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

November 26, 2019

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	Not Present		
Dean Hugh Mighty	Howard University Hospital	Not Present	Michael Crawford	Present
Corey Odol	Psychiatric Institute of Washington			
Denice Cora-Bramble, M.D.	Children's Hospital	Present		
Marc Ferrell	Bridgepoint Healthcare	Not Present	Swenda Moreh	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	Not 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	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
Amelia Whitman	Staff	Office of the Deputy Mayor for Health and Human Services
Rayna Smith	Staff	Office of the Deputy Mayor for Health and Human Services
Fern Johnson-Clarke	Staff	Department of Health
Sharon Lewis	Staff	Department of Health
Lauren Ratner	Staff	Department of Health
Amha Selassie	Staff	Department of Health
Terri Thompson	Staff	Department of Health
Cavella Bishop	Staff	Department of Health Care Finance
Erin Holve	Staff	Department of Health Care Finance
Alice Weiss	Staff	Department of Health Care Finance
Noah Smith	Staff	Department of Health Care Finance
Raessa Singh	Staff	Department of Behavioral Health
Marsha Lillie-Blanton	Staff	Department of Behavioral Health
John Coombs	Staff	Fire and EMS Department
Amy Mauro	Staff	Fire and EMS Department

Public Attendees

Name	Role	Organization
Justin Palmer	Public	D.C. Hospital Association
Hanna Supos	Public	Georgetown Public Affairs
Fernando Martinez	Public	Psychiatric Institute of Washington
Calvin Smith	Public	BridgePoint Healthcare
Regina Knox Woods	Public	MedStar
Feseha Woldu	Public	MedStar
Colette Chichester	Public	CareFirst BCBS
Yulondra Barlow	Public	CareFirst BCBS
Francisco Semiao	Public	MedStar Health
Victoria McNamee	Public	Consultant
Ambrose Lane Jr.	Public	Health Alliance Network
Claudia Schlosberg	Public	Castle Hill Consulting
Lisa Fitzpatrick	Public	Grapevine Health

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

The meeting was called to order at 10:02 am.

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

Rayna Smith took role and quorum was achieved.

Co-Chair David Catania reviewed the structure of the document from which the Commission will be working:

- There are 20 items on the non-consent agenda;
- 29 items were already approved; and
- 4 items were previously tabled or incorporated into other items.

3. Executive Updates on New Hospital **OCA**

Co-Chair Sister Carol introduced Ben Stutz, Chief of Staff to the City Administrator, who provided an update on the new hospital.

- Mr. Stutz stated that the city is continuing its negotiations of the new hospital. We have been meeting diligently with George Washington University Hospital since June and have made significant progress toward an agreement. While the Letter of Intent that was signed last summer has expired, that has not changed our ongoing process of negotiations. At this point, it would be fair to say that there are no outstanding issues that will prevent us from finding common ground. However, as in any complex negotiation, there are many issues to work through.
    - We had established a date for the facility to open in 2023. We are still working towards this goal, but till open as soon as possible. There are many regulatory approvals that are needed and our timeline will continue to be updated as those approvals are received.

- When the agreement will be finalized and ready for Council approval is still to be determined.

Questions from the Commission:

- Co-Chair Catania asked for clarification on the timeline and whether the Executive was looking to open the hospital in December 2022.
  - Mr. Stutz stated that 2023 has been the District's proposed date, which was established last summer. However, we were hopeful that we could have completed the agreement sooner.
- Kelly Sweeney McShane asked about the proposed recommendation regarding next steps and whether that would still be discussed.
  - Co-Chair Catania stated that we tabled it at the last meeting at the suggestion of the Executive. For this meeting, there is some language that we would like to offer up when that recommendation comes up. We want to be clear that we are looking for time tables, but also be sensitive of the ongoing negotiations and not interfering with those. We want to make sure the recommendation is not weaponized against the Executive.

4. **Discussion and Approval of Remaining Recommendations** **Commission Members**
Note: All recommendations and the outcome of votes can be found in Appendix A.

- Co-Chair Catania stated that at the last meeting we left off on the Value-Based Purchasing (VBP) recommendations, which we wanted to discuss in total.

Committee on Value-Based Purchasing – Recommendations considered as a package

- Don Blanchon stated that based on the subcommittees discussion, we believe there is some gaps in knowledge and some need to engage with the public. We need to better understand why people are doing what they are doing, particularly around ED utilization.
  - The second part is that there is also a gap in knowledge between providers and payers around who is using the highest cost care. The easiest place to go for this is to look at Medicaid and DC Health data around particular populations. We need to think through how the community at large can have more insight into data about costs.
  - Finally we need to think about where different groups are vis-à-vis VBP initiatives and readiness. We will need to align incentives across the entire system.
- With the second recommendation, we need more information about what is the city's highest priority and what will provide the most value. In other states, they have used a model with Medicaid or the Health agency leading this work to narrow down a list of community-wide priorities. We know that we want health equity and social determinants of health included in this.
- The third recommendation is about changes that need to take place around infrastructure. This period in the road map is designed to build infrastructure and align policies with that infrastructure.
- The fourth recommendation is geared at alignment of payment with care models.

- The total process is estimated to take six or seven years. We were very mindful of the mix of regulators, payers, and providers on our subcommittee, and the needs of each of those groups..
- Kevin Sowers stated that he is very supportive of VBP and preparing systems, but the recommendations don't specifically address payers getting ready. Mr. Sowers asked if that is embedded in item three or four, as commercial payer readiness is not spelled out.
    - Mr. Blanchon stated that there was a nice set of exchanges about the role of commercial payers. Frankly, they are farther along than Medicaid. We thought that if there was a core set of measures that the city will work on, the commercial payers would then make adjustments based on those priorities, as they see fit. There was intent for commercial payers to come along with Medicaid. There's a risk to Medicaid saying they are doing to do something and commercial payers not doing the same. Our goal was to bond everyone together through measures and population health.
    - Kim Horn stated that the four recommendations should be considered as package and the first applies is all stakeholders. The key part is really accountable care and the notion is that this is needed to get to the point where you can pay based on risk need organized systems. Finally, once you do that, you can align payment – there was reasoning behind the sequence in which they were listed. There's also a debate about whether this should take seven years and whether there will to speed this up along the way.
- Vince Keane asked about who would leave this.
    - Mr. Blanchon stated that this is really a community-wide endeavor – to accomplish it, it needs to be owned by more than a single agency. There is a question of whether some form of this Commission continues or whether there is some sort of implementing body, but it is not a single agency model. There is also a question of how quickly we can do this. Providers are understandably nervous about what it means for them long-term and they need time to adjust. In addition, health disparities are not remotely close to being attacked.
- Dr. Barbara Bazron said that with the timeline, we need to be careful not to rush the process only to end up making mistakes – we should take the time needed to do it right. Past experience in implementing massive change shows that if you rush, it often doesn't come out as well as possible. I'm not sure whether the right time frame is seven years, but we should take the time needed. As it relates to behavioral health, implementation of these will take some time.
- Co-Chair Catania stated that he appreciates the work that went into these and said that he learned a lot from the work. He understands that from the provider perspective, this is scary. He thinks that the more people we have at the table to implement this work, the lower the temperature will be.
- Co-Chair Catania moved the four recommendations en bloc
    - The recommendations were unanimously approved.

Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care

- Recommendation #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.
    - Co-Chair Catania noted that there was a suggestion from co-chairs to fold this recommendation into Recommendation #1 from the Committee on Access, but the Co-Chairs leave it to the chair, Kim Russo, to determine if that is how they would like to proceed.
    - Ms. Russo stated that the committee conferred and while they believe the two recommendations are interrelated, they believe they are different. They believe that a public campaign is really needed to educate community on how to use health care resources. Ms. Russo asked Dr. Holman, who is filling in for Chief Gregory Dean, if there is anything that he would like to add.
    - Dr. Holman affirmed what Ms. Russo said and added that there is work already ongoing with this as part of the Nurse Triage Line.
    - Ms. Russo moved the recommendation.
        - The recommendation was unanimous approved.
- Recommendation #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.
    - Co-Chair Catania noted that there was a suggestion from the co-chairs to this recommendation with recommendation #6 from this committee, and then table those to be incorporated into recommendation #4 from the Committee on Discharge Planning
        - Ms. Russo that should they be incorporated, we look at the specific regulatory issues relating to these issues and that we study facility transfers and drop off.
        - Co-Chair Catania stated that we would incorporate these specific into Recommendation #4 from the Committee on Discharge Planning and moved to table these for incorporation.
            - There was unanimous approval for incorporating these issues.
- Recommendation #8: Expand and develop behavioral health services available to the community to divert patients from the hospital emergency departments.
    - Co-Chair Catania noted that the co-chairs recommended that these be incorporated into the previously passed recommendations regarding Sobering Centers (Recommendation #10 from the Committee on Access) and Comprehensive Psychiatric Emergency Programs (CPEPs) (Recommendation #9 from the Committee on Access)
    - Ms. Russo stated that she is okay with integrating the recommendation, but cautioned that we need to make sure that the sobering center recommendation is not watered down. She stated that the Committee feels that it is really necessary.

- Dr. Holman stated that the sobering center recommendation was really central to the Committee's work. He also stated that it should be a public-private partnership – not a sole government effort.
- Co-Chair Sister Carol stated that she thinks this is one of most important recommendations to come out of this Commission and that it is the ultimate low hanging fruit. It will save money, make emergency rooms safer, and deliver far better care to individuals with substance use disorders (SUD). All of this is a win. We should find a way to note in the report that this is a priority and that it can really make a significant difference, both for people in need of SUD services and others receiving care.
- Dr. Denice Cora Bramble stated that she would like something specific to pediatrics added with regard to behavioral health services as there are serious challenges on pediatric side.
- Co-Chair Catania stated that we will incorporate both parts into previously approved recommendations from the Committee on Access: Integrate subsection (a) into recommendation #10; and integrate subsection (b) into recommendation #9. We will also incorporate a reference to pediatric services. Co-Chair Catania noted that staff is taking very detailed notes and that we will allow them to make edits. He stated that he would also like to incorporate Sister Carol's comments about the urgency associated with sobering centers.
- Dr. Bazron stated that there are some specific differences between sobering centers and CPEPs. There are also some challenges related to sobering centers, particularly with regard to how people get there. To make this successful it will take some thinking through. On its face, it seems like a great idea, but there are some serious challenges.
- Co-Chair Catania stated that it will be left to all of us to play a part in the execution.
- Co-Chair Catania moved that recommendation #8 be divided and additional language be added, as previously discussed.
    - The changes were unanimously approved.

- Recommendation #10: Develop incentives for use of primary care, and disincentives for use of emergency departments, for non-emergency issues.
    - Ms. Russo asked Dr. Holman to go into detail about the committee's thoughts behind this. The goal is to incentivize, not penalize.
    - Dr. Holman stated that many VBP incentives are centered around providers or organizations, but don't really involve patient choices, even though patients are often deciding. The idea behind this is to give patients credits if they achieve their health care goals. The problem is that we are severely limited in terms of Medicaid financial incentives. Dr. Holman thinks that this is a fabulous idea, but acknowledges that we will have federal regulatory challenges to work through.
    - Mr. Sowers stated that, having tried to engage in this strategy before, he would like to know if the committee talked about EMTALA and how you change behaviors at point of entry. There may need to be some sort of outlier waiver around EMTALA.

- Ms. Russo stated that the committee had a lot of conversations around the challenges to this – there are a lot of complexities. The committee is comfortable with the recommendation focusing on doing further discovery on primary care incentive models. There are significant challenges that we will need to engage on about how to incentivize. The initial recommendation is looking at what models exist.
- Maria Gomez stated that she wants to make sure that the disincentive is far less than the incentive so that people are still getting timely care.
- Dr. Holman stated that the committee was very aware of punitive models that have been rejected by courts (such as in Kentucky). We want this to be patient-centered and not punitive.
- Mr. Blanchon stated that the Committee on VBP did talk about this element, buy did not specify that we would have incentive model for patients. However, it could be written into our recommendation about aligning payment if the Commission would want to do that.
- Mr. Blanchon stated that the most important part is that it is beyond primary care – holistic health and wellness models and not just use of a primary care office. This is what has been working in other places.
- Ms. Russo stated that many health systems already have accountable care. All providers are looking at different models that will change behaviors.
- Mr. Keane stated that he is a little concerned about not putting it out as standalone recommendation. He is afraid it will get lost. In addition, a lot of providers already doing programs like this. The reason we were brought together was to do something system wide.
- Co-Chair Catania stated that he would suggest including this as a freestanding recommendation so that perhaps this can move on faster timeline than the VBP recommendations.
- Ms. Russo stated that she does not have an objection to it being standalone, but that we can also look for areas of collaboration.
- Sister Carol stated that this also goes to asking people why they are doing what they are doing. As we get this information, we can make everything we are working on more successful.
- Mr. Sowers noted that the language speaks to both incentives and disincentives. He asked whether we talking about both or just an incentive model.
- Dr. Holman stated that the plan discussed with the committee was to have build in disincentives that are not felt by the patient.
- Karen Dale noted that Mr. Blanchon previously mentioned that we should not only focus on primary care – that we should focus across types of care.
- Co-Chair Catania suggested that we change the language to the appropriate level of care.
- Ms. Dale agreed.
- Ms. Sweeney McShane stated that if the recommendation is written as is, she is concerned about disincentives and how that will be read. She is worried that people will think that it will be punitive.

- Co-Chair Catania stated that the language doesn't strike him as punitive, but he would entertain a suggestion for a change.
- Dr. Holman suggested "non-punitive disincentives."
- Dr. Gregory Argyros stated that he thinks disincentives are different than punitive.
- Ms. Sweeney McShane stated that a community member reading it will not differentiate between disincentives and punitive.
- Mr. Keane suggested using educate.
- Co-Chair Catania stated that he is supportive of the language discussed earlier. He appreciates that we want to be sensitive, but at the end of the day people who over use the emergency department waste public resources and this is something we want to disincentivize.
- The recommendation was moved with a change to the appropriate level of care instead of primary care.
    - The recommendation was unanimous approved.

- Recommendation #11: Support mandated enrollment in case management of all participants in publicly-funded healthcare.
    - Ms. Russo stated that this recommendation is based upon data that shows that the highest utilizers of EDs are typically not assigned a case manager. Currently, individuals can opt out of case management, but we want to make sure that if you are using public health insurance, you are getting a case manager to guide you through getting the right care, at the right time, in the right place.
    - Ms. Sweeney McShane stated that she has concerns about the language, as she has seen that mandatory participation doesn't work. In addition, she has concerns about cost implications and what will happen if someone doesn't participate.
    - Ms. Russo stated that the committee had a lot of discussions around non-participation at the committee level. If a beneficiary is assigned a case manager and they are attempting to engage with you, the beneficiary wouldn't be penalized. The focus is on helping to provide resources.
    - Karen Dale acknowledged Ms. Sweeney McShane's comment about mandatory participation and stated that some things are more effective than others. What we have noted is that despite that there is broad education available, but only reach about 30% of who we are attempting to contact. We can't help who we can't reach. There's a floor, but there's lots of room to do other things to help people. Mandate may be too strong of word, but people need to know that people when they enroll in managed care they have a care manager. In the first 30-60 days, people can spiral if they have needs. They may use unnecessary resources because they didn't get the support they need. We need to establish connections earlier in the process.
    - Melisa Byrd said that regarding the mandate, if it is a condition to participate, that would be problematic from a Medicaid perspective. On the mandate part – if it is a condition in the program its
    - Co-Chair Catania whether opt out would be acceptable.

- Ms. Byrd stated that this is what we have now. Care coordination is usually available, but case management is a choice.
- Ms. Dale asked about whether the system could be more like My Health GPS.
- Ms. Byrd stated that My Health GPS is opt in.
- Dr. LaQuandra Nesbitt stated that she had several thoughts about this initially. First, is what Ms. Byrd already mentioned. However, regarding Ms. Russo's opening comment about the recommendation being data focused on the highest cost users – Medicaid is trying to do some things around this already. They are shifting individuals from fee-for-service (FFS) to managed care organizations (MCOs), and the highest cost users are currently in FFS. With this, there could be a reimagining of how the opt out aspect of the program happens. We may not be able to get to mandated, but taking away the FFS option will ensure that the high cost individuals are in MCOs in the first place and will have the options that come with those programs.
- Mr. Blanchon stated that he would not support this as philosophically it is very paternalistic. Further, to have a mandated enrollment of all publicly funded enrollees, there are operational issues such as staffing. He could live with a recommendation that would say conduct a study around care management models focused on high utilizers.
- Ms. Dale stated that there are two things we are talking about – care coordination, which most people will benefit from. This includes education and support like logistics. The second is care management, which requires clinical expertise. She gets concerned about the focus on the highest cost beneficiaries as statistically we see people migrate from moderate cost to high cost. We need to intervene earlier to improve the delivery system and outcomes.
- Co-Chair Sister Carol stated that when she looks at this, it's not compatible with the Medicaid program, which is the life blood of many people in the District. There is value in having a sense that someone really cares about you. Could we support effective case management of all participants in publicly funded health care? We know that there will be case management in commercial. There's no way we can go on record with something that is illegal in the Medicaid program.
- Co-Chair Catania asked whether changing the language to "Encourage and incentive enrollment in…" would be acceptable. The goal is really to make sure supportive services are available to those who need them.
- Dr. Tu stated that UMC, the most critical part of care is case management. Having a really good social worker or case manager can really move things along. Whatever this morphs into, he wants to stress that effective case management and social worker resources would be very helpful to the community in the East End.
- Co-Chair Catania stated that he hears that Dr. Tu is asking for comprehensive case managed and suggested a language change to

"Encourage and promote enrollment in comprehensive case management for all participants…."
    - Ms. Sweeney McShane indicated that she is comfortable with this.
    - The recommendation was moved.
        - The recommendation passed unanimously, as amended.

Committee on Equitable Geographic Distribution

- Co-Chair Catania moved Recommendation #4, which is about developing a work plan for the transition to a new hospital, but would like to propose an amendment:
    - Co-Chair Sister Carol read the proposed amendment aloud:
    - Develop a work plan for the successful construction of and transition to a new hospital at St. Elizabeths, which should include the establishment of an integrated health system for residents of Wards 7 and 8.

      The Committee recommended the following components of the above-recommended work plan:
        - Strong encouragement for the health system and the hospital to accept of all public insurances.
        - Ways that a new health system will address prenatal and delivery needs for women East of the River.
        - Shared planning and community input as plans for the new hospital are made, so that a network and trust is created upon its opening.
        - A communications plan to explain to the community the type and level of services to be provided at the new hospital and corresponding ambulatory and urgent care facilities that are established as part of the District's partnership.
        - A strategy to engage with the current providers in the medical office building of UMC to provide information about opportunities at the new location.
    - Ms. Jacqueline Bowens stated that we want it to be an integrated health system – period – with a focus on Wards 7 and 8. She is concerned that the language limits this and that it should be reframed to the establishment of an integrated health system, with a focus of residents of wards 7 and 8.
    - Mr. Eric Goulet stated that Councilmember Gray would be fine with that, and would also suggest that we amend the language to say "eastern end of the District" in this sentence as well as the second bullet point.
    - Ms. Dale stated that she feels that the final bullet is too narrow. There are not a lot of providers in the medical office building at UMC, so we should use the data around needs to ensure the right providers are at the new hospital.
    - Co-Chair Catania suggested that we add language around a strategy to engage with current providers and other necessary or relevant providers to provide information about opportunities.
    - Maria Gomez stated that she wants to underscore whether the recommendations should be more general – the goal is to convey that everyone in the District will want to utilize the new facility and when we use language specific to Wards 7 and 8, then it creates a sense of differentness.

- Co-Chair Catania suggested that we change the first line to "Develop a work plan for the success of a new hospital at St. Elizabeths, which should include the establishment of an integrated health system for all Washingtonians, with an emphasis on the East End."
- Ms. Gomez stated that, having been on the Board, we need the hospital to be open to whoever wants to come in and not just DC residents.
- Co-Chair Catania stated that we want to build a system for the success of our residents, but all are welcome. For the last bullet point, he suggested changing the language to "current providers in the medical office building of UMC, as well as other relevant providers."
- Mr. Blanchon noted that the language from the committee talked about integration with existing community providers, which is important to making the hospital work.
- Mr. Stutz responded that with regard to that concern, that will be covered in detail in the agreement itself.
- Mr. Goulet stated there will be opportunities through the Council hearing process and Certificate of need process to hear from everyone. Council is committed to hearing from all providers.
- Mr. Blanchon stated that he would like to trust, but verify by seeing it included.
- Co-Chair Catania stated that one reason that UMC hasn't succeeded is because of the absence of integration and that he believes that the Deputy Mayor and City Administrator, as well as the rest of the Executive Team, certainly appreciate this. It would be malpractice for them not to integrate.
- Co-Chair Catania moved the recommendation with the changes discussed.
  - The recommendation was approved unanimously.

- Recommendation #8: 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-Chair Catania withdrew the recommendation to fold it into Withdrew recommendation to fold into Recommendation #5 from the Committee on Access to Critical and Urgent Care Services.
  - The recommendation was moved as is by Mr. Goulet.
    - The recommendation was unanimously approved.

Committee on Access to Critical and Urgent Care Services

- Ms. Bowens stated that a small group got together to discuss this recommendation after it was tabled at the last meeting. She stated that that they believe the language being proposed is more appropriate and in line with here we stand on the issue. It is also in line with what we are hearing from CMS and the recommendations from the experts on the HIE Policy Board.
  - Recommend that the Mayor consider the final recommendations from the HIE Policy Board to make available necessary patient information from the electronic medical record and the minimum data set that should be transmitted upon discharge to improve transitions of care.
  - Co-Chair suggested a small edit of "… HIE Policy Board, which proposes to make available necessary…"

- Ms. Sweeney McShane stated that the conversation last time focused around providing timely information and asked whether this was addressed here.
- Ms. Bowens stated that the HIE Policy Board will be discussing this in January. The DC Hospital Association (DCHA) did a lot of work on this through a grant and DCHA will be working closely with the Policy Board. At the end of this, we will have timely and relevant information.
- Co-Chair Catania moved the recommendation.
  - The recommendation was unanimously approved.

Committee on Allied Health Care Professionals and Workforce Development

- Recommendation #2 (updated language): Establish a public-private health careers training consortium to strategize around and guide health workforce training investments to: accelerate the expansion of training programs for shortage (e.g. nurse, CAC) and emerging (e.g. telehealth, data analytics) roles; expand early career education; recruit ESL residents; and otherwise ensure training programs are responsive to resident and health system needs.
  - Ms. Gomez stated that she wants to emphasize how important workforce is to everything we are discussing – not just clinical, but also non-clinical to make everything function. Investments in workforce will improve the health of residents because it will improve their ability to be well employed in DC. In this recommendation, we wanted to specify a bit more of how to make sure that we were meeting employer's needs. We want to include all sorts of members in the consortium.
  - Dr. Bazron asked whether nurses and CACs were sited because that is where the committee saw the greatest deficit. There are others like LICSWs and psychiatrists that are critical across the system.
  - Dr. Holman stated that he would echo this and would add paramedics.
  - Ms. Gomez stated that these are examples, which can be removed.
  - Dr. Nesbitt stated that she would suggest we leave in telehealth and data analytics as examples because people don't typically think of these. She also suggested that if don't want to use examples, we could add language around process – we often partner with DOES to conduct sector surveys.
  - Ms. Dale asked about individuals that are not licensed and where the policy changes that are needed to make these parties reimbursable are discussed.
  - Ms. Gomez indicated that this is covered in another recommendation.
  - Co-Chair Catania stated that a private health care consortium of the providers makes sense, but thinks that we should omit the public. His experience is that private people expect the public entities to solve the problem, and then such things don't take legs because no one really takes charge. DCHA and DCPCA could create a consortium and then petition the executive for issues identified to be addressed
  - Ms. Bowens stated that she would echo this as there is already work happening in this area. It is a priority and conversations have started. She also gets a little concerned about how we look beyond training to retention and actually getting people jobs. We have trainings, but when they finish they aren't able to keep a job – how do we create pathways to careers. We support the idea of a consortium, but don't think we should wait or leave leadership to the public sector (outside of

what is already being done by DOES and WIC). We should let the private sector drive this.
    - Co-Chair Sister Carol stated that we should develop consortium and bring in the public components where that's helpful, but keep moving with the people concerned at the table. She would be very comfortable with leaving out public-private component. With everything that people do – whether DCHA or anyone else – if there's a need to do something through the public sector, you just bring that to the attention of the elected officials.
    - Co-Chair Catania asked Ms. Gomez if she would object to taking out public-private.
    - Ms. Gomez stated that she thinks there would be benefit to having the knowledge of the public sector in there. She asked Dr. Nesbitt about her perspective.
    - Dr. Nesbitt stated that she echoes the sentiments and comments of others. There are plenty of opportunities for DC Health to provide data, but its unclear what other contributions would be needed from the public sector that aren't being made through the existing entities that have been mentioned.
    - Ms. Gomez stated that the committee was expecting the public would provide information.
    - Dr. Nesbitt stated that there are arrangements that can be made without the public sector being an official member.
    - Alice Weiss stated that she wanted to share that one idea was that the public could contribute in terms of incentive programs and funding opportunities.
    - Co-Chair Catania moved the recommendation without the phrase "public-private" and the example of Nurses and CACs.
        - The recommendation was approved unanimously.
- Recommendation #4 (updated language): Target provider retention by creating programs that offer incentives beyond loan repayment, such as: home buying support, rental assistance, malpractice insurance assistance, childcare benefits, and education benefits.
    - Ms. Gomez stated that there has not been a conversation about how we are retaining experienced providers once they pay off their loans, or how we retain those without loans. We took out the part about tax incentives from our original recommendation.
    - Ms. Sweeney McShane stated that she liked that the original recommendation included clinical, non-clinical, and operations staff.
    - Ms. Gomez stated she would not have an objective to this.
    - Mr. Sowers asked for clarity on what we are voting on.
    - Co-Chair Catania clarified that we were considering the updated recommendation.
    - Ms. Russo stated that she would like to understand what is meant by target – will this be required? What is the meat behind the recommendation? She struggles with the involvement of the government on her retention efforts.
    - Mr. Sowers stated that it feels very cryptic for private providers and its our responsibility to retain staff.
    - Ms. Russo stated she is not in favor of mandated public entity involvement in her retention efforts.
    - Co-Chair Catania stated that he understands the good intentions, but shares the concern about government overreach. He asked that we table this.

- Ms. Gomez stated she would like to massage it a bit, but keep it on the table. She would like to recommend that we create an incentive program as there is so much difficult in recruiting and retention. She stated that she assumes Ms. Russo has challenges as well.
- Ms. Russo stated that they do have trouble, but that it is her job to manage that.
- Co-Chair Catania stated that he is moving to table the recommendation. If there are further refinements that Ms. Gomez would like to make, she can do so between now and the next meeting. However, he is not in favor of inviting the government's interference.
- Dr. Nesbitt stated that there is a recommendation around the government's loan repayment program that Ms. Gomez could look at to see what specific recommendations could be added to that under the government's current purview that do not impact private employers.
- Co-Chair Catania motioned to table the recommendation.
    - The motion to table was unanimously approved.

- Recommendation #5 (updated language): To explore a frequently-cited barrier to standing up and/or relocating practices in DC, conduct a quality improvement review of the licensure process to address delays in all aspects of clinical licensing, and develop and implement process improvement plans to reduce turnaround time.
    - Ms. Bowens stated that she believes the objective is to minimize barriers to licensure. She is struggling with whether we need the language at the beginning or whether we can just specifically speak to what the issue is – how to minimize issues with licensure. If there are barriers, it's for everyone and we shouldn't limit this to one group.
    - Co-Chair Catania moved the recommendation with the removal of the language about standing up or relocating practices.
        - The recommendation was unanimously approved.

- Recommendation #6: Promote the delivery of team-based, multi-modality clinical care by conducting a review of, update as needed, and educate providers on scope of practice regulations to ensure providers can practice to the top of their training and deliver state-of-the-art medicine (e.g. telehealth, robotics, etc.).
    - Ms. Gomez stated that this recommendation focuses on elements that are in the purview of the administration – ensuring that the health care community is well informed and that the range of patient care team members know what they can deliver. The goal is to align the people, technology, delivery of care with licensing and reimbursement policies.
    - Mr. Sowers stated that if this becomes a mandate, he is trying to figure out how to deal with hat. This is usually guided by local bylaws.
    - Ms. Gomez stated there are not just doctors and social workers – there are lots of other entities coming along. We need to clarify what their job descriptions and their responsibilities are and how public sector can pay for those. We are seeking a system or regulation practice that clarifies what different people do and how its paid for.

- Dr. Argyros stated that he was not clear on the intent – Are you making available what these jobs do? Are you making available continuing education opportunities – either mandated or optional
- Ms. Gomez stated that it's both – understanding what those people do so people can move from one system to another and establishing a level of professionalism in those roles.
- Co-Chair Catania asked whether Ms. Gomez is suggesting that there be an expanded certification and licensure for other allied health professionals.
- Dr. Nesbitt stated that the Health Occupations Revision Act (HORA) guides the scope of practice for health professionals in the District. DC Health cannot create health professions outside of amendments of HORA. If amended, DC Health creates regulations. What happens after that is that each center creates job description that comports with HORA. Each system can choose not to let them all practice – for example, at times this was true for midwives. The issue of payment is totally separate from the regulatory process. Is it establishment of the professions or assuring payment? From the government's perspective, we have grown the number of professions already. We are open to educating individuals on the scope of practice, but it is a different issue to discuss reimbursement.
- Mr. Goulet added that you have to be careful what you ask for on this. The Council is looking at a lot of bills that are putting mandates on careers. He cautioned that it could easily turn into something that works against what you are trying to do.
- Co-Chair Catania stated that he would like to table this recommendation, as well as the remainder for this committee. The committee can further flesh these out and we can discuss at the beginning of the next meeting.

- Co-Chair Catania stated that he would like to add an extra hour to next meeting to give the Commission leeway.

5. Public Comments **Public**

None

6. Adjournment **Commission Co-Chairs**

Co-Chair Catania recognized Amha Selassie before adjournment. He stated that he thinks for everyone when he says how much we value Amha's integrity, honestly, and professionalism.

- Amha stated that it was an honor and privilege to work with everyone.
- Co-Chair Catania's comments were echoed by Regina Knox Woods, Jackie Bowens, and Co-Chair Sister Carol.

The meeting was adjourned at 12:06 pm.

Appendix A: November 27, 2019 – Non-Consent Agenda

Committee on Value-Based Purchasing of Health Care Services			
Recommendation	**Agenda**	**Page**	**Status**
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 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	p. 117	APPROVED
2. Expand quality measurement to capture more data on health system effectiveness and to inform care delivery, payment incentives, and population health. Measures should align with existing measures required by federal and other partners. 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	p. 119	APPROVED *Updated language included to reflect request.*

3. Make key investments and policy changes to promote system integration for accountable care transformation. a. Invest in practice transformation capacities. b. Ensure alignment and integration to enable accountability.	Non-Consent	p. 122	APPROVED
4. Align payments with value-based care goals to move towards a risk-based model encouraging care coordination and health promotion. 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	p. 124	APPROVED

Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care

Recommendation	Agenda	Page	Notes and Co-Chair Comments
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	p. 41	APPROVED
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	p. 48	TABLED for incorporation into Recommendation #4 from the Committee on Discharge Planning and Transitions to Care

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	p. 51	TABLED for incorporation into Recommendation #4 from the Committee on Discharge Planning and Transitions to Care
8. Expand and develop behavioral health services available to the community to divert patients from the hospital emergency departments. 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	p. 53	TABLED in favor of integrating language from: Subsection (a) into Recommendation #10 from the Committee on Access to Critical and Urgent Care Services; and Subsection (b) into Recommendation #9 from the Committee on Access to Critical and Urgent Care Services
10. Develop incentives for use of primary care, and disincentives for use of emergency departments, for non-emergency issues.	Non-Consent	p. 57	APPROVED with language change to *"Develop incentives for use of the appropriate level of care…."*
11. Support mandated enrollment in case management of all participants in publicly-funded healthcare.	Non-Consent (Removed from Consent by request)	p. 59	APPROVED with language change to *"Encourage and promote enrollment in comprehensive case management for all participants in publicly-funded healthcare."*

Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care			
Recommendation	**Agenda**	**Page**	**Notes and Co-Chair Comments**
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	p. 26	APPROVED as amended: *Develop a work plan for the success of a new hospital at St. Elizabeths, which should include the establishment of an integrated health system for all Washingtonians, with an emphasis on the East End."* *The Committee recommended the following components of the above-recommended work plan:* • *Strong encouragement for the health system and the hospital to accept of all public insurances.* • *Ways that a new health system will address prenatal and delivery needs for women on the East End.* • *Shared planning and community input as plans for the new hospital are made, so that a network and trust is created upon its opening.* • *A communications plan to explain to the community the type and level of services to be provided at the new hospital and corresponding ambulatory and urgent care facilities that are established as part of the District's partnership.* • *A strategy to engage with the current providers in the medical office building of UMC, as well as other relevant provider, to provide information about opportunities at the new location.*
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	p. 35	APPROVED

Committee on Access to Critical and Urgent Care Services			
Recommendation	**Agenda**	**Page**	**Notes and Co-Chair Comments**
5. Share hospital discharge information in a timely manner.	Non-Consent (Removed from Consent during deliberations)	p. 81	APPROVED, as amended: *Recommend that the Mayor consider the final recommendations from the HIE Policy Board, which proposes to make available necessary patient information from the electronic medical record and the minimum data set that should be transmitted upon discharge to improve transitions of care.*

Committee on Allied Health Care Professionals and Workforce Development			
Recommendation	**Agenda**	**Page**	**Notes and Co-Chair Comments**
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)	p. 98	APPROVED, as amended: *Establish a health careers training consortium to strategize around and guide health workforce training investments to: accelerate the expansion of training programs for shortage and emerging (e.g. telehealth, data analytics) roles; expand early career education; recruit ESL residents; and otherwise ensure training programs are responsive to resident and health system needs.*

4. Increase and diversify incentive programs to recruit and retain clinical, non-clinical, and operations staff. 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	p. 102	TABLED Proposed Updated Recommendation: *Target provider retention by creating programs that offer incentives beyond loan repayment, such as: home buying support, rental assistance, malpractice insurance assistance, childcare benefits, and education benefits.*

5. Address barriers to standing up and/or relocating practices in DC. 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	p. 105	APPROVED, as amended: *Conduct a quality improvement review of the licensure process to address delays in all aspects of clinical licensing, and develop and implement process improvement plans to reduce turnaround time.*

6. Promote the delivery of team-based, multi-modality clinical care. 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	p. 107	TABLED Proposed Updated Recommendation: *Promote the delivery of team-based, multi-modality clinical care by conducting a review of, update as needed, and educate providers on scope of practice regulations to ensure providers can practice to the top of their training and deliver state-of-the-art medicine (e.g. telehealth, robotics, etc.).*
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.	Non-Consent	p. 109	TABLED Proposed Updated Recommendation: *Pilot a 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.*

8. Standardize the use of non-clinical patient care roles such as care coordinator, discharge planner, and community health worker. 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	p. 111	TABLED Proposed Updated Recommendation: *Promote the use of non-clinical patient care roles such as care coordinator, discharge planner, and community health worker by:* *a. Ensuring VBP initiatives calculate the actual costs of and include sufficient reimbursement to support non-clinical patient care positions* b. *Align position descriptions and titles to facilitate training, recruitment, and reimbursement of non-clinical patient care roles. Alignment will be achieved collaboratively through mechanisms such as: certifications, reimbursement policy, curriculum development, and program guidelines.*
Previously not included	Non-consent	N/A	TABLED Proposed addition (modified from the Subcommittee on Allied Health Care Professionals and Workforce Development report): *Expand pool and targeted recruitment of multi-lingual DC residents into health careers by:* *a. Establishing a Welcome Back Center to assist foreign-trained health care workers to transition into health care careers (clinical or non-clinical) in the US and provide targeted training programs (e.g. Insituto del Progreso Latino) for foreign-born/ESL residents* b. *Expanding bilingual education to DCPS schools across DC.*

Appendix B: Previously Approved Recommendations

Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care		
Recommendation	**Page**	**Status**
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).	p. 20	APPROVED
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.	p. 22	APPROVED
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.	p. 24	APPROVED
6. Pilot a city-wide model, with a focus on Wards 7 and 8, 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 peer support networks, co-management, access to maternal and fetal medicine specialty, improvement in health information exchange, and assistance with transportation.	p. 31	APPROVED 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.	p. 33	APPROVED
9. ~~Train the~~ Provide appropriate training and skill development to students in the Summer Youth Employment Program (SYEP) ~~students to be~~ to facilitate their employment in peer-to-peer health education and support. ~~community, peer, and family health educators.~~	p. 37	APPROVED 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.	p. 39	APPROVED

Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care

Recommendation	Page	Status
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.	p. 44	APPROVED

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.	p. 46	APPROVED
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.	p. 49	APPROVED
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.	p. 52	APPROVED
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. 55	APPROVED

Committee on Discharge Planning and Transitions of Care		
Recommendation	**Page**	**Status**
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. 60	APPROVED
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. 62	APPROVED

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. 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.	p. 64	APPROVED

4. Reduce barriers to operating Advanced Life Support (ALS) and Basic Life Support (BLS) transports in the district through examining licensure and regulatory obstacles. 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.	p. 69	APPROVED
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. 71	APPROVED

6. Establish a telecourt for involuntary commitment and probably 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. 73	APPROVED

Committee on Access to Critical and Urgent Care Services		
Recommendation	**Page**	**Status**
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. 74	APPROVED
2. Implement a health literacy campaign focused on when and how to access care.	p. 76	APPROVED
4. Conduct surveys and focus groups to understand resident's healthcare decision-making priorities.	p. 80	APPROVED
6. Exchange electronic advance directive forms among providers.	p. 83	APPROVED
7. Incentivize the assessment and sharing of social determinants of health during a first prenatal visit.	p. 85	APPROVED
8. Increase the capacity of primary care providers to treat substance use disorders.	p. 87	APPROVED
9. Incentivize the establishment of new Comprehensive Psychiatric Emergency Programs.	p. 89	APPROVED
10. Open Sobering Centers.	p. 91	APPROVED
11. Increase the capacity of health clinics to provide urgent care services.	p. 93	APPROVED

12. Implement cultural competence and implicit bias training for clinicians.	p. 94	APPROVED

Committee on Allied Health Care Professionals and Workforce Development		
Recommendation	**Page**	**Status**
9. ~~Strengthen systems to assess local workforce supply and demand, including training needs, through the~~ Establish~~ment of~~ a center for health care workforce analysis to: • ~~Provide recommendations on minimal data sets that should be collected through the licensure process;~~ • Systematically gather, link, and analyze national and local data on current and projected workforce supply and demand and training needs ~~and publish information on current and projected workforce supply and demand;~~ and • Develop policy documents and recommendations for District agencies, Council, or funders (e.g., shortages to be addressed, emerging industries, data to be collected through the licensure process, common core skill sets, training resources needed, career pathways, etc.) • ~~Link and analyze available data sets.~~	p. 111	APPROVED *Incorporates changes from Recommendation #1 under Allied Health Care Professionals and Workforce Development*

Appendix C: Previously Expired or Incorporated Otherwise Recommendations

Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care		
Recommendation	**Page**	**Status**
5. Facilitate integration of telehealth into medical practices.	p. 29	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. *As this recommendation is more general than those it was tabled in favor of, incorporation is not needed.*

Committee on Access to Critical and Urgent Care Services		
Recommendation	**Page**	**Status**
3. Establish peer support networks for maternal health.	p. 78	Tabled in favor of incorporation into Recommendation #6 from the Committee on Equitable Geographic Distribution of Acute, Urgent, and Specialty Care. *Recommendation was incorporated into #6.*

Committee on Allied Health Care Professionals and Workforce Development		
Recommendation	**Page**	**Status**
1. Establish a health careers intermediary to ensure training meets the demands of the health care system.	p. 95	Tabled in favor of Recommendation #9 from the Committee on Allied Health Care Professionals and Workforce Development. *Recommendation was incorporated into #9.*
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. 100	Unaddressed and expired, but overlap noted with Recommendation #9 from the Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care.