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

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I. Non-Consent Agenda

<table>
<tr><th colspan="4">Committee on Value-Based Purchasing of Health Care Services</th></tr>
<tr><th>Recommendation</th><th>Agenda</th><th>Page</th><th>Notes and Co-Chair Comments</th></tr>
<tr><td>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.</td><td>Non-Consent</td><td>p. 117</td><td>Tabled due time constraints.</td></tr>
<tr><td>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.</td><td>Non-Consent</td><td>p. 119</td><td>Tabled due time constraints, with request to make explicit in recommendation that measures are aligned with existing required measures.

Updated language included to reflect request.</td></tr>
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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	Tabled due time constraints.
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	Tabled due time constraints.

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	Tabled due Committee Chair absence. Co-Chair Recommendation – Table in Favor of Integrating into: ***Recommendation #1*** from the ***Committee on Access to Critical and Urgent Care Services***: "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)

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 due Committee Chair absence. Co-Chair Recommendation – Table in Favor of Integrating into: ***Recommendation #4*** from the ***Committee on Discharge Planning and Transitions to Care***: "Reduce barriers to operating Advanced Life Support (ALS) and Basic Life Support (BLS) transports in the district through examining licensure and regulatory obstacles." (p. 69)
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 due Committee Chair absence. Co-Chair Recommendation – Table in Favor of Integrating into: ***Recommendation #4*** from the ***Committee on Discharge Planning and Transitions to Care***: "Reduce barriers to operating Advanced Life Support (ALS) and Basic Life Support (BLS) transports in the district through examining licensure and regulatory obstacles." (p. 69)
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 due Committee Chair absence: Co-Chair Recommendation – Table in Favor of Integrating into: ***Recommendation #9*** from the ***Committee on Access to Critical and Urgent Care Services***: "Incentivize the establishment of new Comprehensive Psychiatric Emergency Programs." (p. 89) ***Recommendation #10*** from the ***Committee on Access to Critical and Urgent Care Services***: "Open Sobering Centers." (p. 91)

10. Develop incentives for use of primary care, and disincentives for use of emergency departments, for non-emergency issues.	Non-Consent	p. 57	Tabled due Committee Chair absence.
11. Support mandated enrollment in case management of all participants in publicly-funded healthcare.	Non-Consent (Removed from Consent by request)	p. 59	Tabled to November meeting, per Commission member request.

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	Executive to provide update on hospital prior to vote.
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	Tabled for discussion due to concerns regarding integrating as recommended by co-chairs Co-Chair Recommendation – Table in Favor of Integrating into: ***Recommendation #5*** from the ***Committee on Access to Critical and Urgent Care Services***: “Share hospital discharge information in a timely manner.” (p. 81)

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	Tabled to amend and for further discussion. Proposed Updated Recommendation: *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.*

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	Tabled to amend and for further discussion. Proposed Updated Recommendation: *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.*

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 to amend and for further discussion. 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.*

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<td>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.</td>
<td>Non-Consent</td>
<td>p. 105</td>
<td>Tabled until November meeting.

Proposed Updated Recommendation: 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.</td>
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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 until November meeting. 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 until November meeting. 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 to amend and for further discussion. 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	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.*

II. Approved Recommendations (Amended as Requested)[1]

Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care		
Recommendation	**Page**	**Status**
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
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

[1] Additional background and other language from the report may be incorporated, as needed.

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*

III. 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
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
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

IV. 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.