

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**

October 29, 2019

DC Hospital Association: 1152 15th Street NW #900.

WebEx: <https://dcnet.webex.com/dcnet/j.php?MTID=m37b1d2a04b99e93754353cbb1eccb58c>;
1-650-479-3208; Access code: 731 895 034

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	Not 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	Not Present	Dania O'Connor	Present
Denice Cora- Bramble, M.D.	Children's Hospital	Present		
Marc Ferrell	Bridgepoint Healthcare	Not Present		
Don Blanchon	Whitman-Walker Health	Present		
Kim Horn	Kaiser Foundation Health Plan	Not 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	Not 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	Not Present	Tiffany Wilson	Present
Chief Gregory Dean	Fire and Emergency Medical Services	Not Present	Dr. Robert Holman	Present
Councilmember Vince Gray	Council of the District of Columbia, Committee on Health	Not Present	Eric Goulet	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 Government Attendees

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
John Coombs	Staff	Fire and Emergency Medical Services
Noah Smith	Staff	Department of Health Care Finance
Erin Holve	Staff	Department of Health Care Finance
Alice Weiss	Staff	Department of Health Care Finance
Lauren Ratner	Staff	Department of Health
Amha Selassie	Staff	Department of Health
Fern Johnson-Clarke	Staff	Department of Health
Raessa Singh	Staff	Department of Behavioral Health
Marsha Lillie-Blanton	Staff	Department of Behavioral Health

Public Attendees

Name	Role	Organization
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Justin Palmer	Public	D.C. Hospital Association
Roderic Woodson	Public	Parker Poe
Regina Knox Woods	Public	MedStar
Calvin Smith	Public	Bridgepoint
Michael Crawford	Public	Howard University
Feseha Woldu	Public	MedStar
Patrick Canavan	Public	IdeaCrew
Robert Hay, Jr.	Public	Medical Society of DC
Kevin Wrege	Public	Pulse Advocacy
Francisco Semiao	Public	MedStar Health
Elizabeth Davis	Public	Children's National
Miriam A. Markowitz	Public	Developing Families Center
Djawa Hall	Public	1199 SEIU UHWE MD/DC
Elizabeth Garrison	Public	SOME
Paige Wingate	Public	Cushman & Wakefield
Lindsey Groom	Public	Cushman & Wakefield
Matt Sullivan	Public	Cushman & Wakefield
Jack Seher	Public	Cushman & Wakefield
Colette Chichester	Public	CareFirst BCBS
Jessica Hippolyte	Public	Children's National
Claudia Schlosberg	Public	Castle Hill Consulting
Mark LeVota	Public	DC Behavioral Health Association

1. **Call to Order**

Commission Co-Chairs

David Catania called the meeting called to order at 10:04 am.

2. **Commission Administration**

Commission Co-Chairs

Rayna Smith took roll call to determine quorum, but quorum was not achieved.

Commission Administration was delayed until after telehealth presentations to allow for additional Commission members to arrive.

3. **Executive Updates on Telehealth**

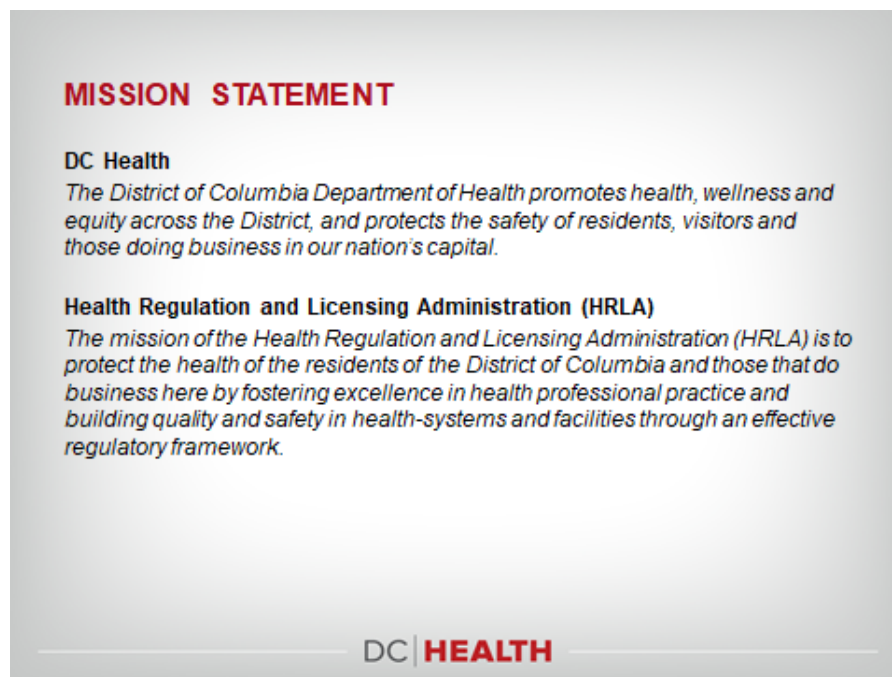
DC Health/DHCF

Dr. LaQuandra Nesbitt introduced the presenters: Frank Meyers (Executive Director, Board of Medicine, Board of Chiropractic, DC Health) presented on behalf of DC Health, and Erin Holve (Director, Health Care Reform and Innovation Administration, Department of Health Care Finance) presented on behalf of DHCF.

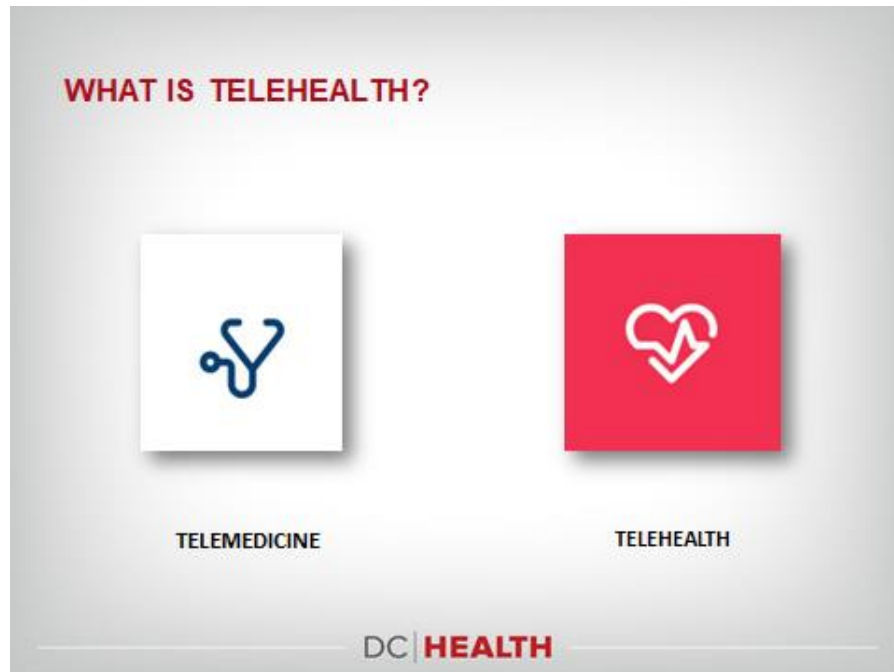
DC Health – Telehealth & Licensure Compacts



- Telehealth and Licensure Compacts go hand in hand.



- Both DC Health and the Health Regulation and Licensing Administration (HRLA) exist for public protection



- Telemedicine is very specific, while Telehealth more broad and can be conducted via anything from phone to fax to the internet.

TERMS & DEFINITIONS

- **Telehealth** - the delivery of health care services, including services provided via synchronous interaction and asynchronous store-and-forward, through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, remote patient monitoring, or treatment. The term "telehealth" shall not include services delivered through audio-only telephones, electronic mail messages, or facsimile transmission.
- **Telemedicine** - the practice of medicine by a licensed practitioner to provide patient care, treatment or services, between a licensee in one location and a patient in another location with or without an intervening healthcare provider, through the use of health information and technology communications, subject to the existing standards of care and conduct.
- **Mobile Health / mHealth** - Healthcare applications and programs patients use on their smartphones, tablets or laptops, that allow patients to track health measurements, set medication and appointment reminders, and share information with clinicians.
- **Synchronous Video** - Two-way video conferencing or communication that allows participants to interact with each other in real time.
- **Asynchronous** - Also known as "Store and Forward"; refers to the capture, storage, and transmittal of patient health information for asynchronous health delivery using data storage and transmission technology.
- **Remote Patient Monitoring** - The reporting, collection, transmission, and evaluation of patient health data through electronic devices such as wearables, mobile devices, smartphone apps, and internet-enabled computers.

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- Telehealth can get very nuanced, as demonstrated by these terms

TELEHEALTH MODALITIES

- Three (3) main types of telehealth services:
 1. Asynchronous (i.e., store and forward technologies);
 2. Synchronous (i.e., real time video); and
 3. Remote Patient Monitoring.

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- There are three main methods by which telehealth is provided. We see all three modalities merging into telehealth in general
- Examples of asynchronous telehealth are shown on the following slides. Asynchronous telehealth is also referred to as “Store and forward.” This allows for the transmission of data (e.g., images, text, video, etc.) across distances.

EXAMPLES – ASYNCHRONOUS



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- This is one of the older versions of asynchronous telehealth – Remote reviews of radiology films

EXAMPLES – ASYNCHRONOUS



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- This example of Teledermatology shows a very clean example of store and forward technology.

EXAMPLES – ASYNCHRONOUS



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- Teleophthalmology is a quickly evolving area of telehealth area. The very fast evolution of phone cameras and attachments provides high resolution images that are often used for preventative screenings.

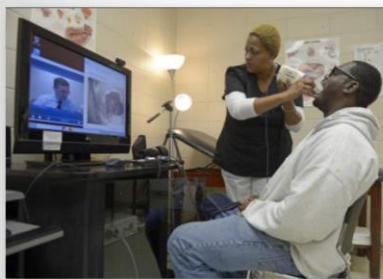
EXAMPLES – ASYNCHRONOUS



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- This is the modern evolution of the first example: Teleradiology, combined with synchronous interaction with specialist. This demonstrates the continued evolution of telehealth, and the combining of both synchronous and asynchronous.
- Examples of synchronous telehealth are shown on the following slides. Synchronous telehealth is two-way video conferencing or communication that allows participants to interact with each other in real time online (e.g., Video Conferencing).

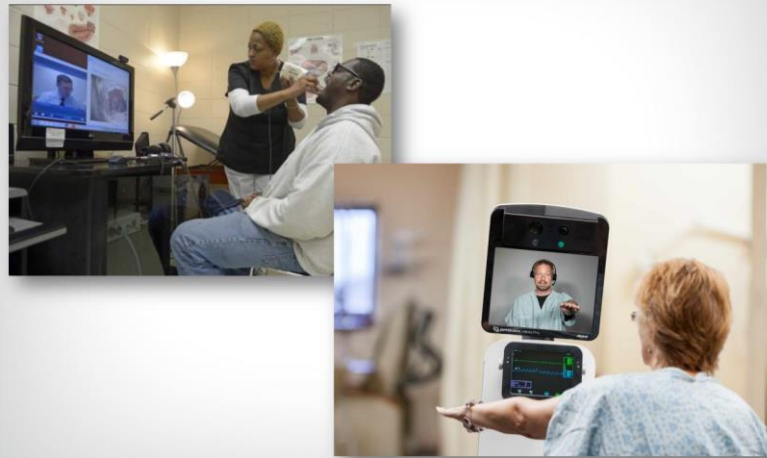
EXAMPLES - SYNCHRONOUS



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- This shows a live interactive video at the Louisiana Department of Corrections, which is utilizing telehealth technologies to allow a remote physician to examine inmates.

EXAMPLES - SYNCHRONOUS



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- This is the Mayo Clinic Emergency Telemedicine Practice. A Mayo Clinic specialist located at a distance from the patient connects via technology with local care teams to assess, diagnose and treat patients.

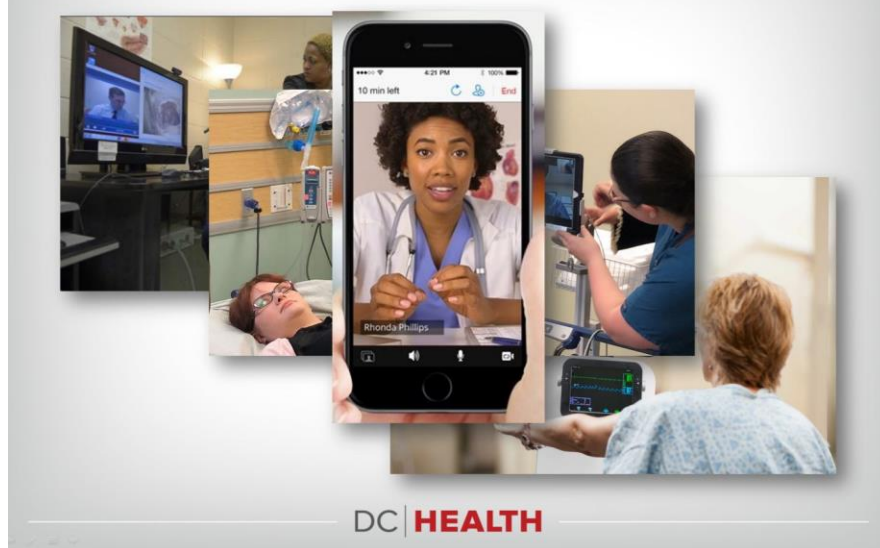
EXAMPLES - SYNCHRONOUS



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- The VA TeleStroke Program connects stroke specialists with hospitals that don't have access to such clinicians, and allow for the examination, diagnosis and treatment of strokes (<https://www.blogs.va.gov/VAntage/48513/va-telestroke-program-helped-va-doctor/>).

EXAMPLES - SYNCHRONOUS



- This shows video visits with primary care practitioner. Most people tend to think of telehealth as this (seeing doctor on your phone).
- Examples of Remote Patient Monitoring (RPM) are shown on the following slides. RPM is the ability to monitor patients directly.
 - It includes the reporting, collection, transmission, and evaluation of patient health data through electronic devices such as wearables, mobile devices, smartphone apps, and internet-enabled computers. While it is very similar to mHealth, mHealth is user focused and more preventative, while RPM is generally focused on follow up care.
 - mHealth includes healthcare applications and programs patients use on their smartphones, tablets or laptops, that allow patients to track health measurements, set medication and appointment reminders, and share information with clinicians (e.g., asthma and diabetes management tools, weight loss and smoking cessation apps, appointment and medication reminders).

EXAMPLES - REMOTE PATIENT MONITORING

- **Due Date Plus** – App that allowed women to record pregnancy milestones, access medical services, and find symptom-related information.
- [Study](#) by Wyoming Medicaid found increased compliance with prenatal care and decreased occurrence of babies born with low birth weights.



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EXAMPLES - REMOTE PATIENT MONITORING



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- This shows remote glucose testing, which are apps that remind patients to take their insulin, while also allowing their physician to monitor the disease.

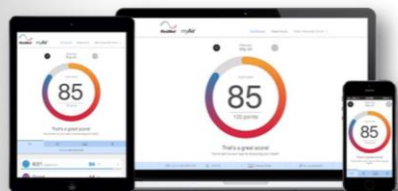
EXAMPLES - REMOTE PATIENT MONITORING



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- mHealth and remote patient monitoring merge with apps and devices which track physical activity, heart rates, and falls, such as the health app in iPhones. It has evolved to the ability to take an EKG, with the ability to link to health records. We can argue about how good this technology is.

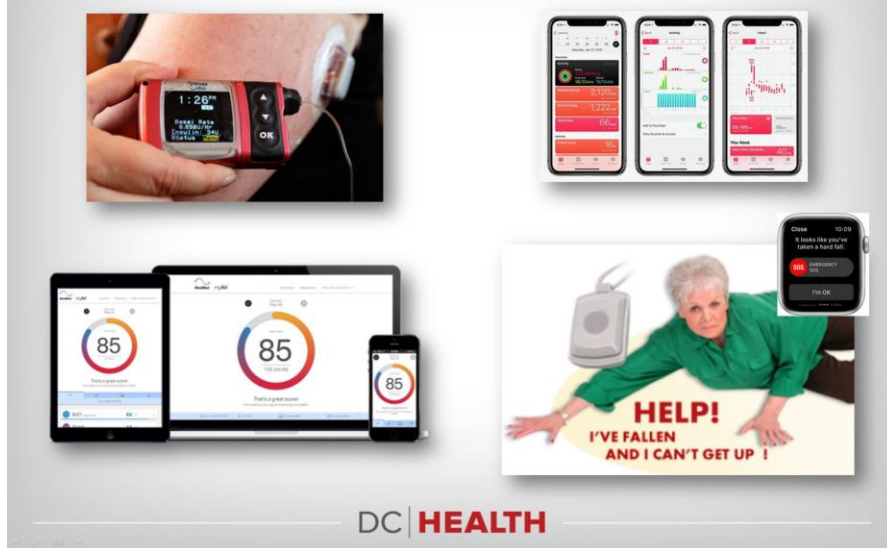
EXAMPLES - REMOTE PATIENT MONITORING



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- CPAP monitoring tracks sleep and can be reported to practitioners (i.e., physicians, polysomnographers).

EXAMPLES - REMOTE PATIENT MONITORING



- The “Help! I’ve fallen and I can’t get up!” alarm is one of the oldest examples of RPM. This has now evolved to the apps that can detect falls and alert authorities through the Apple watch.



- Telehealth is not new – it goes as far back as the telephone and we have used it for as long as medicine has been around. Telephone follow ups are a form of telehealth, but even this – depending on how things are diagnosed and what prescriptions are given, for example – could have a negative impact. However, telehealth is evolving.
 - We try to tell people it’s not a new type of care or practice, it’s a new modality of care.

- We don't regulate the use of a scalpel – physicians are trained on that. Like that, it is a tool to provide health care services, but we recognize that some are better tools than others.

TELEHEALTH IN THE DISTRICT

- **Asynchronous** – Teleradiology, Teleophthalmology, etc.
- **Synchronous** – Remote Emergency Room Triage, Remote Primary Care Visits, etc.
- **Remote Patient Monitoring** – Remote Pacemaker Monitoring, Remote Glucose Monitoring, Remote CPAP Monitoring, Remote Cardiac Holter Monitoring, etc.

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- Telehealth is being used in the District, and some examples are listed on this slide and below. A lot of people don't realize how much and to what extent telehealth is happening.
 - Teleradiology - portable x ray machines and sharing of images digitally with remote radiologists.
 - Teleophthalmology - portable retinal scans and distribution of high-resolution images to a remote ophthalmologist
 - Remote Emergency Room Triage - MedStar Washington Hospital Center provides remote physician assessments of patients in emergency room settings.
 - Remote Primary Care Visits – Kaiser allows for remote follow up visits with your primary care practitioners, either via live video, audio or text message.
 - Remote Glucose Monitoring – Monitoring of glucose levels via tiny sensor implanted into patient, which transmits data routinely to a remote monitor.
 - Remote Pacemaker Monitoring – Monitoring of pacemakers in skilled nursing facilities.
 - Remote Sleep Study/CPAP Monitoring – Kaiser gets daily reports of sleep habits from patient CPAP machines.
 - Remote Cardiac Holter Monitoring – Real-time mote monitoring of ECG for cardiac events.
 - Other services will emerge as they are developed and become available.

DISTRICT OVERSIGHT OF TELEHEALTH

- **Facilities**
 - State Health Planning and Development Agency (SHPDA)
 - Certificate of Need
- **Practitioners**
 - DC Health/HRLA
 - Various health professional licensing boards.
- **Reimbursement**
 - Private Insurers
 - Department of Health Care Finance (DHCF)

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- District oversight of telehealth happens via regulation of facilities, practitioners, and reimbursement
 - Facilities: Many of the models used by hospitals and clinics for telehealth rely on an “originating site / remote site” model, wherein the patient must still go to a local clinic, where they are then put in touch with a specialist. This has raised questions as to whether the originating site (i.e., the patient location) could be considered a new health care service, and whether it requires a Certificate of Need if there is no physical location.
 - Practitioners: Currently the only regulations governing telehealth in DC are from the Board of Medicine (see 17 DCMR 4618). The two (2) major takeaways are (1) practitioners must be licensed wherever the patient is located, meaning if a patient in the District is being treated via telehealth, then the practitioner **MUST** be licensed in the District.; and (2) the standard of care is the same for telehealth as it would be for in person care.
 - Reimbursement (by both private insurers and DHCF): While the vast majority of telehealth services are actually private pay, many new models of telehealth services are being pioneered by Medicare/Medicaid to address issues related to access and cost. Because of this, DHCF has some of the most expansive regulations governing what will and will not be reimbursed for telehealth services (see Telehealth Medicaid Expansion Amendment Act of 2018, and 29 DCMR 910). These laws state that DHCF will cover and reimburse healthcare services appropriately delivered through telemedicine *if the same services would be covered when delivered in person.*

INTERSTATE LICENSURE COMPACTS

DC | HEALTH

HEALTHCARE REGULATION IN THE UNITED STATES

- Board licensure system.
- Volunteer members.
- State by state approach.
- No unified federal system.



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- In the US, we use a Board licensure system, where Boards license healthcare professionals in their jurisdiction. These Boards are mostly made up of volunteer members, and there is no unified federal system.

WHAT IS A COMPACT?

- An interstate compact is an agreement between two or more states. Article I, Section 10 of the United States Constitution provides that "No State shall, without the Consent of Congress... enter into any Agreement or Compact with another State."
- Congressional consent can be obtained in one of three (3) ways:
 1. There can be a model compact and Congress can grant automatic approval for any state wishing to join it, such as the Driver License Compact.
 2. States can submit a compact to Congress prior to entering into the compact.
 3. States can agree to a compact then submit it to Congress for approval, which, if it does so, causes it to come into effect.

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- To help deal with the licensure component as people are seeing patients across state lines, interstate licensure compacts have been developed. Without this, getting licensed in multiple states can be a burden in terms of paperwork and costs. These compacts were designed to address licensure portability without compromising patient safety.

NATIONAL LICENSURE COMPACTS

- Nurse Licensure Compact (NLC)
- Interstate Medical Licensure Compact (IMLC)
- Physical Therapy Licensure Compact (PT Compact)
- Psychology Compact (PSYPACT)
- More to come...

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- There are already several compacts and there are more to come. Each compact is unique – the following slides outline some of these existing compacts.

NURSE LICENSURE COMPACT

- *Nurse Licensure Compact (NLC)*
 - Established in 1997. An updated version was adopted in 2015 and is commonly referred to as the enhanced NLC (eNLC).
 - Driver License Model - Practitioners hold a single license in a member state, which then grants them the “privilege to practice” in other compact states. No additional licenses or documents issued.
 - Currently adopted by approximately thirty-four (34) states.
 - The District of Columbia is **NOT** a member.

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INTERSTATE MEDICAL LICENSURE COMPACT

- *Interstate Medical Licensure Compact (IMLC)*
 - Established in 2014.
 - Reciprocity Model – Practitioners who are licensed in member states can request to be “certified” by the compact, following which they can request additional licenses in other member states. Considered a new pathway to licensure.
 - Currently adopted by approximately twenty-nine (29) states and territories.
 - The District of Columbia **IS** a member.

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PHYSICAL THERAPY LICENSURE COMPACT

- *Physical Therapy Licensure Compact (PT Compact)*

- Established in 2016.
- Hybrid Model – Practitioners hold a normal license in a member state, but then apply for a “Compact Privilege” for each state where they want to practice. Not a pathway to licensure, but additional documents are required to be licensed in another state.
- Currently adopted by approximately 26 states.
- The District of Columbia is **NOT** a member.

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PSYCHOLOGY COMPACT

- *Psychology Compact (PSYPACT)*

- Established on April 23, 2019.
- Hybrid Model – Practitioners hold a normal license in a member state, and can then apply for either an “E.Passport Certificate” for the practice of telepsychology, or an “Interjurisdictional Practice Certificate (IPC)” for temporary in-person, face-to-face practice.
- Currently adopted by eight (8) states.
- Legislation (B23-0145) was introduced at the DC Council in February of 2019, that would make the District a member of the PSYPACT.

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Telehealth in DC Medicaid
***Update for Mayor Muriel Bowser's
Healthcare System Transformation
Commission***

**Erin Holve, Health Care Reform and
Innovation Administration Director**

★ ★ ★

September 24, 2019

Department of Health Care Finance

- Erin Holve is the Director of DHCF's Health Care Reform and Innovation Administration, which is responsible for thinking about new innovations in payment policy and about how use technology to achieve outcomes for Medicaid beneficiaries.
- This presentation focuses on what our payment policy is and issues DHCF has heard from providers.
- As Frank noted, use of this technology is expanding very rapidly

Telehealth Policy Allows and Supports Telemedicine in the District

<p>Telemedicine Licensure</p> 	<p>In 2017, DC Health/Board of Medicine finalized its telemedicine rule:</p> <ul style="list-style-type: none">▪ <i>"In order to practice telemedicine for a patient located within the District of Columbia, a license to practice medicine in the District of Columbia is required..."</i>▪ <i>"For any services rendered outside the District of Columbia, the provider of the services shall meet any licensure requirement of the jurisdiction in which the patient is physically located."</i>
<p>Medicaid Financing</p> 	<p>Since 2016, DHCF provides reimbursement for services delivered via telemedicine for fee-for-service Medicaid beneficiaries.</p> <p>Final Soon! The 4th Emergency and Proposed Rule on Section 910, entitled "Medicaid-Reimbursable Telemedicine Services," Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).</p>

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- The Board of Medicine finalized its telemedicine in 2017.

- DHCF established reimbursement for services via emergency rulemaking – the 4th Emergency and Proposed Rule will become final very soon. This rule covers fee-for-service policy. DHCF was also waiting for this rule to become final to make changes to their Medicaid contracts.

DC Medicaid Telemedicine Framework

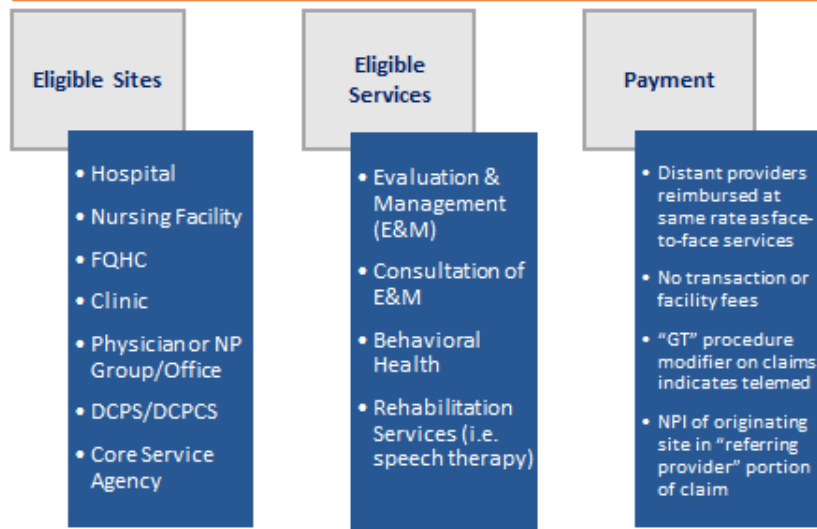
- Telemedicine is a two-way, real-time, interactive video-audio communication for the purpose of evaluation, diagnosis, consultation, or treatment.
- “Hub and Spoke” Model:
 - When Medicaid beneficiary is at an eligible originating site, an eligible distant provider can bill for eligible services delivered via video-audio communication.

Definition of telehealth in District legislation precludes reimbursement for asynchronous modalities (i.e. when patient and provider are not simultaneously present).

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- The framework is built around program integrity concerns to ensure that services being appropriately delivered and that we are leveraging the kinds of services provided.
- DHCF pays for a hub and spoke model, with an originating site of care and a distant site of care. Both of these sites must be enrolled Medicaid providers.
 - Some technologies Frank mentioned are not included within these modalities.

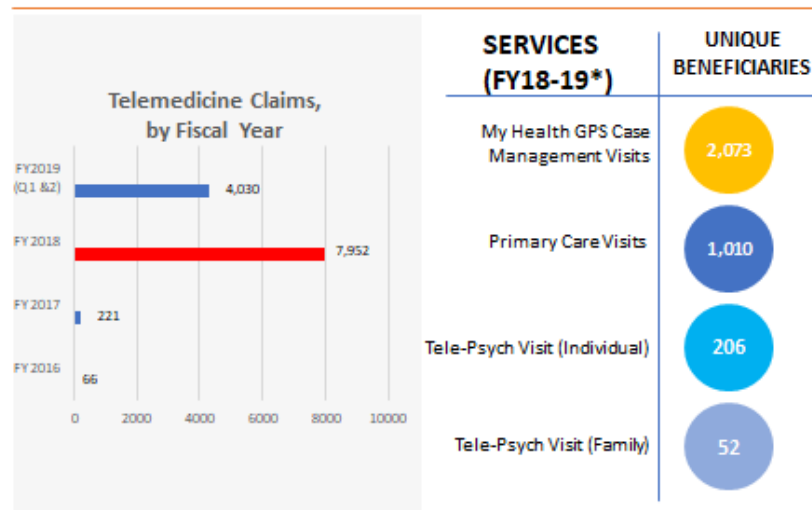
Key Telemedicine Parameters



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- For the eligible sites, it is important to note that home and community-based organizations are not listed. There has been a lot of interest in faith-based organizations participation, which are not currently eligible.
- Eligible services include a standard set of services, with the watch word really being the modality of care.
- There are a series of issues around payment. In the claiming process, telehealth is only indicated by adding a GT modifier so that we are not creating a specific set of telemedicine services, but rather just indicating that the services were delivered via technology.

Medicaid Claims for Telemedicine are Growing; Care Coordination, PCP, & Tele-Psych Services Most Common



Source: DC Medicaid Management Information System (MMIS). Data was extracted in August and September 2019. Telehealth claims were identified as paid claims with a "GT" procedure code modifier.

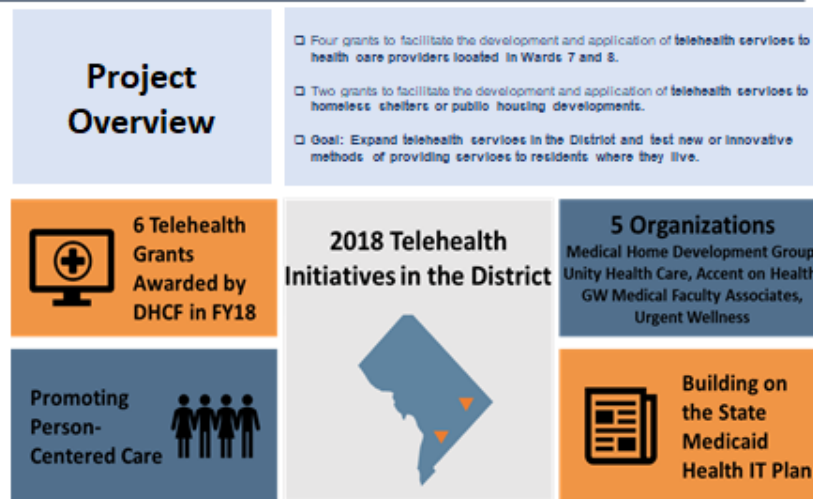
*Analysis includes FY19 Q1-Q2 only

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- The use of the GT modifier is still fairly modest, but has grown substantially since 2017.

- Vast majority of use is under some form of case management services, for example through My Health GPS.
 - Patient methodology reinforces that this is an efficient way of delivering these services
- There is anecdotal evidence that if you like telehealth, you really like it and it works for you.

2018 Telehealth Innovation Grants



Department of Health Care Finance

Department of Health Care Finance |

- DHCF receive support from Council for telehealth in 2018 via Telehealth Innovation Grants, which supported a series of telehealth grants to give DHCF insight around how providers want to use these services.
 - DHCF learned a tremendous amount that will inform how we will move forward.

"Walter's" Story

Patient Name: Walter Smith
Age: 61
Marital Status: Married
Education Level: Associate Degree
Occupation: Retired
Residence: Washington, DC (Ward 5)



"I had a kidney stone and urged [the] urologist to schedule me for a laser treatment but ran into the issue of pre-auth. I called my primary care physician in Ward 8 instead and [he] said we will do something different."

"I showed up to the clinic and all the telehealth equipment was already set up! This experience was different, and I was able to get everything done at once, including seeing the urologist. To see both doctors, within 30-45 minutes was remarkable."

Department of Health Care Finance

Department of Health Care Finance |

- There are a number of ways that providers are primed to use telemedicine. Responding to consumer demand will be an important part of this. Walter's story provides an example of this.

Opportunities and Challenges for Sustainability

Successes	<ul style="list-style-type: none"> □ Each grantee has a model in place to sustain the telemedicine services piloted □ 60+ Telehealth visits conducted in <6 months □ Grantees are pursuing value-based payment approaches under by working with Medicaid MCOs on ongoing telehealth initiatives to address reimbursement issues.
Common Challenges	<ul style="list-style-type: none"> □ Difficulty scheduling visits among providers who use different EHRs, including unaffiliated clinical sites. □ Exchanging clinical data in real time to support clinical care between originating and distant sites. □ Many providers are still operating their offices in a fee-for-service model and express there are challenges covering the cost of transitioning to new technology.

Department of Health Care Finance

Department of Health Care Finance |

- We have learned a lot from early stage implementation. Our focus is person-centered care that reinforces commitment to value-based care.
 - We know there will be work flow and telehealth challenges – for example challenges with navigating diverse technology like scheduling.
 - We also need health information exchange to make sure providers have the full information about the patient.
 - Workforce development is also needed, including technical assistance throughout the pipeline.

DMHHS staff will circulate presenter's names and numbers with the presentations after the meeting, in case there are any questions.

4. Commission Administration (cont.)

Commission Co-Chairs

- Commission members have the consent agenda in front of them, which has 29 of the 52 recommendations in the draft report.
 - These are items that have generally have received enthusiastic support and should not be controversial. We will vote en bloc on this.
 - If there are items members of the Commission would like to have removed from consent, we can do so.
- Once we have voted on the consent agenda, we will move to the non-consent items and deliberate.
 - We will ask the chairman of each committee to present the items from their committee on the non-consent.

- For items where there is overlap, we recommend that we defer to the items on the consent agenda, but we can incorporate additional elements if needed.

5. Discussion and Approval of Recommendations

Commission Members

Note: A list of all recommendations, as well as a summary of the outcome of all votes is included in Appendix A

Consent Agenda

- First item of business: Are there any items on the consent agenda that a voting member would like to move from non-consent agenda:
 - Kelly Sweeney McShane asked to remove Recommendation #11 from the Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care to the Non-Consent agenda:
 - Support mandated enrollment in case management of all participants in publicly-funded healthcare.
- Co-Chair Catania moved the vote consent agenda as amended by removing Recommendation #11 from the Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care.
 - The motion passed unanimously.
 - 28 recommendations were moved

Non-Consent Agenda

- Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care
 - Recommendation #4: Develop a work plan for the successful transition of the new hospital, which should include an integrated health system located throughout Wards 7 and 8, for calendar years 2020-2023.
 - Executive has asked that we table this item until the next meeting so that they can provide an update on the status of the new hospital.
 - No objections – Tabled.
 - Recommendation #5: Facilitate integration of telehealth into medical practices.
 - Co-Chairs have cross-referenced other recommendations where there is overlap: Recommendation #7 from the Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care; Recommendation #5 from the Committee on Discharge Planning and Transitions of Care; and Recommendation #6 from the Committee on Discharge Planning and Transitions to Care. Are there objections to tabling this recommendation in light of the others?
 - A Commissioner noted that one recommendation listed was to replace with telehealth with mobile court and how this interacts with tabling this.
 - Co-Chair Catania explained that this item would be subsumed by the others listed, which will either be taken up via consent or non-consent.
 - No objections - Tabled.

- Recommendation #8: Develop a shared, central repository of emergency department (ED) and urgent care access data to promote understanding of changes in patient use of ED, urgent, and primary care services over time.
 - Co-Chairs recommend tabling in favor of Recommendation #5 from Committee on Access to Critical and Urgent Care Services.
 - Oliver Johnson requested to take this up just for discussion to understand logistics of the tabling in favor of other recommendations.
 - Co-Chair Catania said that at the end, the Commission will ask staff to integrate items as needed or desired by the Commission. The goal is to capture recommendations where there was 90% overlap, and take recommendations that were more fully vetted and approved.
 - To use this an example, this recommendation is more explanatory and less specific in terms of recommendation, so it would be folded into Recommendation #5 from the Committee on Access to Critical and Urgent Care Services, which was on the consent agenda.
 - Kevin Sowers stated that he has concerns regarding Recommendation #5 from the Committee on Access to Critical and Urgent Care Services around 24-48 hours of discharge and differentiation between utilization vs discharge data, as these are different work streams.
 - Co-Chair Catania stated that the language would be merged. If there is an objection to integrating #8 into #5, then Commissioners should raise it.
 - There was a motion to table #8 and revisit it at the next meeting.
 - Motion passed unanimously.
- Recommendation #9: Train the Summer Youth Employment Program (SYEP) students to be community, peer, and family health educators.
 - Dr. Malika Fair stated that the rationale for this recommendation was that high school students could be our future health professionals. The Committee discussed curriculum or a structured way to get experience in health professions. This could be easily adapted to fit with the current SYEP program.
 - Co-Chair Sister Carol stated concerns over young people's capacity to hold this position as navigators often have the same disease as those they are working with or are mothers who have raised one or two children. A 16 year old serving in this role isn't realistic. However, she would love to see curriculum developed so by the end of the program they are more educated about their health care. For example, perhaps they could work with the PR firms who will hopefully do pro bono work around the health education campaign.
 - Dr. Fair stated that there is already have a curriculum in use at Anacostia and Ballou High Schools. Students participate throughout the year and are seen as peer health educators in their community. We can learn and adapt from this organization, but she would be open to amendments.
 - Dr. Denice Cora-Bramble stated that similar program have been implemented in other jurisdictions. For example, church-based programs

where they become peer educators. She understands the concern of them working with a 65 year old diabetic, but they can serve as peer educators.

- Eric Goulet suggested a wording change along the lines of training students to be peer health educators year round and integrating this with the SYEP for students to be paid over summer hours. What has been suggested is year-round activity and not just something someone is picking up over the summer. There would be a lot of benefits to students on the east end of the city with a program of this kind.
- Ben stated that SYEP programs now includes ages 18-24 – we would like to have more comprehensive work placements for this older cohort. One suggestion would be to encourage DOES to partner with organizations that provide this type of training.
- Co-Chair Catania stated we could word smith these recommendations to death and he would like to avoid that. He noted that there is a young women's empowerment group that does an extraordinarily job with this work in the city – they have been effective with reproductive and safe sex conversations. It sounds like this is what was envisioned by the group, and it is a great entrée into the health care profession and they are stealth like in their advocacy.
- Co-Chair Sister Carol stated that the SYEP is very different than what talking about. If we can make a wording clarification that they will be well trained and will work peer to peer, she will be happy with this recommendation.
- Co-Chair David asked that the Commission approve the recommendation and ask staff to incorporate changes, as reflected by this discussion. He moved the recommendation, with the request for staff to incorporate the intent that they be appropriately trained and skilled at providing services.
 - Recommendation passed unanimously.
- Recommendation #10: Use existing certificate of need (CON) fees to support State Health Planning and Development Agency's (SHPDA) CON responsibilities, and utilize recurring local funds for modernization, innovation, and special projects to meet the needs of medically underserved areas, as well as to develop the health systems plan.
 - Dr. Fair deferred to Eric Goulet to explain: The Council has had a lot of challenges with CON process and it has become a sort of popularity contest. Organizations must seek a waiver from Council, and it is usually for very good and legitimate reasons; However, it shouldn't be that the organization who can find the right Councilmember gets it waived. In addition, when the fee is waived it currently creates a hardship for the program. They need to find a way to cover the costs so that staff aren't laid off as a result. Therefore, it makes sense to provide local dollars and allow SHPDA flexibility to waive fees in case of hardship or extraordinary circumstance. If there is money left over, they can use these funds for innovation. For example, we have heard there are issues with technology and the requirement for a hard copy drop off rather than electronic submission.

- Jackie Bowens requested a point of clarification: Is the idea that funds would be used to support operations of SHPDA, but where there are specific needs, local funds would be used.
 - Mr. Goulet said that right now Council has to waive the fee and then go budget for the money and to pay for it. It can be two or three years before someone gets their money back for the fee. This is trying to allow DC Health to look at hardship cases. For example, this may include incentives to move into an underserved area, etc. In other cases, if fee waivers are not needed, they can really ramp up innovation. That requires agreement between the Executive and Council to not sweep the money that builds up. It will also allow them to have a stable stream of funding for staffing.
 - Ms. Bowens stated that hospitals need to be sure we aren't setting up a system where we are delaying modernization, which needs to happen. We want to make sure that this is not shifting priorities.
 - Dr. Nesbitt stated she wanted to highlight that, for DC Health, when the Council is involved in the process it exempts people from the process on occasion – we want everyone going through the process. We shouldn't assume a service is needed and SHPDA really needs to be able to use a planning approach. To Jackie's point, we will not be delaying modernization.
 - Mr. Johnson stated for clarification that the proposal is to provide a mechanism to waive fees that still requires everyone to go through the process regardless of whether the fee is waived.
 - Dr. Nesbitt stated that this is correct, and it also puts SHPDA in charge of whether the fee is waived.
 - Co-Chair Catania stated that he supports the recommendation because it provides certainty and consistency of funding for SHPDA. They won't be under pressure to not waive fees because of funding. By giving staff certainty, it allows them to prioritize what is best for the city.
 - Co-Chair Sister Carol moved the recommendation for approval.
 - The recommendation passed unanimously.
- Recommendations from the Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care were tabled until the next meeting due to Committee Chair absence.
- Committee on Discharge Planning and Transitions to Care
 - Recommendation #6: Establish a telecourt for involuntary commitment and probable cause hearings, and consider providing District funding for all District providers, which care for FD-12 (involuntary) individuals, to have a secure platform to interface with the courts in all commitment and probable cause hearings.
 - A Commissioner asked whether this will be rolled into something else, or whether something will be rolled into this.
 - Co-Chair Catania explained that Recommendation #5 from the Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care, which was general, was tabled in favor of specific ones like this one.
 - Marc Ferrell deferred to Dr. Gregory Argyros to provide the rationale: Currently, people are required to go to court for involuntary commitment.

- This recommends that we re-establish a system for telecourt where patient can stay on their unit and participate in a telecourt discussion with a judge.
- Co-Chair Catania indicated that we expect this would be safer for the patient as well.
 - Dr. Bazron shared that she strongly agrees with this recommendation.
 - Co-Chair Catania moved the recommendation.
 - The recommendation passed unanimously.
 - Committee on Access to Critical and Urgent Care Services
 - Recommendation #3: Establish peer support networks for maternal health.
 - Co-Chairs recommended tabling this recommendation in favor of Recommendation #1 from the Committee on Access to Critical and Urgent Care Services, which was on the consent agenda.
 - Dr. Hugh Mighty said that the only thing he is that if you look at Recommendation #1 it is about acute care more specifically, but unlike acute care, maternal care is more longitudinal. If we roll it in, we should capture this in the language.
 - Co-Chair Catania stated that if Dr. Mighty recommends that we consider Recommendation #3 on its own merits, we can do that.
 - Ms. Sweeney McShane suggested that it could be rolled in with Recommendation #6 from the Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care on consent agenda.
 - Co-Chair Catania stated that his sense from Dr. Mighty that this may be its own issue.
 - Dr. Mighty requested that we see if it can stand on its own.
 - Karen Dale asked if the Committee discussed reimbursement. She expressed concern over how we maintain and sustain this model in terms of reimbursing the services.
 - Dr. Mighty stated that the concept is more peer support networks, not professionals.
 - Ms. Dale stated that we typically pay peers.
 - Dr. Mighty said the gap that exists now is that a majority of women in this population are taken care of by FQHCs or academic health centers, but the care is not very well coordinated. Women get care in community and then arrive at hospital with or without their information. Establishing a better network among providers would be part of it and payers are a big driver in this. It's likely more payment for the infrastructure rather than payment for the services that is needed.
 - Co-Chair Sister Carol said she recalls that an idea was to have the educators in clinics pull peer groups together and hold education sessions with the peer groups. It may require adding some money for peer to peer work in the groups, but wasn't a huge new expansion as much as it was being more intentional about bring people in the clinics together and having peer to peer conversations about pregnancy, child bearing, child rearing.
 - Dr. Mighty stated that he would be fine with rolling it into Recommendation #6 from the Committee on the Equitable Geographic

- Distribution of Acute, Urgent, and Specialty Care, but would recommend expansion from Wards 7 and 8 to whole population.
- David explained that we would need to move to reconsider the consent agenda, move to remove item #6, and move the consent agenda again without this item.
 - Reconsideration of the consent agenda passed unanimously.
 - Removal of Recommendation #6 from the Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care passed unanimously.
 - The consent agenda, with the recommendation removed, passed unanimously.
 - Co-Chair Catania moved Recommendation #6 from the Committee on Equitable Geographic Distribution of Acute, Urgent, and Specialty Care that was previously on consent agenda, with the recommendation to fold in Recommendation #3 from Committee on Access to Critical and Urgent Care Services and make Recommendation #6 city-wide.
 - Ms. Sweeney McShane stated that she nervous about broadening because there is a particular need in Wards 7 and 8.
 - Co-Chair Catania requested that we make it a city-wide model, but put an emphasis on Wards 7 and 8.
 - Recommendation passed unanimously.
 - Committee on Allied Health Care Professionals and Workforce Development
 - Recommendation #1: Establish a health careers intermediary to ensure training meets the demands of the health care system.
 - Tamara Smith, on behalf of Maria Gomez, stated that the language is very Recommendation #9 from this Committee, which was on the consent agenda. She suggested that we integrate it into Recommendation #9 by stating training to meet the needs of the system.
 - Recommendation #8: Standardize the use of non-clinical patient care roles such as care coordinator, discharge planner, and community health worker.
 - Ms. Smith stated that, similarly, she would like to integrate this recommendation into Recommendation #2 from this committee, which was on the consent agenda.
 - Recommendation #3: Expand pipeline and early career education programs to recruit District students into healthcare Clinical, Administration, and Health Technology careers through establishing a health careers education consortium to facilitate development, expansion, and implementation of health careers education.
 - Tamara Smith stated that this recommendation is very similar to the one discussed regarding SYEP.
 - To consider these changes, Co-Chair Catania moved to reconsider the consent agenda, move to remove items #2 and 9, and move the consent agenda again without these items.
 - Reconsideration of the consent agenda passed unanimously.
 - Removal of Recommendation #2 and 9 from the Committee on Allied Health Care Professionals and Workforce Development.

- The consent agenda, with the recommendation removed, passed unanimously.
- Recommendation #2: Accelerate the expansion of training programs for shortage (e.g., nurse, certified addiction counselor) and emerging (e.g., telehealth, data analytics) roles, and, in the immediate, for roles that provide reimbursable services under DHCF's Behavioral Health 1115 Waiver (e.g. peer recovery specialists, social workers).
 - Ms. Smith would like to integrate Recommendation #8.
 - Dr. Cora Bramble requested that we clarify terms to level set. In addition, as it relates to My Health GPS, the recommendation talks about expanding, but the program needs to be fully funding for what we currently do before we expand.
 - Ms. Smith said that she wants to make sure that we are including expansion of training programs for roles where there are shortages – care coordinators, discharge planners, and community health workers.
 - Co-Chair Catania suggested that we take professions identified in Recommendation #8 and fold into Recommendation #2.
 - Ms. Smith offered an additional amendment that we take out subsection b from Recommendation #8, which is on My Health GPS.
 - Dr. Cora Bramble stated taking it off the recommendation does not address the issue.
 - Co-Chair Catania recommended that separate conversations are had to address concerns before the next meeting. At that meeting, the Co-Chairs want to build time in for the more difficult conversations.
 - Dr. Nesbitt stated that this is inherently expanding patient care team and would be part of value-based payment arrangements. She suggested that we table this item until we talk about the Value-Based Payment recommendations, and include in that improving programs like My Health GPS. However, she does not hear objections to recommendations around expanding the care team. The considerations are around what other enablers make that successful.
 - Ms. Smith stated that she agrees – one is providers and one is reimbursement.
 - Co-Chair Catania stated that we will take Recommendations #2 and #8 and place them on the on non-consent agenda for the next commission meeting.
 - Ms. Bowen said that, along the same lines, Recommendation #8 subsection a is about standardizing funding. She would like to understand what that means in terms of who is funding and who is setting the rate. She is confused about the objective.
 - Ms. Smith stated that standardized positions and roles and responsibilities are needed, secondarily standardized recruiting is needed, and third standardized reimbursement for these providers is needed. They are very different aspects that the Committee is trying to integrate.
 - Co-Chair Catania asked that Ms. Smith and Ms. Gomez produce amended recommendations that can be circulated no later than Friday before the next meeting. In addition, they should talk to Dr. Cora Bramble, Dr. Nesbitt, and Ms. Bowens while amending the recommendations.

- Ms. Bowens stated that, as written, the hospital industry would have some concerns.
 - Recommendation #9: Strengthen systems to assess local workforce supply and demand through the establishment of a center for health care workforce analysis.
 - Ms. Smith moved to combined Recommendation #9 with Recommendation #1.
 - Recommendation passed unanimously.
 - Recommendation #4: Increase and diversify incentive programs to recruit and retain clinical, non-clinical, and operations staff.
 - Dr. Robert Holman requested that paramedics be added to this recommendation.
 - Co-Chair Catania stated that he has concerns about the tax incentives and suggestion regarding employer-based incentives. He stated that he believes these items are beyond our swim lanes. He would appreciate tabling this item until the next meeting and Ms. Smith and Ms. Gomez addressing these concerns, as well as the consideration from FEMS. We should not concern ourselves with employers and their staffs.
 - Ms. Smith stated that there were two parts tax incentives and the loan program, which they seek to expand to more than just doctors and nurses.
 - Co-Chair Catania requested that we can keep to government funded programs and avoid telling council how to exercise their tax authority. We can put the recommendations as discussed on the non-consent agenda for next meeting.
 - Ms. Sweeney McShane noted that there are several recommendations from this Committee that have not been discussed and asked what will happen to those.
 - Co-Chair Catania stated that they are simply unaddressed at this point.
 - Ms. Smith asked whether they will be able to be addressed at the next meeting.
 - Co-Chair Catania that if Ms. Smith would like to table until next meeting, she can move to do that.
 - Ms. Smith moved to table Recommendations #5, 6, and 7 to the next meeting.
 - Motion passed unanimously.
- Committee on Value-Based Purchasing of Health Care Services
 - Co-Chair Catania noted that what this Committee provided was more of a framework and goals than recommendations.
 - Don Blanchon agreed with this assessment and noted that there was a need for us to learn and understand much more, even amongst the Committee, so they felt that a framework rather than detailed recommendations was needed.
 - Co-Chair Catania noted that he would like to make sure that there is plenty of time to deliberate and requested that we start the discussion now and pick it up at the beginning of the next meeting, with all votes for this Committee waiting until then.
 - Recommendation #1: Engage the community for the road ahead: a. Survey patients and caregivers about current behaviors and perspectives informing

access to care choices; b. Share total cost of care information for specific populations by payer with all stakeholders; c. Engage patients and other key stakeholders (i.e., health care groups, payers, and government) in ongoing community dialogue about current Value-Based Purchasing (VBP) and Accountable Care models and potential options for the District of Columbia; and d. Conduct operational readiness assessments of all major health care groups for VBP.

- Mr. Blanchon explained that Recommendation #1 and its four parts are really about trying to get stakeholders to a baseline level of understanding about VBP, including more understanding from patients and families. The Committee had a really robust discussion about why patients do what they do, but we need to understand this data in a broader way. This would create a framework or understanding of what is going on in the community. Each payer has VBP activities that have some ability to be integrated across the District and we also need to understand what's happening and how to scale these existing activities.
 - This stuff is complicated. Only about 12-15 states have aggressively pursued such initiatives either across all of Medicaid or across all payers.
- Co-Chair Catania asked if there were any questions.
- Mr. Blanchon stated that the Committee's thought process was considering moving entirely to VBP overtime and what that would look like. Melisa Byrd can talk about moving fee-for-service (FFS) beneficiaries into managed care organizations (MCOs). We expressed support for this and then continue to move the needle.
- Co-Chair Catania asked which 20,000 FFS beneficiaries DHCF is moving, and whether the objective is to move all 50,000 FFS beneficiaries to MCOs.
- Ms. Byrd said, yes, the goal is to move them over the next five years.
- Co-Chair Catania asked how DHCF plans to move the subsets of beneficiaries.
- Ms. Byrd stated that the first phase is to move 22,000 beneficiaries served through FFS to managed care. This group is mostly or entirely adults and consist of the populations who can opt out from managed. This opt out option will go away. Individuals living with HIV can option out. About one-third go into MCOs, while the rest currently opt out. The rest SSI or non-duals. DHCF will take other steps over the next one to two years to try to expand integrated care through implementation of the Program of All-Inclusive Care for the Elderly (PACE), which will go live in 2020. DHCF is also working with Dual Eligible Special Need Plans (D-SNP) for individuals in Medicare Advantage (MA) and in Medicaid to align benefits – perhaps paying a partial capitation to MA plans – so that there is alignment between the plans and not complete segmentation. Towards the end of five years, DHCF is looking to move the Long-Term Services and Supports population to managed care as well.
- Co-Chair Sister Carol stated that the Committee was really struck by slide Deputy Mayor Turnage showed early on, which showed that people are going far for their health care. The Committee wanted to make sure that

value-based doesn't get rolled into economical and that it is value-based that makes people happier with the quality of care they get.

- Co-Chair Catania reminded the Commission that we would vote after we review all recommendations since they are an integrated package.
- Recommendation #2: Expand quality measurement to capture more data on health system effectiveness and to inform care delivery, payment incentives, and population health: a. Refine the core measure set of health priorities; b. Engage health care groups to achieve multi-payer alignment; c. Adopt public reporting to disseminate performance on the core measurement set.
 - Mr. Blanchon stated that this recommendation focused around the idea that we are what we measure. There are so many measures across so many activities, but a community-wide measurement system is needed – not just in publicly funding world. We looked at Kaiser Permanente and what they are doing, how Rhode Island is integrating Medicaid with private payers, and population measures across payer groups. We examined what the core sets of measures are and how are they measured. The Committee looks to DC Health to guide this. The last piece is consistency around transparency and what we are reporting. You'll see notion of public reporting throughout recommendations. We asked questions about what a population health scorecard look like and how do we measure ourselves.
 - Mr. Sowers stated that he is very supportive of measurement and quality measurement. In Maryland, there are federal and state measures that ask to measure the same thing with different methods. He asked that we don't create different definitions that are unique to the District. He stated that he doesn't think this was the intent, but wanted to express this.
 - Co-Chair Sister Carol stated that it would for the recommendation to be good to be explicit about this.
 - Co-Chair Catania asked for information on how this dovetails with comparison of disparities for those who weren't on the Committee.
 - Mr. Blanchon stated that the Committee thought through disparities and key population health priorities and thought this could be a great place to start and could be at the forefront. The recommendation has Dr. Nesbitt leading the process to set these measures.
 - Co-Chair Catania stated that we need to not only measure disparities, but also do something about them.
 - Mr. Blanchon stated that there is so much being measured across so many programs and there is a need to focus attention around key disparities. We need to be able to understand what's most important so we can narrow our focus and put more effort on impact.
 - Dr. Bazron stated that she would like to make sure that measures around behavioral health (BH) are included. SAMHSA requires certain data and there are internal measures DBH collects data on. There are other performance measures that may or may not dovetail with HEDIS and other primary health care measures. DBH is interested in moving towards a VBP system, but it is very complex with BH and at the national level it has been a struggle. She wants to make sure some consideration for that and that there is good representation in terms of BH as we move forward.

- Mr. Johnson requested that we go back to Recommendation #5 from the Committee on Access to Critical and Urgent Care Services on the consent agenda:
 - Mr. Johnson stated that this recommendation includes transmittal of data within 24-48 hours. He asked that it be moved to non-consent for the purpose of discussing this timeframe.
 - Co-Chair Catania moved to reconsider the consent agenda, move to remove items #5, and move the consent agenda again without this item.
 - Reconsideration of the consent agenda passed unanimously.
 - Removal of Recommendation #5 from the Committee on Access to Critical and Urgent Care Services.
 - The consent agenda, with the recommendation removed, passed unanimously.
- Recommendation #5: Share hospital discharge information in a timely manner.
 - Mr. Johnson expressed his concern regarding feasibility for the reference to data transmission within 24-48 hours for discharges. He supports providing discharge data, but would like more general language around the timeframe.
 - Ms. Dale said that information is needed in a timely manner. She asked how we can harness the information resident in hospitals' systems at the point of discharge.
 - Mr. Johnson said the data will not reliably be resident at the point of discharge. He agrees with the need for it to be provided, but the question is what time frame is feasible.
 - Co-Chair Catania asked Mr. Johnson to take the lead on making a recommendation on how this can be changed, working with other body members to come up with language that is acceptable.
 - Dr. Mighty noted that if we don't set timelines, things don't get done. Part of the Commission's role is to push what is possible.
 - Mr. Johnson will work with Ms. Byrd, Ms. Bowens, Dr. Argyros, Dr. Mighty, Dr. Bazron, and Karen Dale who indicated they would like to be involved.
 - Co-Chair Catania moved to move Recommendation #5 to the non-consent agenda for the November meeting.
- Co-Chair Catania stated that there are two remaining meetings – November and December. He expects to go through remaining recommendations in November and take up the issues that were tabled. In December, we will take up the recommendations as a whole and until it is finally adopted at that time, the Commission can continue to make changes.
- Co-Chair Sister Carol noted that the ability to get public comment the recommendations has been raised by some members. We certainly had all the meetings open to the public, but even for the Commissioners it is really hard to get ones arms around this. We need to look at what was the Commission was asked to do, which was to come up with recommendations and give them to the Mayor for her use. The Mayor asked that we operate under District laws and rules and have meetings open, but we would be open to the Mayor telling us if there's any other way she wants us to do this. We feel very strongly about getting public input.

- Dr. Holman asked that the items from the Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care on the consent agenda be reconsidered.
- Lauren Ratner noted that an item was missing from the Workforce recommendations around multilingual providers.
 - Co-Chair Catania asked that she discuss this with Ms. Smith, and Ms. Smith can look and we can revisit if she believes it is warranted.

6. Public Comments

Public

- Rod Woodson commended the work of Commission and noted that what has transpired before this body has been enormous. At the beginning of the Commission, DC Health noted that there were eight components to health care in the city, one of which was pharmacy. Mr. Woodson noted that nothing has been said about pharmacies, though they have a central role between citizens and health care. He asked what the Commission intends to say about pharmacies.
 - Sister Carol stated that we can certainly have that as an agenda discussion and if Mr. Woodson or the pharmacy association has recommendations, the Commission would certainly like to have them beforehand to consider them.

7. Adjournment

Commission Co-Chairs

The meeting was adjourned at 12:12 pm.

APPENDIX A: Voting Results

Recommendation	Agenda	Outcome ¹
Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care		
1. Provide increased loan repayment/incentives to recruit and retain primary care and designated specialty providers in Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs).	Consent	PASSED
2. Facilitate health system integration by providing legal and regulatory technical assistance to providers who wish to develop clinically integrated networks (CINs), Accountable Care Organizations (ACOs), and Independent Physician Associations.	Consent	PASSED
3. Adjust the closure date of United Medical Center (UMC) to align UMC's operations with the opening date for a new hospital, to allow for sufficient overlap with the new hospital. This includes ensuring smooth transition for the residents of the skilled nursing facility at UMC.	Consent	PASSED
4. Develop a work plan for the successful transition of the new hospital, which should include an integrated health system located throughout Wards 7 and 8, for calendar years 2020-2023.	Non-Consent	Tabled per Executive's request to provide update on hospital at November meeting
5. Facilitate integration of telehealth into medical practices.	Non-Consent	Tabled in favor of Recommendation #7 from the Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care; Recommendation #5 from the Committee on Discharge Planning and Transitions of Care; and Recommendation #6 from the Committee on Discharge Planning and Transitions to Care

¹ Recommendations tabled in favor of other recommendations will be integrated into the favored recommendations, as needed.

6. Pilot a model to better connect prenatal care, currently 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 health information exchange, and assistance with transportation.	Non-Consent (Removed from Consent during deliberations)	PASSED with incorporation of Recommendation #3 from the Committee on Access to Critical and Urgent Care Services and a change to city-wide model with an emphasis on Wards 7 and 8
7. Maintain the obligation that requires financial resources received from the redevelopment of Reservation 13 be used for initiatives focused on the uninsured and addressing health care inequities.	Consent	PASSED
8. Develop a shared, central repository of emergency department (ED) and urgent care access data to promote understanding of changes in patient use of ED, urgent, and primary care services over time.	Non-Consent	Tabled for discussion at next meeting due to concerns regarding integrating into #5 from the Committee on Access to Critical and Urgent Care Services
9. Train the Summer Youth Employment Program (SYEP) students to be community, peer, and family health educators.	Non-Consent	PASSED with request for staff to incorporate the intent that students be appropriately trained and skilled at providing peer to peer health education and support
10. Use existing certificate of need (CON) fees to support State Health Planning and Development Agency's (SHPDA) CON responsibilities, and utilize recurring local funds for modernization, innovation, and special projects to meet the needs of medically underserved areas, as well as to develop the health systems plan.	Non-Consent	PASSED
Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care		
1. Develop a citywide, broad-based community public relations campaign regarding available health resources in the District, including how to access these medical services, along with the proper use of 911.	Non-Consent	Tabled due Committee Chair absence
2. Convene governmental and non-governmental partners to build on the initial successes of the Fire and Emergency Medical Services (FEMS) "Right Care, Right Now" Nurse Triage Line program, with the goal of diverting an additional 15% of calls that are non-emergent.	Consent	PASSED

3. Evaluate other models of care to meet the demand of medical services requested in the field – such as the federal Emergency Triage, Treat, and Transport (ET3) Medicare model, community paramedicine responders, and community health workers – with the goal of directing individuals to the right level of care, and reducing the overutilization of the resources of emergency departments and FEMS.	Consent	PASSED
4. Evaluate the regulations allowing 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.	Non-Consent	Tabled due Committee Chair absence
5. Implement the National Emergency Department Overcrowding Score (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 penalties or further scrutiny to the healthcare facility.	Consent	PASSED
6. Evaluate and improve the throughput of patients from FEMS drop off and into emergency departments/hospitals, to make patient transfer of care more efficient. This process should include a review of regulatory requirements that apply to patients, who require an intermediate level of care that may not include hospital admission, as well as any regulatory changes that may relieve hospital constraints on the flow of patients.	Non-Consent	Tabled due Committee Chair absence
7. 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 should be assessed to entice participation by providers and patients. A successful model should include telehealth reimbursement rates that meet the market rate/cost of the service.	Consent	PASSED

<p>8. Expand and develop behavioral health services available to the community to divert patients from the hospital emergency departments.</p> <ul style="list-style-type: none"> a. Establish Sobering Centers, as an alternative care site, for intoxicated individuals who do not require acute medical attention. This recommendation, if implemented in the short term, could have a significant, immediate impact on overuse of emergency resources. b. Endorse the Department of Behavioral Health proposal for a comprehensive waiver to redesign the Comprehensive Psychiatric Emergency Program. 	Non-Consent	Tabled due Committee Chair absence
<p>9. Engage in a comprehensive process to address the specialized needs and challenges presented by justice-involved individuals, with the goal of treating these patients safely in appropriate care settings, e.g., the Central Cell Block or other Department of Corrections facilities. This effort should include a focus on the safety of first responder and other health care workers, as well as reducing costs associated with such treatment.</p>	Consent	PASSED
<p>10. Develop incentives for use of primary care, and disincentives for use of emergency departments, for non-emergency issues.</p>	Non-Consent	Tabled due Committee Chair absence
<p>11. Support mandated enrollment in case management of all participants in publicly-funded healthcare.</p>	Non-Consent (Removed from Consent by request)	Tabled to November meeting, per Commission member request
Committee on Discharge Planning and Transitions of Care		
<p>1. Place a DC Medicaid eligibility staff member onsite at certain qualified providers, such as hospitals or skilled nursing facilities (SNFs). This practice will allow care management departments to obtain eligibility decisions more quickly, thereby reducing delays in discharges, turning over patient beds for new admissions, and moving patients efficiently. The Medicaid specialist will serve as a liaison between the DC Medicaid office and member hospitals. Qualified providers will be required to share in the cost of an onsite specialist.</p>	Consent	PASSED

<p>2. Approve a retrospective review process (as opposed to prospective) to improve the efficiency of approvals and transfers of patients. Develop acceptable pre-admission criteria, in cooperation with medical providers, which will expedite the process of transitioning some of the Districts most medically complex patients to the correct level of care.</p>	Consent	PASSED
<p>3. Expand the availability and support for medical respite facilities by reviewing and updating the regulatory requirements, which may create barriers to additional medical respite options.</p> <ul style="list-style-type: none"> a. Recommend a State Plan Amendment to provide for Medicaid coverage to finance medical respite care services generally, rather than relying disproportionately on local grants. b. Adopt standards for defining medical respite programs such as those from the National Health Care for the Homeless Council. c. Develop regulations to address qualifications and standards for medical respite providers. Services should be defined in accordance with the licensed professionals who provide them. Qualifications on admissions and discharges shall be clarified. d. Amend the D.C. Law 22-65 “Homeless Services Reform Amendment Act of 2017” to exempt Certificate of Need (CON) 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. e. 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. 	Consent	PASSED

<p>4. Reduce barriers to operating Advanced Life Support (ALS) and Basic Life Support (BLS) transports in the district through examining licensure and regulatory obstacles.</p> <ul style="list-style-type: none"> a. Temporarily or permanently standardize licensing regulations to harmonize within the DMV region, providing reciprocity to ALS and BLS providers licensed in Virginia and Maryland allowing them to be able to drop off AND pick up from DC based facilities. b. For a two-year period, temporarily provide an expedited CON process to approve additional (ALS/BLS) transportation providers. c. Conduct a review of the EMS regulations, last changed in 2003, reviewing and updating current practices to meet the needs of the District. d. Expand the quality reporting program to include more relevant measures such as 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 the number of vehicles used within the District for non-FEMS services daily. 	Consent	PASSED
<p>5. Fund a pilot program with District skilled nursing and long-term acute care facilities in order to determine how telemedicine consultations might reduce unnecessary ED visits and 911 calls.</p>	Consent	PASSED
<p>6. Establish a telecourt for involuntary commitment and probable cause hearings, and consider providing District funding for all District providers, which care for FD-12 (involuntary) individuals, to have a secure platform to interface with the courts in all commitment and probable cause hearings.</p>	Non-Consent	PASSED
Committee on Access to Critical and Urgent Care Services		
<p>1. Ensure there is a single, easily accessible citywide healthcare advice line, staffed by clinicians, to provide medical advice, health care system navigation, and appointment scheduling to all residents.</p>	Consent	PASSED

2. Implement a health literacy campaign focused on when and how to access care.	Consent	PASSED
3. Establish peer support networks for maternal health.	Non-Consent	Tabled in favor of incorporation into Recommendation #6 from the Committee on Equitable Geographic Distribution of Acute, Urgent, and Specialty Care
4. Conduct surveys and focus groups to understand resident's healthcare decision-making priorities.	Consent	PASSED
5. Share hospital discharge information in a timely manner.	Non-Consent (Removed from Consent during deliberations)	Tabled to amend and for further discussion
6. Exchange electronic advance directive forms among providers.	Consent	PASSED
7. Incentivize the assessment and sharing of social determinants of health during a first prenatal visit.	Consent	PASSED
8. Increase the capacity of primary care providers to treat substance use disorders.	Consent	PASSED
9. Incentivize the establishment of new Comprehensive Psychiatric Emergency Programs.	Consent	PASSED
10. Open Sobering Centers.	Consent	PASSED
11. Increase the capacity of health clinics to provide urgent care services.	Consent	PASSED
12. Implement cultural competence and implicit bias training for clinicians.	Consent	PASSED
Committee on Allied Health Care Professionals and Workforce Development		
1. Establish a health careers intermediary to ensure training meets the demands of the health care system.	Non-Consent	Tabled in favor of Recommendation #9 from the Committee on Allied Health Care Professionals and Workforce Development
2. Accelerate the expansion of training programs for shortage (e.g., nurse, certified addiction counselor) and emerging (e.g., telehealth, data analytics) roles, and, in the immediate, for roles that provide reimbursable services under DHCF's Behavioral Health 1115 Waiver (e.g. peer recovery specialists, social workers).	Non-Consent (Removed from Consent during deliberations)	Tabled to amend and for further discussion

<p>3. Expand pipeline and early career education programs to recruit DC students into health care Clinical, Administration, and Health Technology careers through establishing a health careers education consortium to facilitate development, expansion, and implementation of health careers education.</p>	Non-Consent	Unaddressed and expired, but overlap noted with Recommendation #9 from the Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care
<p>4. Increase and diversify incentive programs to recruit and retain clinical, non-clinical, and operations staff.</p> <ul style="list-style-type: none"> a. Expand District loan repayment programs to include clinical, non-clinical patient care, and operations staff not currently eligible for the Health Professional Loan Repayment Program. b. Create new tax incentive programs to target provider retention including options such as home purchase support, rental assistance, childcare benefits, and educational benefits. c. Leverage the U.S. Public Health Service Programs to recruit providers. d. Encourage voluntary employer-based incentives, with a focus on retention, that include such things as: higher salaries for high-need positions, flexible scheduling, extended leave, professional development, career pathways, career coaching, tuition reimbursement, continuing education and support, and other employee benefits such as parking, discounted lunches, and transportation. e. Encourage DC Government and local associations to support employer efforts to expand employer-sponsored incentives through private-sector funding and legislation (e.g., tax rebate and tax exemption programs for employers). 	Non-Consent	Tabled to amend and for further discussion

<p>5. Address barriers to standing up and/or relocating practices in DC.</p> <ul style="list-style-type: none"> a. Provide incentives to attract and retain new providers and include options such as subsidies for malpractice insurance, tax incentives for office locations in economic improvement zones, and enhanced reimbursement or subsidized payment for providers in high need/low income geographic zones. b. Have the Department of Health conduct a quality improvement review of the licensure process to address delays in all aspects of clinical licensing. Develop process improvement plans to reduce turnaround time. c. Explore participation in additional interstate licensure compacts and compact alternatives such as reciprocity agreements with neighboring states and address any barriers that prevent the Department of Health's implementation of the physician licensing compact. d. Research and invest in best practices on safety and security to address violence and security threats in and around health care settings. 	Non-Consent	Tabled until November meeting
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<p>6. Promote the delivery of team-based, multi-modality clinical care.</p> <ul style="list-style-type: none"> a. Update and educate providers on scope of practice regulations to ensure they practice to the top of their licenses and deliver state-of-the-art medicine. b. Expand cross-training of staff; for example, behavioral health for all patient care staff and advanced training for medical assistants to deliver reimbursable services. c. Expand training in trauma-informed care, implicit bias, managing behavioral health patients in any setting, quality improvement, etc. d. Establish workflow changes and practice supports (e.g., use of scribes) and best practices in patient scheduling to create efficiencies that allow providers to engage in quality improvement and population health initiatives. 	Non-Consent	Tabled until November meeting
<p>7. Create and fund a new zone-based population health management structure with zone health managers who jointly represent the zone's providers and are responsible for the health of the populations in their zones.</p>	Non-Consent	Tabled until November meeting
<p>8. Standardize the use of non-clinical patient care roles such as care coordinator, discharge planner, and community health worker.</p> <ul style="list-style-type: none"> a. Standardize funding for positions shared across multiple organizations (providers, MCOs, etc.) since positions assist in navigating across services and organizations. b. Expand reimbursement programs that pay for enabling services, such as the My Health GPS bump up rate. c. Expand grant programs to eliminate restrictions on services to specific populations. d. Standardize position descriptions and titles to better assist with recruitment and to better link to reimbursement. 	Non-Consent	Tabled to amend and for further discussion

<p>9. Strengthen systems to assess local workforce supply and demand through the establishment of a center for health care workforce analysis to:</p> <ul style="list-style-type: none"> • Provide recommendations on minimal data sets that should be collected through the licensure process; • Systematically gather and publish information on current and projected workforce supply and demand; and • Link and analyze available data sets. 	Non-Consent (Removed from Consent during deliberations)	PASSED
Committee on Value-Based Purchasing of Health Care Services		
<p>1. Engage the community for the road ahead.</p> <ul style="list-style-type: none"> a. Survey patients and caregivers about current behaviors and perspectives informing access to care choices. b. Share total cost of care information for specific populations by payer with all stakeholders. c. Engage patients and other key stakeholders (i.e., health care groups, payers, and government) in ongoing community dialogue about current value-based payment (VBP) and accountable care models and potential options for the District of Columbia. d. Conduct operational readiness assessments of all major health care groups for VBP. 	Non-Consent	Tabled due time constraints
<p>2. Expand quality measurement to capture more data on health system effectiveness and to inform care delivery, payment incentives, and population health.</p> <ul style="list-style-type: none"> a. Refine the core measure set of health priorities. b. Engage health care groups to achieve multi-payer alignment. c. Adopt public reporting to disseminate performance on the core measurement set. 	Non-Consent	Tabled due time constraints, with request to make explicit in recommendation that measures are aligned with existing required measures.
<p>3. Make key investments and policy changes to promote system integration for accountable care transformation.</p> <ul style="list-style-type: none"> a. Invest in practice transformation capacities. b. Ensure alignment and integration to enable accountability. 	Non-Consent	Tabled due time constraints

<p>4. Align payments with value-based care goals to move towards a risk-based model encouraging care coordination and health promotion.</p> <ul style="list-style-type: none"> a. Expand current value-based payment measures into other appropriate provider settings. b. Establish a Medicaid accountable care organization (ACO) certification. c. Adopt value-based payment models. 	Non-Consent	Tabled due time constraints
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