Sexual Violence Prevention Community of Practice (SVPCoP). Over the last year, we have provided valuable training to school staff to help them address teen dating and sexual violence in schools, including teen dating violence dynamics, trauma-informed care, and the Sexual Assault Victims' Rights Amendment Act. Moving forward, we plan to continue working to identify state-level indicators of dating and sexual violence and to create a strategic plan for youth dating and sexual violence prevention to break generational cycles of abuse. However, to ensure these prevention efforts are deployed widely across the District, significant investments and resources must be made.

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[3] Dating violence is a pattern of abusive and coercive behaviors where a partner exerts power and control over someone they are dating or involved in some type of relationship. The abuse can be physical, emotional and/or sexual.

[4] *Violence against young women and girls*. Violence Against Young Women and Girls | National Center on Safe Supportive Learning Environments (NCSSLE). (n.d.). Retrieved March 1, 2023, from https://safesupportivelearning.ed.gov/violence-against-young-women-and-girls

[5] Breiding, M.J., Chen J., Black, M.C. (2014). Intimate Partner Violence in the United States 2010. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[6] DC Community Health Needs Assessment, Executive Summary 2019; Retrieved from https://ourhealthydc.org/dc-chna/

Through DC Health, the Coalition receives a small grant of federal funds originating from the Center for Disease Control, Rape Prevention and Education funding and we are excited to continue our collaborative work to enhance DC's violence prevention work. This year, with the support of DC Health, we have been able to assist DC Public Schools with the implementation of the Expect Respect curriculum. This curriculum features age and developmentally appropriate dating violence prevention education geared towards grades 6-12. However, our efforts have only been able to reach a limited amount of school staff and students due to funding and school schedule constraints. With an increase in prevention education funding, we will be able to continue to expand the implementation of this curriculum in other schools with other organizations serving youth survivors in the District. While DC has made significant local investments (through the Safer Stronger DC initiative[7]) in responding to community-based violence, there is little to no local funding dedicated to domestic and dating violence primary prevention.

DC Health is one of the only prevention focused potential funding streams available. It is long overdue for DC to prioritize primary domestic violence prevention education. DC must not only recognize that primary prevention allows us to curb violence before it occurs but that funding is necessary to implement these transformational programs. With multi-year funding from DC Health and a budget allocation of $400,000 toward prevention, the Coalition and our member programs will be able to continue and expand efforts to develop and deliver prevention education programming.

Funding for Domestic Violence Prevention

The True Cost of Survivor Safety[8] increases and is compounded by failing to address prevention. Allocating funding toward prevention and public health approaches to stop domestic violence now will save hundreds of thousands of dollars – and lives – in the future. Unfortunately, this reality is currently not being addressed by the budget. We continue to see months long waiting lists for domestic violence specific mental health and other services. Survivors may not have their needs fully met because program staff, beds, or

[7] Id 9
[8] www.DCCADV.org/TrueCost

programs are beyond capacity. Preventing domestic violence before it begins would begin to taper this need over time while also directly supporting DC Health's goals.

Domestic violence is a direct contributor to higher rates of HIV/AIDS, Hepatitis, sexually transmitted infections, and tuberculosis. A national study published in 2021 found a series of concerning linkages between HIV and domestic violence. Overall, this study found that coupling HIV treatment with domestic violence screening, supportive services, counseling, and prevention may lead to improved safety and HIV clinical outcomes and decreased need for emergency and inpatient medical services.[9]

Evidence also shows that having experienced the trauma of domestic violence has a detrimental impact on psychological health: compared to district women who have never had an abusive partner, those who survive violence experience higher rates of suicidality, depression, post-traumatic stress symptoms, and greater use of drugs or alcohol.[10] These linkages are particularly concerning for youth. The CDC's *Youth Risk Behavior Surveillance Data Summary & Trends Report: 2009-2019* recently demonstrated that youth who experience poor mental health are also at greater risk for substance use, experiencing violence, and sexual behaviors that put them at risk for HIV, sexually transmitted infections, and unintended pregnancy.[11] The poor mental health outcomes from experiencing violence places DC residents, specifically youth, in a viscious cycle of experiencing more violence, more trauma, and more adverse health impacts specifically related to HIV and sexually transmitted infections.

Domestic violence is also a direct contributor to mother and child morbidity and mortality. It is well known that domestic violence is a leading health problem among women during pregnancy and is a leading cause of

[9] Ibid.
[10] Bonomi, A.E., Thompson, R. S., Anderson, M., Reid, R.J., Carrell, D., Dimer, J. A., & Rivara, F.P. "Intimate Partner Violence and Women's Physical, Mental, and Social Functioning. American Journal of Preventive Medicine 30 (2006): 458-466; Stockl, H., Devries, K., Rotstein, A., Abrahams, N., Campbell, J., Watts, C., & Moreno, C.G. "The Global Prevalence of Intimate Partner Homicide: A Systematic Review." The Lancet 382, (2013): 859-865.
[11] https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBSDataSummaryTrendsReport2019-508.pdf

death during pregnancy.[12] Intimate partner violence during pregnancy has been correlated with pre-term birth and low birth weight; both contributing factors to infant mortality.[13]

A funding allocation of $400,000 for the prevention of domestic violence helps DC build healthier families and communities, thus decreasing the burden on our public health systems. Without dedicated funding to address the root causes of domestic violence, the increasing need for more resources to serve the victims will not stop. As such, the public health system will continue to pay for the effects of domestic violence on children, adults, families, and communities.

Conclusion

We greatly appreciate the Council's commitment to addressing the needs of survivors of domestic violence and the organizations working with them. I am happy to discuss any questions you may have. Thank you, Chairperson Henderson, for the opportunity to testify.

[12] https://www.ucsfhealth.org/education/domestic-violence-and-pregnancy

[13] Alhusen JL, Ray E, Sharps P, Bullock L. Intimate partner violence during pregnancy: maternal and neonatal outcomes. J Womens Health (Larchmt). 2015 Jan;24(1):100-6. doi: 10.1089/jwh.2014.4872. Epub 2014 Sep 29. PMID: 25265285; PMCID: PMC4361157.

Testimony for The Committee on Health

April 10, 2023

Submitted By Cristela Buruca

Family Support Worker / Home Visitor

Mary's Center for Maternal and Child Care, Inc.

to Councilmember Henderson

Good morning, Chairwoman Henderson and members of the Committee on Health. Thank you for the opportunity to speak to you to conduct this budget oversight hearing or DC Health. My name is Cristela Buruca and am a DC Native with an immigrant background. My purpose in life has always been to become the voice of the people and to protect the children of our community from child abuse and neglect. Growing up in DC I have experienced personally and professionally how certain environmental factors have impacted our community immensely. I started my journey as a Home Visitor about 5 years ago at MC and even before that I was a patient at Mary's Center since I was born. If it weren't for the investments made in the direction of services like those offered at MC, my family would not have benefitted from these resources. It is when the city chooses to invest in family well-being that families are able to find themselves accessing positive health outcomes. I am here to educate you on what Home Visiting is like and the impact that our service has on families. DC has seen many tragedies occur since the pandemic started from domestic violence to high levels of stress and depression, Home Visiting has allowed me to decrease many stressors and intimate partner violence in the community resulting in increased health outcomes. One example is a long-term enrolled family with a history of intimate partner violence and depression; who has maintained a healthy relationship with family and a low depression screening rate. The resources and support provided to this family through home visiting has empowered them in developing

healthy boundaries, strong bonding and attachment with children, and higher literacy rates. Statistically, Home visiting programs have proven to decrease gun violence, gang violence, lower-incarceration rates, and lower child abuse and neglect rates.

Some of the positive impacts of Home Visiting Healthy Families America are: HFA moms are 5 times more likely to enroll and participate in school and training programs, and teen moms are nearly twice as likely to complete at least one year of college compared to teen moms not receiving HFA. Children are more likely to have health insurance and fewer moms report being homeless in the six years since enrollment in HFA. HFA moms show improved mental health, lowered parenting stress, and increased avoidance of risky behaviors (including reducing alcohol and marijuana use by nearly half and increasing the use of condoms by almost 40%).

To conclude, It is important that DC Health restores and increases investments into HV of a total of $1.2M, 500K to restore what was cut in FY23 and Increase grants by 700K to increase workforce retention. Medicaid reimbursement is an option DC Health

should explore and implement programs that support families to have stable durable funding streams for long-term stability. Thank you!

Bibliography

https://www.healthyfamiliesamerica.org/our-impact/evidence-of-effectiveness/

Testimony for The Committee on Health

April 10, 2023

Submitted By Carolyn Babendreier

Healthy Start Program Supervisor

Mary's Center for Maternal and Child Care, Inc.

to Councilmember Henderson

Hello, my name is Carolyn Babendreier. I am the supervisor for the Healthy Start Program at Mary's Center. I started out as a Community Health Worker and want to thank you all for the support that you have provided struggling families through the current investments in home visiting. I firmly believe, as I know you all do, that investing in families and the health and wellbeing of our children is most essential.

In my direct work with families as a home visitor I have seen how transformative these interventions can be for children and their whole family. However, insufficient funding and investment in Home Visiting is resulting in negative impacts on staff and a reduction of services; ultimately affecting the families on our caseloads. I have also experienced the challenges with providing consistent services through staffing departures and turnover due to DC Grants not facilitating thriving wages for the workforce. I see how unsustainable this is, even more now as a supervisor and hiring manager. This has been especially true since the pandemic where the need for support that families seek has increased and so too the burden on our home visitors; however, our home visitors do not receive the fiscal support that would ensure their long-term stability and success in the role. Our families and programs deserve long term stability which requires livable wages for our staff and sustainability options such as the Medicaid reimbursement you have heard of from some of my peers. Now is not the time to reduce investments that support family wellbeing. Now is the time to make sure families and children are able to access the resources and supports that ensure their wellbeing. **Our** community is only as strong and healthy as our neighboring families and children are.

My own team has been managing staff turnover for over a year while not being fully staffed. The staff that has remained in the role in the year and half of partial staffing have not received any increase in salaries since their time covering unfilled positions in the program. As a hiring manager we try to hire quality candidates who can quickly train and begin supporting families, but I have seen qualified wonderfully engaged and passionate candidates shy away from the position after hearing the maximum salary we can offer. This is not sustainable for our program participants. We lose on high quality candidates when we can't offer thriving wages. Participants lose on high quality support when our programs are undervalued and overburdened.

Home visiting is an investment in communities – a holistic, preventative approach to supporting families and their health, well-being, economic stability, etc. especially when some participants face more challenges. For this to continue, we need to be competitive in attracting candidates and incentivizing workers. We want qualified and passionate candidates to remain in the role long term so that they can focus on their work with families rather than be concerned for their own economic stability. How can Home Visitors expect to support families to get economically stable if they themselves are struggling to do the same with the wages these grants force us to offer? Our Home Visiting professionals should be able to support their families without worry. I am here among HV programs and partners asking that DC Health restore and increase HV investments of 500K restoring the FY23 funds that were cut and 700K for salary increases that will support workforce retention that decreases interruptions to families seeking care and support a total of of $1.2M. I also recommend that DC Health explore and implement a Medicaid reimbursement plan so that evidence based HV programs can bill for Home Visits that increases positive health outcomes for families. Lastly, I welcome Councilmember Henderson to shadow one of our Home Visits so that you can see the impact of our program services and see what your investments can do when we are funded and resourced to support family health and wellbeing.

Thank you!

D.C. Council Committee on Health: Department of Health Budget Hearing
Monday, April 10, 2023
Testimony by Lauren Lapointe,
Sexual and Reproductive Health (SRH) Program Manager at Latin American Youth Center

Thank you, Councilmember Henderson and members of the Committee on Health, for allowing me to submit my testimony. My name is Lauren Lapointe and I am the Sexual and Reproductive Health (SRH) Program Manager at Latin American Youth Center or LAYC. LAYC is in Ward 1 and has been an important part of the District and region for over 50 years. We serve over 4,000 youth and families annually and operate programs in the District, and Prince George's and Montgomery Counties.

LAYC is a proud member of the Fair Budget Coalition and I work in partnership with Fair Budget Coalition for an equitable DC. Our organization is one of the many that works on HIV, STIs, and pregnancy prevention within the Fair Budget Coalition. In DC, we have some of the highest rates of STIs and HIV in the country. Our work focuses on the prevention of these cases, and it starts with our young people.

Our Counseling, Testing, Referrals, and Linkages program (CTRL) allows a safe, non-judgmental space for our DC youth to attain necessary resources to prevent pregnancy, sexually transmitted diseases (STIs), and Human Immunodeficiency Virus (HIV). We empower each youth to take steps to prioritize their health and their future through free and confidential HIV, STI, and pregnancy testing and individual counseling sessions.

I believe in the wide-ranging work of Fair Budget Coalition as I work on sexual and reproductive health. We expect the HIV and STI Testing and HAHSTA Pregnancy Prevention to be refunded for FY24 and future years. We want to continue LAYC's efforts to ensure DC youth have access to free, confidential HIV, STI, and reproductive health information and services, allowing them to make informed and healthy decisions for themselves and their families.

Thank you for your time. I am happy to answer any questions you may have.

Lauren Lapointe
SRH Program Manager

Latin American Youth Center
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Good afternoon Councilmember Henderson and members of the committee,

My name is Travis Ballie and I am a resident of Ward 7, testifying as a public witness. I am also a former Executive Committee member of Fair Budget Coalition, which fights for an equitable DC. I stand in solidarity with the member organizations of Fair Budget. I believe in the wide-ranging work of Fair Budget even as I focus especially on early childhood education issues.

I am an individual supporter of Under 3 DC, a coalition which is committed to securing a strong start for every infant and toddler in DC. My testimony today will focus on the importance of home visiting for a strong, effective, and connected early childhood system in the District.

I support the coalition request for a $1.2 million increase to the total local home visiting investments to raise home visitor wages, adjust for inflation, and enable programs to meet the urgent needs of families. For my ward of Ward 7, home visitation for new parents and children is especially critical. Over ⅓ of our District's children live East of the River. In addition, Wards 7 & 8 have the 2nd and 1st largest populations of children in the District.

Numerous studies have showed correlation between home visitation programs and enhanced maternal and child health. Some programs have even reduced the hospitalization rate among participating mothers and children.

For East of the River communities, who are underserved with medical facilities, home visiting programs are literal lifesavers. Medical centers such as MedStar Washington Hospital Center, MedStar National Rehabilitation Hospital, Children's National Hospital and the Washington DC VA Medical Center require East of the River residents to travel long distances with their children, and many of these hospitals are not located near a metrorail stop. Nationally, 3.6 million Americans miss medical appointments every year due to transportation issues. In urban areas like Washington DC, this acutely impacts young children and their parents.

Home visitors are critical to the success of young children and their parents, especially by bringing healthcare directly to East of the River families who might otherwise be one of those millions of Americans missing appointments every year. Increasing wages for home visitors will help retain a workforce critical to achieving District goals of reducing maternal mortality and building a first-class early childhood system. In closing, I want to reiterate my strong support for a $1.2 million increase to the total local home visiting investments so that we can reward some of the most dedicated, yet underpaid professionals working with District families and children for years, our home visitors.

Thank you very much for your time.

Mary's Center

Quality healthcare. Stronger communities.

Testimony for

The Committee on Health

April 10, 2023

Submitted By

Fernanda Ruiz

Home Visiting Director

Mary's Center for Maternal and Child Care, Inc.

to

Christina Henderson, Chair

Testimony for 2023 Budget Hearing
Committee on Health
DC Health
April 10, 2023

Fernanda Ruiz
Home Visiting Director
Mary's Center for Maternal and Child Care, Inc
2333 Ontario Rd NW

Good morning, Chairwoman Henderson and Members of the Committee,

Thank you for the opportunity to testify today. My name is Fernanda Ruiz, and I am the Home Visiting Director at Mary's Center, a member of the Under 3DC Campaign and a District resident from Ward 4. In my role I support the Healthy Families America (HFA), Parents As Teachers (PAT), Healthy Start and Nurse Family Partnership (NFP) programs funded by the Department of Health (DC Health) and other home visiting models currently implemented in the District through other funding sources.

I am here today to request an increase of $1.5 million to local home visiting funds in FY24- $500,000 to restore the home visiting local funds that were cut in FY23, $700,000 for DC Health grants for workforce retention, and $300,000 for CFSA for workforce retention-, for DC Health to continue their investment in the home visiting programs at Mary's Center, including funding for the First Time Mothers grant supporting NFP and for Medicaid to be leveraged to help sustain and grow evidenced based home visiting programs to better support District birthing persons and their children.

These programs have proven to be effective at supporting families and improve maternal child health and early childhood outcomes through the strategy of home visiting[1][2][3]. Funding for these programs needs to be recurrent and needs to be adjusted to inflation and to the current demands placed on home visitors to support families during the pandemic.

[1] Data Source: Our Impact (2021). *Healthy Families America*. Retrieved from: https://www.healthyfamiliesamerica.org/our-impact/evidence-of-effectiveness/
[2] Data Source: Proven Results (2022). *Nurse Family Partnership*. Retrieved from: https://www.nursefamilypartnership.org/about/proven-results/1386-2/
[3] Data Source: Evidence Based Research and Results (2022). *Parents As Teachers.* Retrieved from: https://parentsasteachers.org/research-and-quality-improvement-index

A variety of reports have shown how inequities in District residents exacerbate infant mortality rates disproportionately[4][5][6][7]. Families come in all shapes and forms. After many years in the field, we recognize the importance of having a robust perinatal and early childhood system. A continuum of support of diverse home visiting programs, that accounts for the small differences among families and allows families to engage in the model that best meets their needs. Mary's Center currently offers four home visiting models and a community health worker case management program. Allowing us to engage families through different phases of perinatal and early childhood years.

Home visitors are educated, well trained, dedicated and committed individuals. They are passionate about working with families. 81% of home visitors have a bachelor's degree in human services, child development or another relevant field with our remaining team joining us as District residents with experience in early childhood development, community health and other areas that support our participants. Yet, as many social services jobs, home visiting is a job that is mostly done by women and people of color[8]. Historically, community members that are underpaid. Home visitors find their jobs rewarding and meaningful. However, a rewarding position is only one aspect of what allows us to be engaged in our work; we also need to ensure our compensation matches the importance, skill level and quality that we bring. As an agency that has implemented home visiting for 26 years, we know what is necessary to be effective and we know home visiting staff deserve pay that reflects the time and investment that the team has put into their role to ensure the highest quality of care and support to our communities.

Funding and compensation greatly impact participant outcomes and staff retention. We have presented testimony every year outlining the impact of staff turnover, so often due to needing a salary more reflective of their skills and abilities. We've reviewed how lapses in funding impact consistency and continuity of services, including loss of contact with families and loss of trained staff who have built trusting relationships with families. We know that lower pay is correlated to lower staff retention[9].

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[4] District of Columbia Department of Health (2018). Perinatal health and infant mortality report. Retrieved from https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/DC%20Health%20Perinatal%20Health%20%26%20Infant%20Mortality%20Report_FINAL.PDF

[5] Siddiqi, A., Jones, M. K., Bruce D. J., & Erwin, O. C. (2016). Do racial inequities in infant mortality correspond to variations in societal conditions? A study of state-level income inequality in the U.S., 1992-2007. *Social Science & Medicine*, 164, 49-58. doi: 10.1016/j.socsimed.2016.07.013

[6] DC Fiscal Policy. (2018). *DC's growing prosperity is not reaching Black residents, Census data show.* Washington, DC: Ed Lazere. Retrieved from: https://www.dcfpi.org/all/dcs-growing-prosperity-is-not-reaching-black-residents-census-data-show/

[7] District of Columbia. (2016). *Community Health Needs Assessment*. Washington, DC: Merrill, C., & Searcy, K. Retrieved from: http://www.dchealthmatters.org/content/sites/washingtondc/2016_DC_CHNA_062416_FINAL.pdf

[8] Data Source: Home Visitors Experience Report (2021). *DC Home Visiting Council*. Retrieved from: http://www.dchomevisiting.org/uploads/1/1/9/0/119003017/home_visitors_experience_report-final_english.pdf

[9] Data Source: Home Visitors Experience Report (2021). *DC Home Visiting Council*. Retrieved from: http://www.dchomevisiting.org/uploads/1/1/9/0/119003017/home_visitors_experience_report-final_english.pdf

Last week, you heard several testimonies advocating for Medicaid reimbursement as a funding mechanism and long-term sustainability strategy for home visiting programs. Our evidence-based home visiting programs working with perinatal participants, are working with the same DC community members served by Medicaid and DC Alliance to achieve and support improved maternal and child health outcomes. In more than 40 other States, NFP, and other evidence-based home visiting programs, are funded through a mix of both private and public dollars. At least 37 states cover evidence-based home visiting programs, including NFP and HFA through the Medicaid program and that list is growing. While rates and payment structures vary depending on the methodology used, we know that leveraging Medicaid dollars to support evidence-based home visiting is cost effective. For example, based upon our current NFP projected program costs, if Medicaid funding was used, the cost per family per month is $187. Funding NFP and other evidenced based home visiting programs through Medicaid is not only cost-effective it also promotes better coordination of care and services for pregnant persons and babies who are enrolled in Managed Care.

Mary's Center continues through our social change model to be committed to the health, education and safety of families in the District. We urge DC Health to continue their investment in prevention services and that we do not remove these essential supports for families of young children. We hope we can build from here to continue our shared commitment to serve families in the District with the goal of improving maternal and child health outcomes. We continue to manage racism, trauma, inequity and loss, let's recognize the importance of maintaining investment in our programs within our system of care towards safe and healthy families that lead to safe and healthy communities.

Thank you very much for your attention and time. I am happy to take any questions.

EDUCATING DC RESIDENTS ABOUT HOSPICE CARE AND REDUCING MEDICAID COSTS

My name is Steve Cone, Chief of Communications, Marketing & Philanthropy. And my name is Audrey Easaw, SVP of Philanthropy & External Affairs, and Executive Director of Capital Caring Health's Center for Health Equity.

IN WASHINGTON DC – CAPITAL CARING HEALTH HAS BEEN THE ONLY HOSPICE ENTITY COMMITTED TO PROVIDING ESSENTIAL INPATIENT HOSPICE CARE FOR OVER A DECADE. **WE ARE A NONPROFIT HOSPICE THAT TURNS NO ONE AWAY REGARDLESS OF ABILITY TO PAY.**

1. WHY AN INPATIENT FACILITY? When a DC resident becomes terminally ill and enrolls in hospice care, most of the time that care is provided in their home or wherever they reside. But there are situations when comprehensive around-the-clock care is required which is why we operate an inpatient hospice care center.

2. FIRST AT PROVIDENCE HOSPITAL: For many years we provided inpatient hospice on a dedicated floor at Providence Hospital. We had to vacate Providence in February of 2022 because essential support utilities were no longer available.

3. OUR SIBLEY CENTER OPENED FEBRUARY 2022: When our inpatient care center opened at Sibley Memorial Hospital, we were able to transfer several patients from Providence directly to our new state-of-the-art 10-room facility at Sibley.

4. WE ARE IT! **We have been and remain the only hospice entity willing to operate an inpatient facility in DC**. Insurance reimbursement only covers 50% of our cost and thus we lose over 1 million dollars a year providing 24-hour medical, social, and spiritual care for both patients and their families. We also allow visitation 24 hours a day for two family members, including sleepovers if they wish.

5. WITHOUT THE DISTRICT'S HELP: There is the distinct possibility we might have to close this facility since we cannot afford to lose over one million dollars a year.

Capital Caring Health is requesting $1million annually from the District of Columbia to offset a portion of the operating costs, so that we can continue providing this important service to patients and their families

EDUCATING DC RESIDENTS ABOUT HOSPICE CARE AND REDUCING MEDICAID COSTS

When needed, most residents of Washington DC do not take advantage of the hospice care benefit of up to six months which is covered by Medicare, Medicaid, or Private Insurance or by us for the under or uninsured.

In a nationwide survey before the COVID pandemic, Washington DC ranked 48th among the 50 States in hospice utilization. This fact is a tragedy because it means far too many terminally ill residents and their families suffer the unrelenting stress of rushing to emergency rooms plus hospitalization, often resulting in the patient dying alone in an ICU.

Moreover, DC residents who do enroll in hospice care only do so for two weeks or less. If more terminally ill residents choose hospice over hospitalization and for several months instead of several days, their end-of-life experience and that of their families would be vastly improved. It also means the District of Columbia could potentially save several million dollars a year in Medicaid expenses since hospice care is less costly than hospitalization during the last 60 days of life.

Capital Caring Health proposes an awareness campaign sponsored by the District of Columbia which explains the hospice benefit and why families are far better off if they utilize it for longer periods than a few days. The request amount is $150,000 to launch a three-month campaign and track increased utilization and Medicaid savings.

Throughout the proposed campaign, Capital Caring Health will continue working with our partners in the faith-based community, and educational institutions to increase awareness of how hospice adds to the quality of end-of-life experience for patients and their families, and in many cases, their larger community.

Respectfully Submitted,
Steve Cone and Audrey Easaw, Capital Caring Health
4/24/2023

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Fiscal Year 2024
Budget Oversight Hearing

Testimony of
Sharon Williams Lewis DHA, RN-BC, CPM
Interim Director, DC Health

Before the
Committee on Health
Council of the District of Columbia
The Honorable Christina Henderson, Chairwoman

April 12, 2023
12:00 PM
The John A. Wilson Building
1350 Pennsylvania Avenue NW
Washington, DC 20004

Good afternoon, Chairwoman Henderson, members of the Committee on Health, and staff. My name is Dr. Sharon Lewis, Interim Director of the District of Columbia Department of Health, or DC Health. I am pleased to offer testimony before you today on Mayor Bowser's Fiscal Year 2024 (FY24) Proposed Budget and Financial Plan, entitled "A Fair Shot."

I am joined today by DC Health's Chief Operating Officer (COO), Mr. Keith Fletcher, our Agency Fiscal Officer (AFO), Ms. Adreana Deane, and members of the Executive Leadership Team, all of whom worked diligently to contribute to the formulation of the agency's budget proposal for the Mayor's consideration.

While Mayor Bowser's proposed budget continues to support District residents and businesses' recovery from the pandemic and make new investments in the future, the financial outlook does require us to make some tough choices. This budget reflects those financial realities while still ensuring that we are giving more Washingtonians a fair shot by investing in a safer, stronger, healthier, and more equitable DC.

As Mayor Bowser has noted, this is the first year since 2009 that the District's revenue has decreased. Deputy Mayor Turnage shared during his testimony last week that the Health and Human Services (HHS) cluster's $6.29 billion dollar funding for FY24 represents a 32% decrease in the operating budget from last year. While 5% of that funding goes to DC Health, the other 95% is also geared towards improving population health and funding critical health services. The proposed expenditures within both the HHS cluster and other agency clusters will leverage the social determinants of health to align with DC Health's investments and improve population health.

DC Health's total operating budget is $8.1 million higher than last year and will allow us to continue providing the services that residents, workers, and visitors need while modernizing our infrastructure and policies. Additionally, DC Health's capacity is strengthened through an increase of 33 full-time equivalents (FTEs). These resources will drive our new and expanded activities in chronic disease prevention, IT modernization, and strategic partnerships with community-based organizations and other federal, state and local partners to drive improvements to the District's public health systems.

DC Health's mission is to promote health, wellness, and equity across the District, and protect the safety of residents, visitors and those doing business in our nation's capital. To achieve that mission, we use the Public Health 3.0 (PH3.0) modern framework to improve population health and address the social determinants of health. The proposed FY24 budget advances the five key components of PH3.0 by providing flexible and sustainable funding to leverage partnerships through our grantmaking, expand our infrastructure to better address emerging public health threats, invest in our workforce as we emerge from the pandemic and improve our data and analytics capabilities. This budget will advance an equitable future for all our District's residents, workers, and visitors.

We also know that there are nontraditional key factors that have a significant impact on health. The FY24 proposed budget includes a variety of investments in what DC Health calls the nine key drivers of health: education, employment, housing, transportation, food environment, community safety, medical care, outdoor environment, and income. The Mayor's investments ensure that the social determinants of health are addressed and allow DC Health and its public

health partners to effectively address the unmet health needs of residents, less fettered by the other needs of housing, employment, and education.

The Community Health Administration (CHA) and the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) continue to make up nearly two-thirds (62%) of the agency's budget. However, most of these funds are federal dollars and tightly restricted to specific programs and allow only for specific expenditures. The proportion of DC Health funding that comes from federal funds compared to local funds has increased in FY24 due both to the decrease in the revenue projections and DC Health's aggressive federal grant seeking. Key enhancements by the Mayor's FY24 proposed budget include:

- $550,000 to provide free dental services for seniors.
- $324,000 to Capital Area Food Bank to support their Joyful Food Markets east of the river.

Having released its Framework for Improving Community Health in early 2023, CHA will expand its efforts to improve population health through innovations in its maternal health, tobacco control, school health and brain health programs. Highlights include:

- Provide all new mothers in the District free access to Pacify, a mobile app that provides around-the-clock, on-demand, video-enabled consultation from certified lactation consultants;
- Launch two mass-reach media campaigns: one to discourage youth and young adults from starting to use tobacco products and one to encourage established smokers to quit;
- Implement the District's Alzheimer's and Related Dementias State Plan to address the growing needs of individuals living with dementia and their caregivers; and,

- Implement the electronic Universal Health Certificate (eUHC) and electronic Asthma Action Plan (eAAP) to reduce the burden on families to return paper copies to schools.

The Center for Policy, Planning, and Evaluation (CPPE) activities will be expanded next fiscal year with $3 million in additional federal funds to:

- Release the Healthy DC 2030 Framework and Action Plan, the city-wide shared community agenda to improve population health;
- Update data in statistical reports on topics of importance to the District, such as maternal and infant mortality;
- Implement a non-influenza respiratory surveillance program; and,
- The State Health Planning and Development Agency (SHPDA) will publish a new Health Systems Plan which will serve as a guide for the next five years of public health and healthcare improvements in the District.

HAHSTA will continue its efforts through a "no wrong door" approach and continue to ensure that housing and preventative supports are accessible to all. The agency's HIV/AIDS elimination activities build upon the past successes of the Ryan White program and highlights in FY24 include:

- Planning for an expansion of the Ending the HIV Epidemic PrEP (pre-exposure prophylaxis) housing program to a different high-risk population; and,
- Piloting an Over-the-Counter PrEP Program where District residents can obtain PrEP directly from the pharmacy, completing tests at local labs, and follow ups via telehealth, thereby reducing barriers to PrEP.

The Health Emergency Preparedness and Response Administration (HEPRA), which supported the pandemic response over the past three years, will continue to prepare for future pandemics by reviewing and updating plans, regulations, and trainings based on lessons learned from the pandemic. This includes:

- Revising DC Health's Medical Countermeasures plans, which were used as the foundation for the COVID-19 public vaccination campaign. This revision will ensure that the agency incorporates the knowledge and lessons learned from the COVID-19 response;
- Improving the Medical Reserve Corps (MRC) volunteer training and retention program to better prepare staff and volunteers to respond to future public health emergencies. These updates will ensure that plans, equipment, and personnel are up to date and prepared for any future public health emergency; and,
- Updating the EMS regulations, which will both strengthen and modernize the EMS system in Washington, DC. These changes will codify additional levels of EMS care and create opportunities for additional EMS education in the District.

DC Health's Health Regulation and Licensing Administration (HRLA) is undertaking expansive efforts to improve the District's healthcare workforce. This includes:

- Introduce an updated Health Occupations Revision Act (HORA) and align board regulations with the new HORA;
- Build on the Board of Medicine reciprocity agreement established in FY23 by implementing additional regional reciprocity agreements for other health professions with Maryland and Virginia;

- Issue regulations required by the Dementia Training for Direct Care Workers Support Amendment Act to ensure all direct care workers in covered facilities are trained on issues surrounding dementia;
- Issue report on criminal background checks as required by the updated Removing Barriers to Occupational Licensing for Returning Citizens Amendment Act; and,
- Introduce an updated Radiation Protection Act and update radiation regulations accordingly.

DC Health continues to view all its work through an equity lens to reduce population health disparities. As the District's health equity thought leader, the Office of Health Equity (OHE) will continue to take a leadership role within and outside of the agency to drive these improvements. To that end, OHE will:

- Complete the Health Literacy Portal and expand reach and use by consumers;
- Roll out and socialize the functioning DC Health Opportunity Index Model 1.0 which will provide new insight into the impacts of multi-sectoral contributions; and,
- Demonstrate the utility and power of multi-sector partnership/engagement to improve population health through the new HealthyDC Steering Committee and, by December 2023, approve the first Action Plan.

The FY24 proposed budget also moves the Public Health Laboratory (PHL) to DC Health. This move, which would bring DC into alignment with 45 other states, will streamline the existing relationship between DC Health and the PHL. The PHL is in part funded through the Centers for Disease Control and Prevention (CDC), but such funding must flow through the state department of health which in the District, is DC Health. Due to that requirement, DC Health has always had

a close financial relationship with the lab, and this change would reduce administrative burdens on staff in transferring funds. It will also better connect our epidemiology and public health data teams with the lab analyses and better equip our agency and the District to respond to future outbreaks.

Finally, our agency continues to aggressively pursue additional competitive grants to supplement our budget. This includes a recently awarded CDC grant entitled, Strengthening the D.C. Public Health Infrastructure, Workforce, and Data Systems. This funding of $8.5 million over five years, starting in FY23, will support DC Health's modernization of its data infrastructure and workforce to continue moving our agency forward.

Mayor Bowser's FY24 proposed Fair Shot Budget continues a strong commitment to investing in equitable health outcomes for District residents, visitors, and workers. I would also like to thank our dedicated team of public health professionals for their continued efforts to support our agency's goals as it confronts the new post-pandemic reality. I look forward to working with you, Chairwoman Henderson, members of the Committee on Health, and the Council in support the agency's proposed FY24 budget to keep all District residents healthy and safe.

This concludes my testimony. I am available to respond to questions at this time.