GOVERNMENT OF THE DISTRICT OF COLUMBIA
Executive Office of Mayor Muriel Bowser

Office of the Deputy Mayor for Health and Human Services

COMMISSION ON HEALTHCARE SYSTEMS TRANSFORMATION
MEETING AGENDA

September 24, 2019
DC Hospital Association: 1152 15th Street NW #900.
Phone: 1-650-479-3208, 859 154 611

Commission Members

Name	Affiliation/ Designation	Attendance	Designee	Attendance
David Catania	Co-Chair	Present		
Sister Carol Keehan	Co-Chair	Present		
Kimberly Russo	George Washington University Hospital	Present		
Kevin Sowers	Johns Hopkins Medicine, Sibley Memorial Hospital	Present		
Oliver Johnson	MedStar Health	Present		
Dr. Malika Fair	United Medical Center	Present		
Dean Hugh Mighty	Howard University Hospital	Present		
Corey Odol	Psychiatric Institute of Washington	Present		
Denise Cora-Bramble, M.D.	Children's Hospital	Present		
Marc Ferrell	Bridgepoint Healthcare	Present		
Don Blanchon	Whitman-Walker Health	Present		
Kim Horn	Kaiser Foundation Health Plan	Present		
Maria Harris Tildon	CareFirst BlueCross BlueShield	Present		
David Stewart	University of Maryland, Family Medicine	Present		
Kelly Sweeney McShane	Community of Hope	Present		
Maria Gomez	Mary's Center	Present		

City Administrator Rashad Young	City Administrator	Not Present	Ben Stutz	Present
Deputy Mayor Wayne Turnage	Deputy Mayor for Health and Human Services	Present		
Dr. LaQuandra Nesbitt	D.C. Health	Present		
Dr. Barbara Bazron	Department of Behavioral Health	Present		
Melisa Byrd	Department of Health Care Finance	Present		
Dr. Faith Gibson Hubbard	Thrive by Five	Present		
Chief Gregory Dean	Fire and Emergency Medical Services	Present		
Councilmember Vince Gray	Council of the District of Columbia, Committee on Health	Present		
Tamara Smith	D.C. Primary Care Association	Present		
Jacqueline Bowens	D.C. Hospital Association	Present		
Dr. Gregory Argyros	Washington Hospital Center	Present		
Karen Dale	AmeriHealth Caritas DC	Present		
Vincent Keane	Unity Health Care	Present		
Dr. Raymond Tu	Medical Society of DC	Present		

Additional District GovernmentAttendees

Name	Role	Office or Agency
Rayna Smith	Staff	Office of the Deputy Mayor for Health and Human Services
Amelia Whitman	Staff	Office of the Deputy Mayor for Health and Human Services
Amha Selassie	Staff	DC Health
Marsha Lillie-Blanton	Staff	Department of Behavioral Healt
Fern Johnson-Clarke	Staff	DC Health
Lauren Ratner	Staff	DC Health
Sharon Lewis	Staff	DC Health
Frank Meyers	Staff	DC Health
Terri A. Thompson	Staff	DC Health
John Coombs	Staff	Fire and Emergency Medical Services
Robert Holman	Staff	Fire and Emergency Medical Services
Noah Smith	Staff	Department of Health Care Finance

Erin Holve	Staff	Department of Health Care Finance
Jordan Kiszla	Staff	Department of Health Care Finance
Alice Weiss	Staff	Department of Health Care Finance
Raessa Singh	Staff	Department of Behavioral Health

Public Attendees

Name	Role	Organization
Justin Palmer	Public	D.C. Hospital Association
Patrick Canavan	Public	IdeaCrew
Regina Knox Woods	Public	MedStar
Calvin Smith	Public	Bridgepoint Healthcare
Francisco Semiao	Public	MedStar Health
Robert Hay	Public	Medical Society of DC
Elizabeth Davis	Public	Children's National
Eric Wolff	Public	DCHCC
Desiree de la Torre	Public	Children's National Hospital
Michael Crawford	Public	Howard University
Kevin Wrege	Public	Pulse Advocacy
Feseha Woldu	Public	MedStar
Colette Chichester	Public	CareFirst BCBS
Ammar Alhaddad	Public	GWU
Jennifer Hirt	Public	DC Hospital Association
Layo George	Public	Wolomi

Agenda and Minutes

1. **Call to Order** **Commission Co-Chairs**

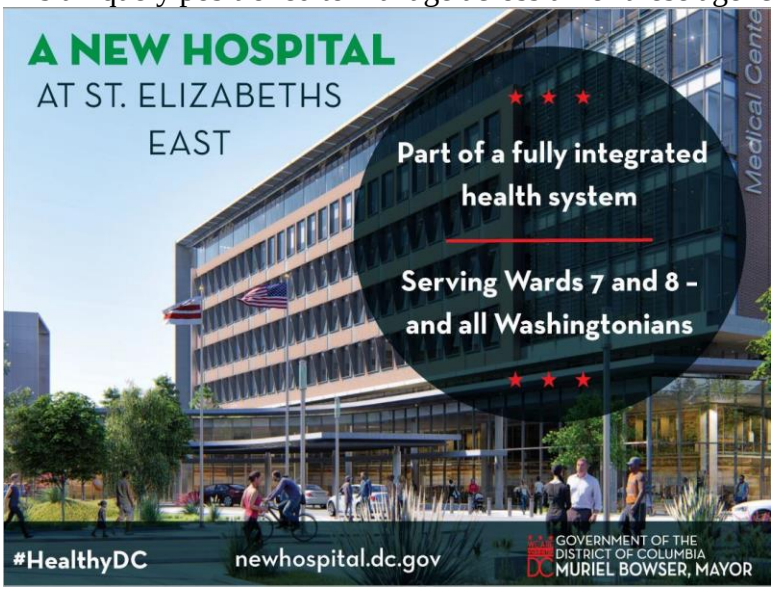
   The meeting was called to order at 10: 05 am.

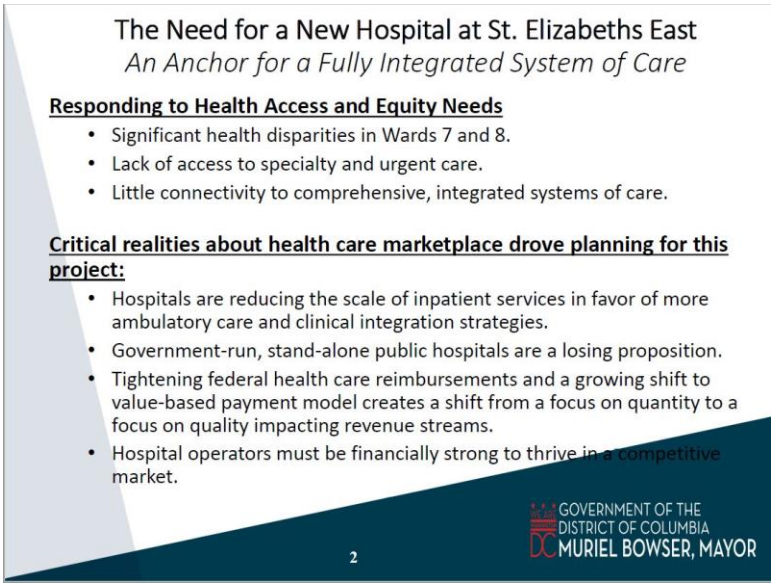
2. **Commission Administration** **Commission Co-Chairs**

   - Co-Chair David Catania reminded the Commission that subcommittee reports are due September 27. We will share the recommendations publicly so there is transparency and the ability for the public to weigh in.
     - Once reports are received, the co-chairs will collect the reports and integrate the recommendations. We will then have subcommittees present across the next two meetings, with three presenting in October and three in November.
   - Plan to circulate for October meeting on the 21st

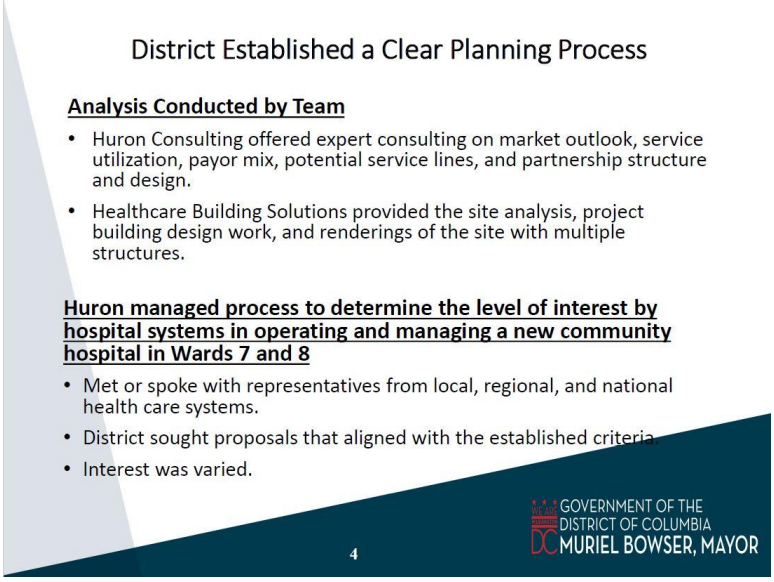
3. **New Hospital at Saint Elizabeths East Update** **Office of the City Administrator**

- Ben Stutz, Chief of Staff to the City Administrator presented on the status of the new hospital at Saint Elizabeths East.
- Ben began with an orientation for why the project is in the Office of the City Administrator (OCA): The components of the project touch multiple agencies across the government – from health agencies, to the Office of Planning, Department of Human Services, Department of Energy and Environment, and the Office of the Deputy Mayor for Planning and Economic Development. OCA OCA is uniquely positioned to manage across all of these agencies.

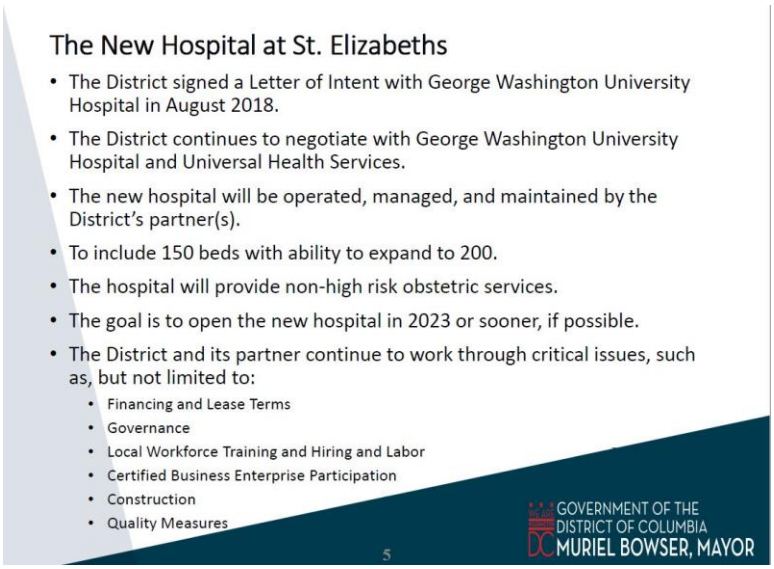




- The project seeks to respond to the health disparities, lack of access, and lack of connectivity east of the river. There are existing assets in Wards 7 and 8 and we are focused on how existing resources can connect with a local community hospital that can provide a continuum of care.

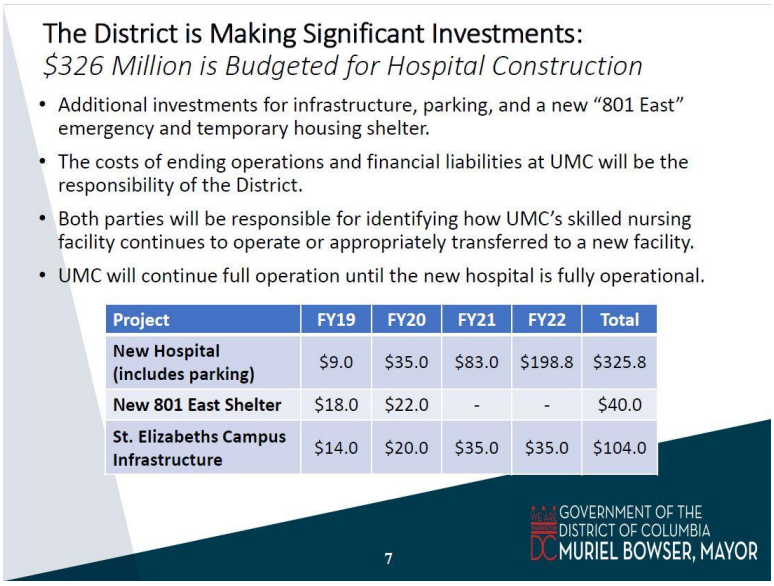


- When we began the project, Huron created a number of reports for the District (found here), developed renderings, and conducted a preliminary analysis of the site. In order to find a partner, Huron and the District engaged with hospital systems form across the region and country to determine their interest in operating and managing a facility east of the river.
    - The interest was varied across systems. In some cases it did or did not align with how they deliver care or their financial portfolio. The level of interest really depended on the system, how they thought about the project, and whether thought it was feasible or them.

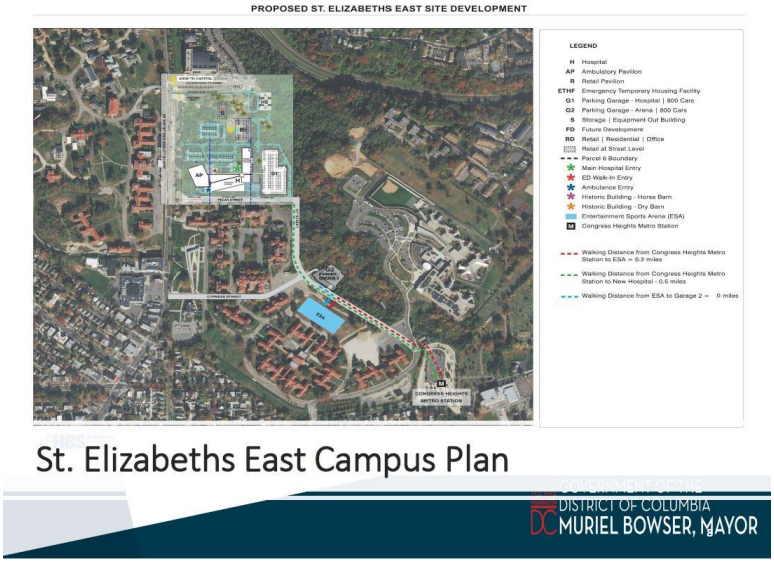


- We are looking to create a community hospital with 150 beds, with the ability to expand by 200 beds; operated and maintained by the District and its partner or partners; and inclusion of non-high risk obstetric services. The goal is to open in 2023 or sooner.
    - There are a number of key issues that remain, which are listed at the bottom of this slide.

- One of the components the District was seeking in a partner was a level of investment to match the district's investment, or otherwise be significant.

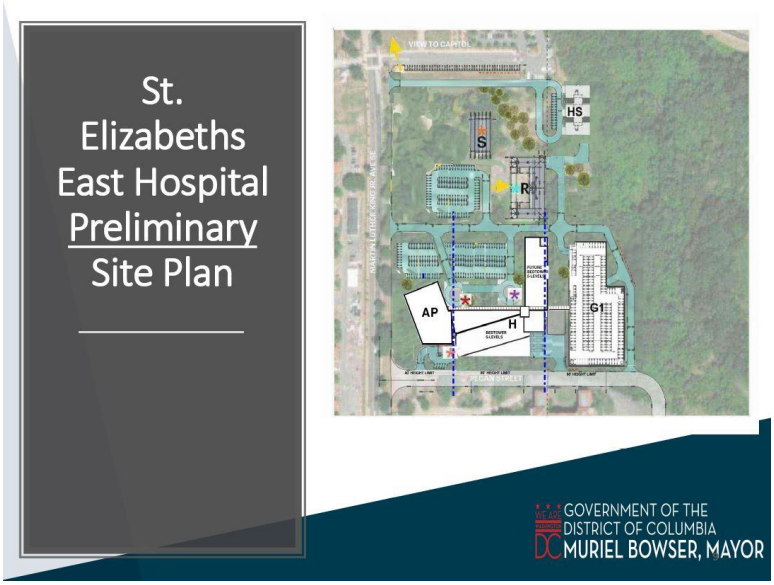


- The District is investing $326m for construction of facility. Other work for this project includes:
    - Infrastructure work to allow St. Elizabeths to become functional again – this work has already done on southern areas; and
    - Development of a shelter to replace the 400 bed men's shelter. We have $40 million in the budget for this project, which is already underway.
- We believe that UMC must maintain full operations until a new hospital is open. We must have a hospital east of the river.

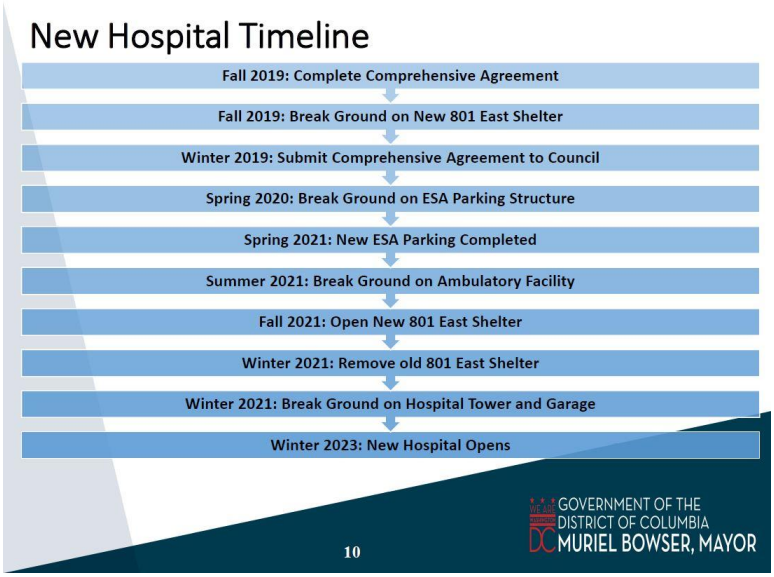


- This is the sight plan for the campus. The Congress Heights Metro Station is in southeast corner (bottom right). Everything south of the entry road has been installed and includes the RISE Demonstration Center, Apartments, and the Entertainment and Sports Arena.
- In the north parcel, there is a notable lack of historic buildings.
- There are some important elements to staging, including creating fully operational public streets and moving the shelter. The new shelter must be open before we

can break ground on the hospital, but we envision opening an ambulatory center before the hospital.



- This is a close up of the hospital parcel.



- This timeline spans the next four years at very high level. The new shelter will take two years to complete – we hope to complete it in fall of 2021, and then quickly break ground on the new hospital.

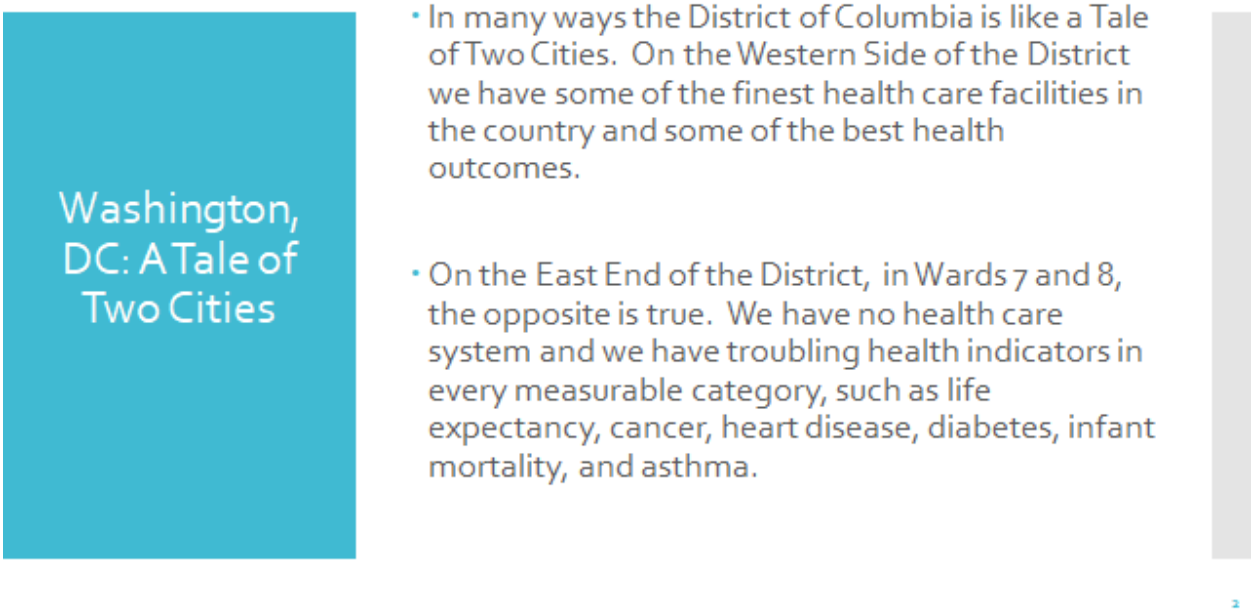
- Questions:
  - Dr. Barbara Bazron: The Saint Elizabeths Psychiatric Hospital is next door to this. How do you envision relationship between this existing hospital and the new hospital? I think it is important as think about the infrastructure and relationship between new hospital and system of care
    - Ben: I couldn't agree more. We have internal working groups and we will make sure DBH is there. This is also an issue we should discuss with the new partner.

- Jackie Bowens: Regarding the desire to have smooth transition and have UMC sunset in concert with the opening of the new hospital, how are the Skilled Nursing Facility beds being considered?
    - Ben: We intend for the SNF beds to be transitioned as well, in order to keep the beds in system. Mazars did some work on some potential opportunities. If a partnership can be worked out, then we would see that, but if not, we would work with the partner to keep beds in the system.
- Jackie: Along the same lines, what about the behavioral health beds?
    - Ben: The behavioral health beds are very important as well. We need to work with the partner to determine how they see these beds in relation to the other beds at the facility.
    - Jackie: I think everyone would agree that behavioral health beds may be an emerging area of crisis.
- Maria Gomez: Will the relationship with Children's that exists now at UMC continue at the new hospital?
    - Ben: We think that Children's has a big role to play east of the river. We are hopeful that, working with our partner, this can continue. It is certainly our intent to ensure access to those services continue.
    - Dr. LaQuandra Nesbitt: When you talk about hospitalization, Children's does not provide inpatient services at UMC. As we get into further detailed conversations with our partner, we can have conversations about this.
- Co-Chair Sister Carol Keehan: Have you worked out a plan with regard to high risk OB? The demographic surrounding this hospital will produce the highest number of high risk OB needs and we want to ame sure we have a smooth program for transitioning.
    - Ben: That's an excellent point. We have been very clear with our partner that non-high risk OB does not mean that people who are high risk cannot receive the services they need. If needs cannot be met east of the river, we expect them to be received at another facility. Part of this is an expansion of pre-natal care, which can hopefully reduce high risk OB needs.
- Dr. Gregory Argyros: The need for more support for chronic management of behavioral health patients would argue for need to augment what Saint Elizabeths Hospital currently offers. This is a crisis that isn't going to get any better.
    - Deputy Mayor Wayne Turnage: We are in the middle of rethinking how mental health services are delivered city-wide. We have an 1115 Waiver that DHCF is working on with DBH that contemplates an expansion of CPEP. Hospitals weren't necessarily built to deal with people in behavioral health crises. There are facilities that are funded and designed to do this do a much better. We are looking at this to move mental health care away from acute care and more to CPEP and PIW.

- Ben: I want to recognize and thank Councilmember Gray who has been supportive of the Executive's approach. He has been pushing us to do better and be quicker.
- Co-Chair Catania: We all need to open up to make this happen and all need to be rowing in the same direction. It won't work if we all insist on focusing on what we want and our individual interests. The bottom line should be that if it works for residents, we make it work; if it doesn't, we don't.

4. Presentation and Discussion with the DC Council's Committee on Health **Councilmember Gray**

- Councilmember Gray began by thanking the Commission for including him and allowing Eric Goulet to represent him at our meetings.



- When it comes to healthcare, DC is basically a tale of two cities. The western side of the city has some of best health care in world, while the opposite is true in Wards 7 and 8.

Answering Three Questions

- As Chair of the Council's Committee on Health and as Councilmember for Ward 7, I will try to answer three important questions regarding DC health systems in this presentation:
  - How did we get to where we are?
  - Where are we now? and
  - What is the future of DC health systems?

3

Question #1

HOW DID WE GET TO WHERE WE ARE?

A RECENT TIMELINE OF DC HEALTH SYSTEMS

4

Funding A New Hospital on the St. Elizabeths Campus in FY 2015 Budget

- On April 3, 2014, to address the health system disparities, I included $355,876,000 in my Mayor's proposed Fiscal Year 2015 budget to replace the existing United Medical Center with a new East End Medical Center on the St. Elizabeths Campus.
  - The new hospital would be a full-service community hospital, run by a private operator. It would be responsible for serving the emergency health care needs of East End of the District and anchoring the creation of a true, fully-integrated health care system.
  - The hospital was scheduled to open in 2019, and the proposed capital budget reflected the project scope and hospital location recommended by Huron.

5

Funding for the New Hospital is Eliminated from the FY 2015 Budget

- **Fiscal Year 2015 Budget** – Funds for the capital projects are reduced from $355,876,000 to just $155,000,000.
  - The cuts began when the then Chairperson of the Committee on Health transferred $22.2 million of hospital capital funds to earmarked grants.
  - Then, at the full Council level, the Council Chairman removed another $178.7 million from the project, and the project scope was reduced to simply implement the capital maintenance of the existing UMC building. All reference to a new hospital was removed.

6

Ward 7 Summit and Action Plan

- After I was re-elected to serve the residents of Ward 7 for the second time, even before returning to office, I held a day-long **Ward 7 Summit** in December 2016, where over 400 Ward 7 stakeholders provided policy recommendations.
- One of the top priorities of those in attendance was creating a comprehensive health system that serves the residents of Ward 7 and 8.
- Based on the recommendations from the Summit, I created the **Ward 7 Action Plan**, which called for "fully funding a comprehensive health care system serving the residents of Wards 7 and 8".

7

Funding for the New Hospital is Restored in the FY 2018 Budget

- **Fiscal Year 2018 Budget** – The Council approves $300 million for a new hospital and established by law that it must be located on the St. Elizabeths campus
  - In its May 17, 2017 budget mark-up, the Committee on Health re-created the capital project for a new hospital on the St. Elizabeths campus and allocated $236 million for the new hospital, of which $100 million was transferred to the Committee on Health by Councilmember Mary Cheh.
  - At the full Council, Chairman Mendelson added another $64 million, increasing the total funding for the new hospital to $300 million.
  - In Section 5092 of the "Fiscal Year 2018 Budget Support Act of 2017" the Council legislatively mandated that the new hospital would be located at St. Elizabeths.

8

- We have restrored the budget, which is now up to $325 million.

Visiting the Martin Luther King Hospital in Los Angeles

- On May 8, 2018, I visited the Martin Luther King, Jr. Hospital in Los Angeles, CA and met with hospital CEO Dr. Elanie Batchlor.
- The MLK hospital is a 131-bed community hospital that is certified as a Level 2 Trauma Center.
- The hospital successfully serves the health needs of the communities of Compton and Watts and demonstrates that this model can succeed here in the District of Columbia.

9

Additional Service Reductions Expand Health Access Disparities

- **August 7 , 2017** – Citing serious patient safety concerns, Dr. Nesbitt suspended obstetrical care services at United Medical Center after serious medical errors were made.
- **July 26, 2018** – Ascension announced elimination of acute care services at Providence Hospital. This followed previous elimination of inpatient behavioral health beds at Providence and elimination of obstetrical services at both Providence and United Medical Center.

10

George Washington University Hospital is selected through a competitive process to operate

- On August 10, 2018 Mayor Bowser announced that the Executive Branch had selected George Washington University Hospital, through a competitive process, to operate the new hospital of 100-125 beds, but GWUH later agreed to increase the physical capacity of the new community hospital to 200 beds.

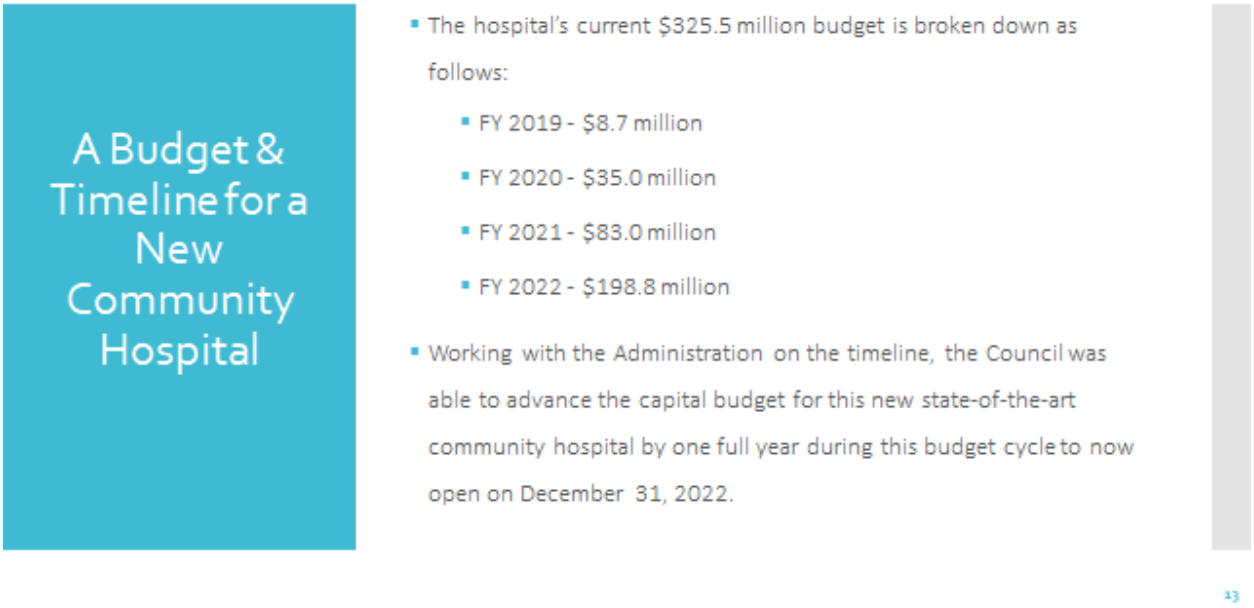
11

Question #2

WHERE ARE WE NOW?

THE CURRENT STATUS OF OUR DC HEALTH SYSTEMS

12



- This shows the breakdown of the budgeted $325 million, across fiscal years.

- We have been hammering at trying to get this moved quickly, as we have already seen what happens when things slow down. We were able to move the date forward to open the new hospital to December 31, 2022. We will work hard to try to make that happen, but whether we are successful remains to be seen.

A Continuity of Emergency Services

- If unforeseen circumstances force us to delay the opening of the new hospital, we will extend the closure date for United Medical Center from January 31, 2023 to whatever date is required to ensure that we have a continuous presence on the East End of the District and a smooth transition of patients to the new hospital.

15

- If can't open on time, we will keep UMC open and operating as we continue making progress on building and opening the new hospital.
- Thank you to Wayne who identified DSH funds in the amount of $11 million, which will have major impact on ensuring UMC has the resources so it can continue to operate.

Positive Momentum in Health Care

- I am optimistic for the future of health care in the District of Columbia.
- Executive Branch agencies have made relatively recent key hires with Wayne Turnage serving a dual role as Deputy Mayor for Health and Human Service and Dr. Barbara Bazron hired to lead the Department of Behavioral Health. This brings important leadership to these key positions.

16

Positive Momentum in Health Care

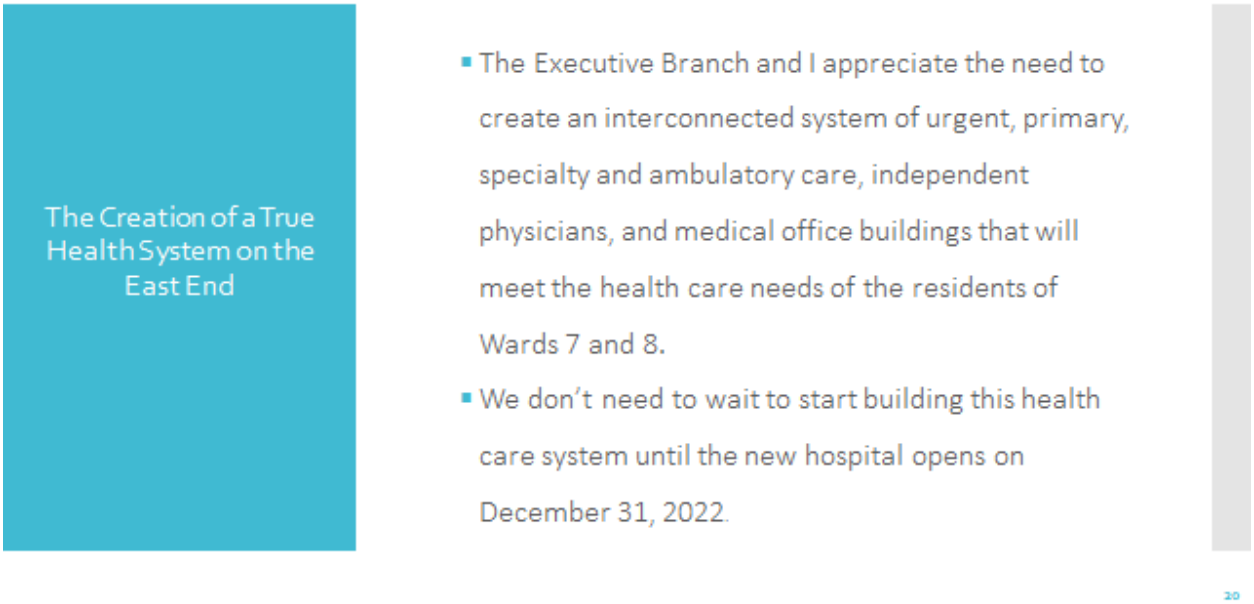
- Creation of the Commission on Healthcare Systems Transformation is another key step forward, because it has brought together talented health care professionals enabling us to sit in one room together.
- I am delighted to serve as Vice-Chair of the Subcommittee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care. I especially want to thank Dr. Malika Fair who has done a great job chairing our subcommittee.
- I also want to thank my former colleague, David Catania and Sister Carol Keehan who are doing a super job co-chairing this task force.

17

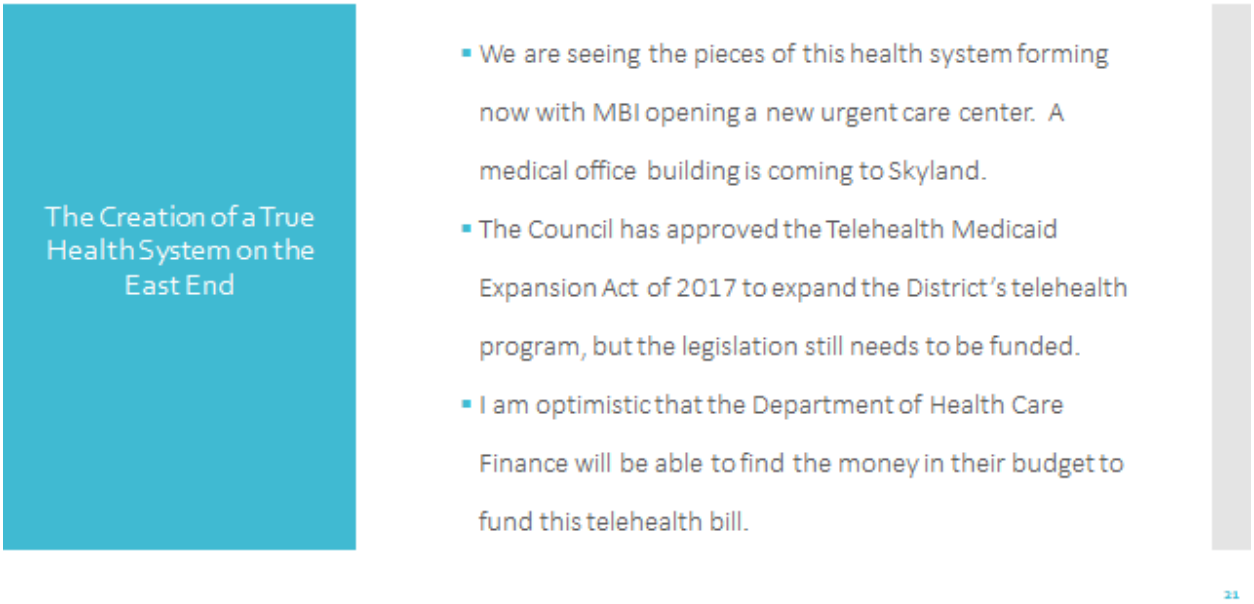
Positive Momentum at United Medical Center

- We have also seen very positive progress at United Medical Center in recent months, both from a financial perspective and quality of care perspective.
- In this year's budget, the Council set a cap on the subsidy to UMC of $15 million of recurring funding, plus an additional $7 million of one-time funding. The UMC Board and Mazars have risen to the challenge and hit cost reduction targets and generated $21 million in additional DSH revenue.
- I continue to see improvement in the quality of care with GW Medical Faculty Associates now serving patients at United Medical Center.

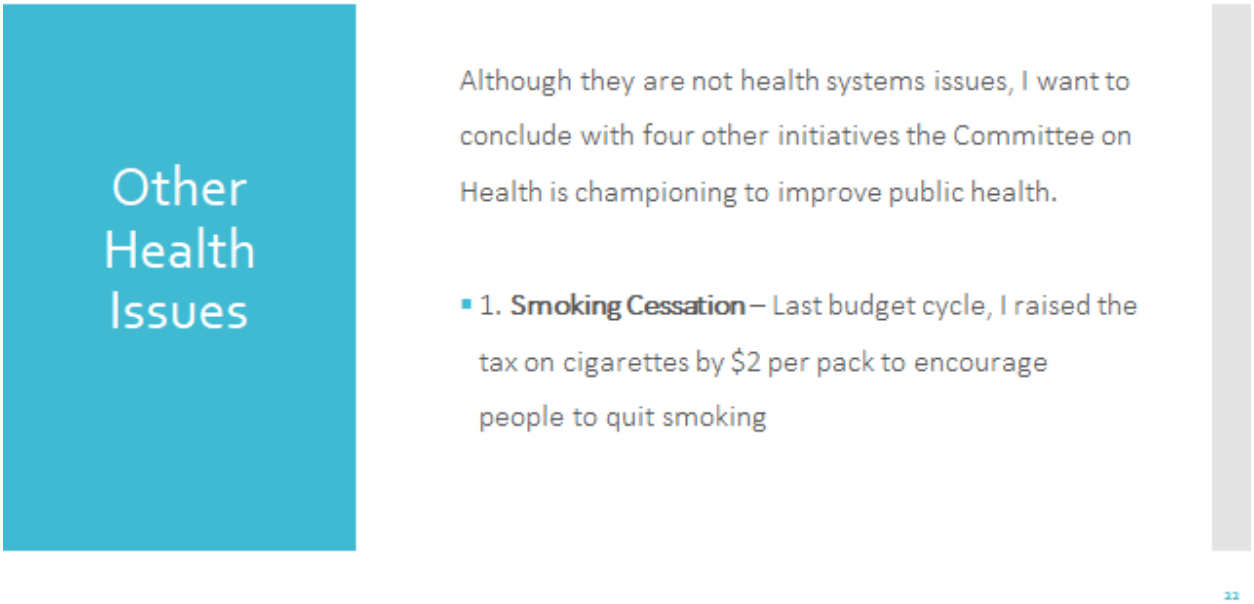
18



- I have believed all along that we can't wait for a new hospital to open to address the other needs in the District.

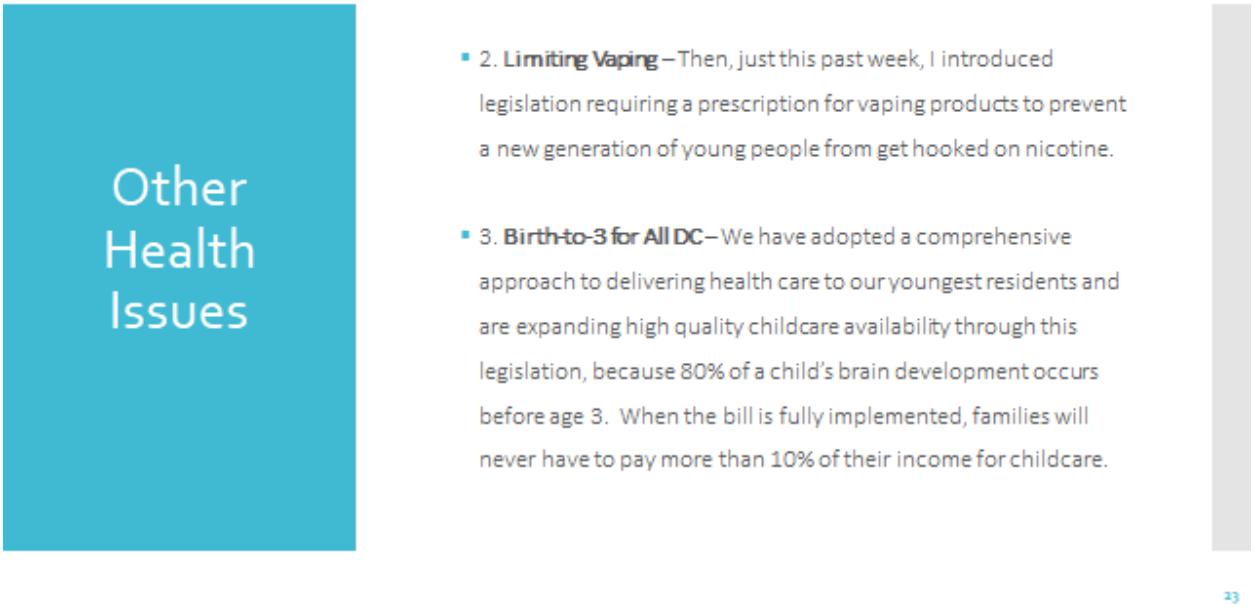


- MBI is opening urgent care center in Ward 7 at the intersection of Nannie Helen Burroughs and Divsioin Avenue. The intention is to open by end of November.
- I have also been working with the people building Skyland Town Center. They have announced a medical office building, which we hope will attract a number of physicians looking to practice east of the river. We don't have a date as to when it will open.



- In addition to the telehealth bill, Council passed a smoking cessation bill to add $2 per pack for cigarettes to try to tamp down people who smoke in DC. The data

regarding smoking is staggering – in Ward 2 or 3 about 10% of residents smoke, while in Wards 7 and 8 25-30% of resident smoke.



- We also want to seek to limit vaping and hoping to have a hearing on this in the next few months.
- I am proud of the work we have done on Pre-K – we are the foremost leader on serving children ages 3 and 4 in the nation. However, I would like us to bring universal services from birth to three.

- I am also working to try to improve situation with regard to food deserts in Wards 7 and 8. There are precious few grocery stores on the east end of the city.

- Questions
    - Vincent Keane: What are the top two or three barriers to getting the hospital going?
        - CM Gray: Time has been a barrier – we have really wanted to get started sooner than we are and that has not been possible because of the shelter.
        - Ben: Yes, I agree that is a critical component. This is also a case study in critical pathways that need to align. We are also very interested in seeing it move when we send it to Council. There are a lot of moving parts to this project.
        - CM Gray: Another barrier or challenge is getting the contract over to the Council and getting it approved so we can move forward with who the operator will be.
            - As it has been stated more than once GWU has been selected, and we have been supportive.
            - We would like to get the contract over to the Council as this will take a lot of the uncertainty out.
            - I know the administration has been working to get that done and we would like to have as soon as possible so that we can continue the discussion about how we proceed.
        - I do hope that we will go ahead and move forward with some of the services in the community with the medical office building and urgent care capacity in order to build a system and not just rely on the hospital.
        - We are working closely with Sibley, who has brought their oncology services to the Parkside Center. We look to continue that relationship so it's clear that people can receive services on the east end.
    - Maria: Is the plan for financing operating costs in the works?
        - Ben: We have been very conscious of the need for a sustainable facility. This is really one of the things we are focused on with our partner. We are working through that, but it is dependent on many things – volume, payer mix, etc. We are really looking to GW and UHS's expertise to ensure that the hospital is on strong footing, not just on day 1 but in year 10. We don't want the District to be the payer of last resort for another facility as this is not sustainable.

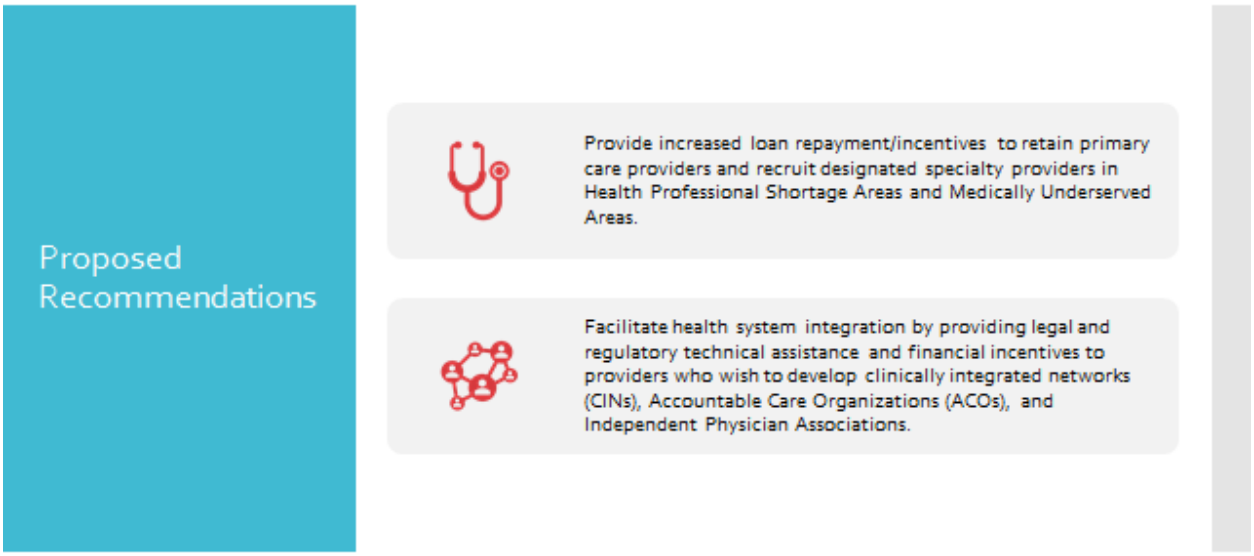
5. Executive Presentations on Telehealth **DC Health/DHCF**

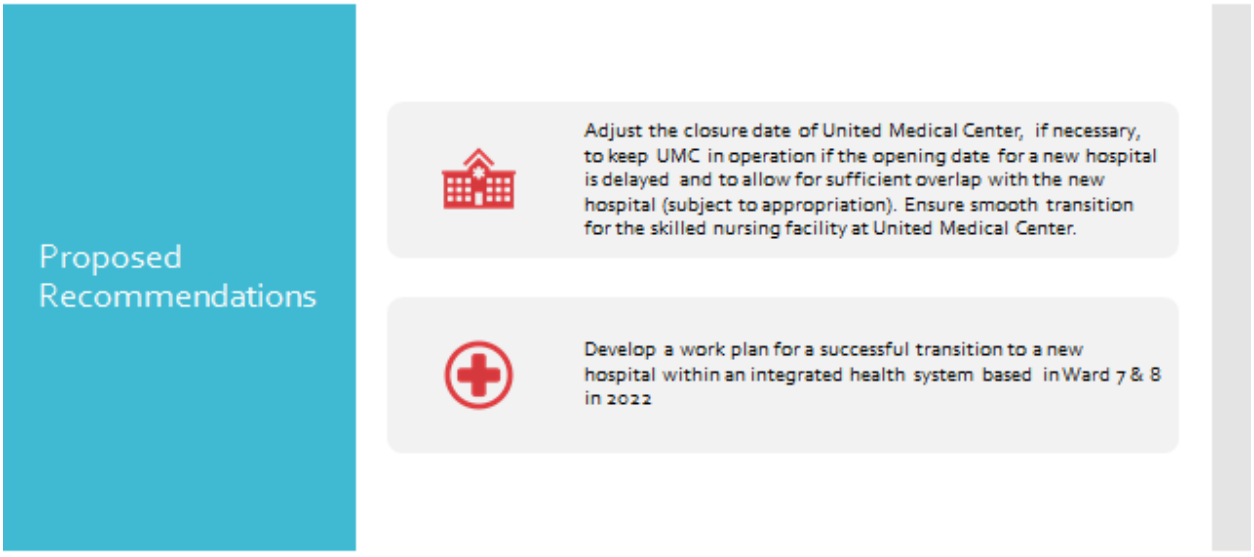
This agenda item was postponed to the November meeting.

6. Subcommittee Reports **Subcommittee Chairs**

- Co-Chair Catania asked that subcommittee chairs take ten minutes each to present where they are and any major obstacles.

- Subcommittee on Equitable Distriction of care (Dr. Malika Fair):
    - The subcommittee is fairly close to finalizing their recommendations, which span the challenges presented today and in previous meetings.
    - Dr. Fair shared slides with the committee's draft recommendations.





Transition Work Plan

- Cross-Agency Project Manager
- Community Education and Input
- Collaboration with existing providers
- Employment for local residents
- Plan for high-risk OB deliveries and trauma care

Proposed Recommendations

Facilitate integration of telehealth into medical practices

Pilot models to better connect prenatal care being provided in Wards 7 and 8 to the labor and delivery options in other parts of the city– through co-management, access to maternal and fetal medicine specialty, improvement in HIE, and assistance with transportation.

- There is one final recommendation in the works.
- Many of the recommendations may overlap with other committees, but we hope we can improve access to care across the city.

- Subcommittee on Access to Critical and Urgent Care Services (Dean Hugh Mighty)
  - The subcommittee will be on time in delivering report.
  - The subcommittee would generally say that challenges in access to services is as much about ability to know when, how, and where as the availability of services
    - Specific gaps include maternal and behavioral health.
  - Have 11 recommendations so far, under four categories.
    - Access to Urgent Care Services
      - As an alternative to 911, establish a 24/7 Citywide Healthcare Advice Line, staffed by clinicians, to help residents understand and navigate their health care choices and connect them to services that already exist.
      - Expand and sustain health literacy campaigns to help residents understand their options in seeking health services before they are sick.
      - Eliminate or reduce the burden for certificates of need for urgent care centers.
      - Incentivize Hospitals to share discharge information in a timely and standardized manner to best inform future care.
    - Access to Behavioral Health Services
      - Increase the capacity of primary care providers to identify and treat substance use disorder in their clinics.

- Incentivize the opening of new CPEP facilities in the city to ease the burden on hospital emergency departments.
- Learning from recent experiences in Maryland and California, open and sustain sobering centers, consistent with need, to allow a safe place to recover from alcohol and drug intoxication.
- Electronically capture and share advanced directives to ensure patient's wishes are met, even when they are in acute crisis or emergency.

▪ Access to Maternal Health Services
- Establish and sustain peer support networks for expectant mothers and women planning to become pregnant to create communities of care and encourage residents to understand and seek out health services before, during and after their pregnancies.
- Standardize assessments of social determinants of health during initial prenatal care visits and share information with case managers to ensure social needs are addressed early in a pregnancy.

▪ General Access Issues
- Conduct surveys and focus groups to better understand District residents' health care priorities and choices.

- Subcommittee on Emergency Room Overcrowding and General Reliance on Intpatient Hospital Care (Kim Russo)
  - The subcommittee will be on time and is ready to submit final recommendations.
  - The subcommittee has four overarching recommendations, with sub-recommendations totaling about 18.
  - 1. Public Awareness Campaign: Develop a citywide, broad-based community PR campaign on health resources available and access to medical services in the District of Columbia, proper use of 911, etc.
    - Maximize Utilization of Existing Resources: Utilization of already funded community groups to drive health impact/education on resources available to guide the community on the appropriate use of hospital emergency room, urgent care, FQHC, etc.
    - Public Information Centers on Healthcare Resources: Development of information centers on alternative and ambulatory care options for community awareness located in the Emergency Room waiting rooms and Urgent Care centers.
    - Reduction in Workplace Violence in Emergency Departments and in the Field: Collaborate with hospital emergency departments, FEMS, DC Health and DC Behavioral Health on tools and resources for a reduction in workplace violence in the emergency departments and in the field. Workforce in the hospitals and emergency responders are all at risk of burn out and violence

which must be combated with a systems approach to promote psychological and environmental safety.

- 2. Preserve Resources for Critical Care: Preserve emergency resources to support the community in need of critical medical care by diverting individuals to appropriate care sites to receive non-emergent care.
    - Set a District goal of reducing medical 911 calls by 25%: "Right Care, Right Now" Nurse Triage Line program to be further leveraged to divert additional calls that are non-emergent. Goal of 25% reduction of calls to 911.
    - Evaluate Other Models of Care: Evaluate other models of care to meet the demand of medical services requested in the field, such as Ready Responders, community health workers, etc. with the goal of directing individuals to the right level of care, reducing the overutilization of FEMS resources.
    - Recommend Effective Regulatory Framework to Facilitate Transfers of Care: Evaluate the regulations requiring facility-to-facility transfers to use FEMS resources via 911. Examples provided include Long-term acute services calling 911 for transfers for scheduled routine procedures.
    - Expand and Simplify Points-of-Entry Opportunities for Behavioral Care: Expand and develop behavioral health services available to the community to divert patients from the hospital emergency departments – Department of Behavioral Health has proposed a comprehensive waiver to redesign the program and presented on expansion opportunities of services already provided to include chemical dependency.
    - Implement National Emergency Department Overcrowding Score (NEDOCS): Implement NEDOCS in all acute care hospitals as a validated tool to assist FEMS in adequate level loading of emergent transfers and surge management within the facilities. Implementing surge management protocols during periods of overcrowding should not result in a penalty or further scrutiny to the healthcare facility.
    - Develop Comprehensive Model for Telehealth Expansion and Utilization: Use telehealth to provide initial consultations, pre-arrival assessments, and follow-up care to promote appropriate care intervention in a timely fashion. Incentives and regulatory constraints to be assessed to entice participation by providers and patients.
    - Infrastructure Support for FEMS: To achieve at or below national benchmark standards for turnaround time of FEMS resources.
- 3. New Approaches to Delivery of Care
    - Establish Sobering Centers for alternative care site for intoxicated individuals that do not require acute medical attention.
    - Assess Mobile Health Delivery and Effectiveness: Determine expansion of resources for point of care in the community,

reducing recidivism and non-emergent utilization of hospital emergency departments.
        - "FD-12" Reform: Require detainees of the criminal justice division to receive non-emergent medical evaluations in alternative care sites versus hospital based emergency departments; reducing costs associated with care and enhancing safety of all personnel involved.
        - Incentivize Utilization of Primary Care: Develop enhanced transportation options that compete with the free FEMS transportation to the hospital emergency departments.
    - Enhancement of Resources to Reduce Recidivism (Emergency Super Users)
        - Case Management Resources: Invest in case management resources to support the street call teams and consumers of behavioral health resources to ensure a "warm handoff" and engagement in the treatment plan established for the individual.
        - Require Case Management Enrollment: Legislative support to require enrollment in case management of all participants in public funded healthcare. Current system allows participants to opt out which has resulted in poor health outcomes and follow up.
        - Behavioral health facilities: we need to further express the need to community and institutional services that meet the needs of the community to reduce recidivism.
- Co-Chair Sister Carol: It is clear that subcommittees have been giving these a lot of thought. There is really nice overlap so far. We have seen some really challenging statistics through this process.
- Kim: We also have data that we will embedding in recommendations around not knowing where to get care.

- Subcommittee on Workforce (Maria Gomez)
    - The subcommittee's recommendations seek to ensure that we have an appropriately trained workforce, as well as appropriate reimbursement for providers, including administration and non-clinical services.
        - Create alignment between health careers training programs/universities and health industry employers.
        - Expand pipeline and early career education programs to recruit DC students into health care careers: Clinical, Administration, Health Technology).
        - Increase and diversify incentive programs to recruit and retain clinical, non-clinical, and operations staff
        - Address barriers to standing up and/or relocating practices in DC.
        - Promote the delivery of team-based, multi-modality clinical care.
        - Blend and braid funds for staff that can address needs across families/populations.

                - This funding can be used for innovative ideas, such as zone health managers who can know and understand communities better than we do now.
            - Expand pool and targeted recruitment of multi-lingual DC residents into health careers.
            - Standardize the use of non-clinical patient care roles such as care coordinator, discharge planner, CHW.
            - Strengthen systems to assess local workforce supply and demand.
        - It is very important to have DHCF at the table because they informed us about what could and couldn't be done on payer side.

- Subcommittee on Discharge Planning and Transitions of Care (Marc Ferrell)
    - The subcommittee will be on time with our recommendations.
    - We have five focused areas with three recommendations under each. We wanted to come up with common sense ideas that were easily implemented, and would have immediate impact with the smallest cost possible. Throughout our discussions we had five presenters join us and took a field trip.
    - Discharge planning and transitions of care is the process by which patients move throughout the system. It requires careful planning and coordination. We sought system and process improvements that will allow people to move more efficiently throughout system.
    - The recommendations currently drafted are:
        - 1. Eligibility/Guardianship: Medicaid Specialist - Obtaining remote Medicaid eligibility is inefficient and cumbersome for the providers. Many states have embraced an alternate model. Obtaining guardianship can delay providers from transitioning patients to the correct level of care.
            - Place a DC Medicaid eligibility staff member onsite at a qualified provider (Hospital, Skilled Nursing) to improve efficiencies and reduce delays in activities related to Medicaid applications and updates to Medicaid status. The specialist will serve as a valuable liaison between the DC Medicaid office and member hospitals.
            - Define a qualified provider.
            - Determine cost sharing model between qualified provider and DHCF.
        - 2. Medicaid Fee for Service Authorizations: The current process is inefficient and slows down the movement of patients to valuable post-acute settings by requiring a cumbersome prior authorization process that can take as long as 19 days to complete.
            - Modernize the pre-admission process to use industry acceptable pre-admission criteria and focus existing resources on retrospective reviews by the Quality Improvement Organization. This will streamline the process of transitioning some of the Districts most

medically-complex patients to the right level of care efficiently.
    - Update the process to include standardized and industry accepted pre-admission criteria.
- 3. Medical Respite
    - Expand Medicaid coverage to finance medical respite care services, rather than relying disproportionately on local grants.
    - Adopt standards for defining medical respite programs such as those from the National Health Care for the Homeless Council.
    - Develop regulations to address qualifications and standards for medical respite providers. Programs should be defined as to type and elements related to medical services. Services should be defined in accordance with the licensed professionals who provide them. Qualifications on admissions and discharges shall be clarified.
        - Amend the D.C. Law 22-65 "Homeless Services Reform Amendment Act of 2017" to exempt certificate of need requirements for a medical respite provider of services. The exemption should include a clear definition of the services in question to distinguish them from covered services.
        - Amend the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, D.C. Law 5-48 ("the Act") to define a medical respite program as a health care facility under the Act and to outline the guidelines needed for the clients, staff and operation of the program. Amendment should address any exemptions that apply to providers.
- 4. Transportation: Significant gaps in the availability of private ambulance services for emergent, urgent or routine services have been identified. Lack of reporting relevant quality metrics provides a false sense of transportation needs. The FEMS 911 system has been the safety net for providers when timely ALS/BLS services are not available.
    - DC Health should conduct a review of the Emergency Medical Services (EMS) regulations, last changed in 2003, reviewing and updating current practices.
    - DC Health should consider expanding quality reporting to include: transport refusals, delays, transport times, waiting times, and cash fee schedules for ambulance providers licensed to pick-up within the District.

- Require ambulance providers to identify number of vehicles used within the district for non-FEMS services daily.
- Standardize licensing regulations in the DMV region allowing reciprocity for Advanced Life Support (ALS) and Basic Life Support (BLS) providers (including EMT's) licensed in Virginia and Maryland.
- Work with the State Health Planning and Development Agency (SHPDA) to encourage the approval of additional ALS and BLS transportation providers to serve the needs of the post-acute care providers in private ALS/BLS.

▪ 5. Telemedicine: Telemedicine could be used to reduce unnecessary ED visits from nursing home facilities, urgent care facilities, community clinics, as well shorten ED visits. Telemedicine physicians could consult with referring community providers/patients and help determine if patient truly requires emergency visit or if alternative outpatient evaluation and management can be safely done.

- Provide a grant to study how telemedicine can reduce unnecessary ED visits, improve physician specialist coverage in post-acute care facilities thus reducing unnecessary hospital admissions and transportation costs.

- Subcommittee on Value-Based Payments (Don Blanchon):
  - We have had a litany of conversations working to address the difficult issue of repositioning systems based on volume and transition them to value.
  - We plan to submit on time. Our last meeting is tomorrow, so today I will frame some issues we worked on.
  - We have worked from a frame of creating an accountable, equitable, system of care for all District residents. The data is there to show we need transformation. This transformation requires a set of core beliefs:
    - Transparency builds trust
    - We are what we measure
      - We expect that there will be some consensus around a defined list of population health measures that we are all working across. We measure so many different things, but we need to create value.
    - Changing long-standing behaviors take more time than we think.
    - There will be a need for new community partnerships. This is essential to accountable care models.
    - Another fundamental value is that the money follows the patient.
      - We have to get away from volume models and think about the way budgeting and resources go to individual patients.
  - We also have five other considerations, including distinct recommendations:

        - Expansion of current VBP measures to hospitals and community PCPs
        - Establishment of Medicaid Accountable Care organization in the DC Managed Care Program
            - DHCF's 2017 RFI found a fair amount of interest and identified five key factors for establishing such an entity: adequate time to prepare for change, startup funds, better HIT/data exchange, financial transparency, and defined service population.
        - Adoption of community-wide initiative defined by a set of community measures.

- Co-Chair: Thank you to all the subcommittees for all of your work. for everything. We have one mayor and 13 Councilmembers to make a system as sophisticated as the state of California's work. We have an ecosystem of frustration because there are too few hands on deck. This commission has been able to lighten the load by adding thoughts and different perspectives. I'm excited about the repetition as it shows the different perspectives that lead to the same conclusions. We are a resource rich city, but we don't have the hands on deck to look at everything as often as we need to. We need citizens like us to come forward.
    - The Marion Barry SYEP has 10,000 young people every year which has been underutilized.
    - I'd like to hear what would you like Sister and I to focus on as we compile these.
- Co-Chair Sister Carol: We also welcome public input.
- Jackie: It is important that we set priorities around what we can do in short, medium, and long term. I appreciate the conversation about how we are a resource rich environment – there is a lot out there that people don't know about, but how do we also make sure we maximizing resources, while paying attention to readiness. We need to look at and assess readiness and make decisions around that.
    - Co-Chair Sister Carol: That is very important observation. A lot of the work of the task force in the next two months will be to look at priorities, timing, and possibilities. We will set it up for discussion, but this will fall to the task force.
- Vincent Keane: Regarding the process moving forward, you will get the recommendations on Friday – what is the process for subcommittees from here? Have we done our work? Is it possible that the Commission will send some of it back for refinement? Is there a general process for that?
    - Co-Chair Catania: Sister and I will work with staff to integrate and cross-pollinate the recommendations. We will circulate this by October 21, which will allow you to review by the next meeting on October 29.
- Kelly Sweeney McShane: Regarding getting public feedback, I know we are on a tighter timeline, but I don't think online is significant. Can we take the themes and

over the next month and get public feedback? We need other opportunities other than just posting online.

- Co-Chair Sister Carol: I think this is very important. I always worry that we tell low income people how they should be cared for rather than ask them. It will be really important to hear from residents. I'm looking forward to the public awareness recommendation. We need to be creative in getting input as not everyone has access to a website.
- Co-Chair Catania: I don't disagree and I raised this issue at the very beginning. But then we are faced with reality: The recommendations won't be finalized until November 26, which gives us three weeks until our last meeting, one of which is Thanksgiving. If we take the unfinished recommendations to the community, that may be an issue as well. There is no perfection here. One option may be to put it in the register. We won't be executing these – they will be handed over to the Exeuctive and Council to make policy. Would you mind coming up with a recommendation of how we do this?
- Kelly: There are very themes that came out that are very similar. Maybe we can present these themes. The question is whether whether they need to be fully cooked to present to the public.
- Jackie: We could go to subcommittees to do this work.
- Co-Chair Catania: We could ask the Mayor if we could provide the recommendations, but then do community meetings to discuss what was recommended, with the idea of how to make better.
- Tamara Smith: There are a couple of upcoming community meetings – MCAC, health councils around the city, etc.
- Co-Chair Catania asked anyone interested in helping recommend a process for this to work with Kelly Sweeney McShane.

7. Public Comments **Public**

- Desiree de la Torre, Children'sNnational: Health and medical care account for just 20% of health. I'd ask the Commission to consider how we work with the other parts of the government on the others policies that impact health.
- Francisco Semiao, MedStar Health: I would suggest that the Commission consider including goals or measureable outcomes with the recommendations, so that people can understand how it will impact them.

8. Adjournment **Commission Co-Chairs**

The meeting was adjourned at 12:05 pm.