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

August 27, 2019
1152 15th Street NW, Suite 900
10:00 am – 12:00 pm

Commission Members

Name	Affiliation/ Designation	Attendance	Designee	Attendance
David Catania	Co-Chair	Present		
Sister Carol Keehan	Co-Chair	Present		
Kimberly Russo	George Washington University Hospital	Present		
Kevin Sowers	Johns Hopkins Medicine, Sibley Memorial Hospital	Present		
Oliver Johnson	MedStar Health	Present		
Dr. Malika Fair	United Medical Center	Present		
Dean Hugh Mighty	Howard University Hospital	Present		
Corey Odol	Psychiatric Institute of Washington	Present		
Denise Cora-Bramble, M.D.	Children's Hospital	Present		
Marc Ferrell	Bridgepoint	Present		
Don Blanchon	Whitman-Walker Health	Present		
Kim Horn	Kaiser Foundation Health Plan	Present		
Maria Harris Tildon	CareFirst BlueCross BlueShield	Not present		
David Stewart	University of Maryland, Family Medicine	Present		
Kelly Sweeney McShane	Community of Hope	Present		
Maria Gomez	Mary's Center	Present		
City Administrator	City Administrator	Not present	Ben Stutz	Present

Rashad Young				
Deputy Mayor Wayne Turnage	Deputy Mayor for Health and Human Services	Present		
Dr. LaQuandra Nesbitt	D.C. Health	Present		
Dr. Barbara Bazron	Department of Behavioral Health	Present		
Melisa Byrd	Department of Health Care Finance	Present		
Dr. Faith Gibson Hubbard	Thrive by Five	Present		
Chief Gregory Dean	Fire and Emergency Medical Services	Present		
Councilmember Vince Gray	Council of the District of Columbia, Committee on Health	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		
Vincent Keane	Unity Health Care	Present		
Dr. Raymond Tu	DC Medical Society	Present		
Karen Dale	AmeriHealth Caritas	Present		

Additional District Government

Name	Role	Office or Agency
Raessa Singh	Staff	Department of Behavioral Health
Fern Johnson-Clarke	Staff	DC Health
Lauren Ratner	Staff	DC Health
Amha Selassie	Staff	DC Health
Amy Mauro	Staff	Fire and Emergency Medical Services
Dr. Robert Holman	Staff	Fire and Emergency Medical Services
Noah Smith	Staff	Department of Health Care Finance

Agenda and Minutes

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

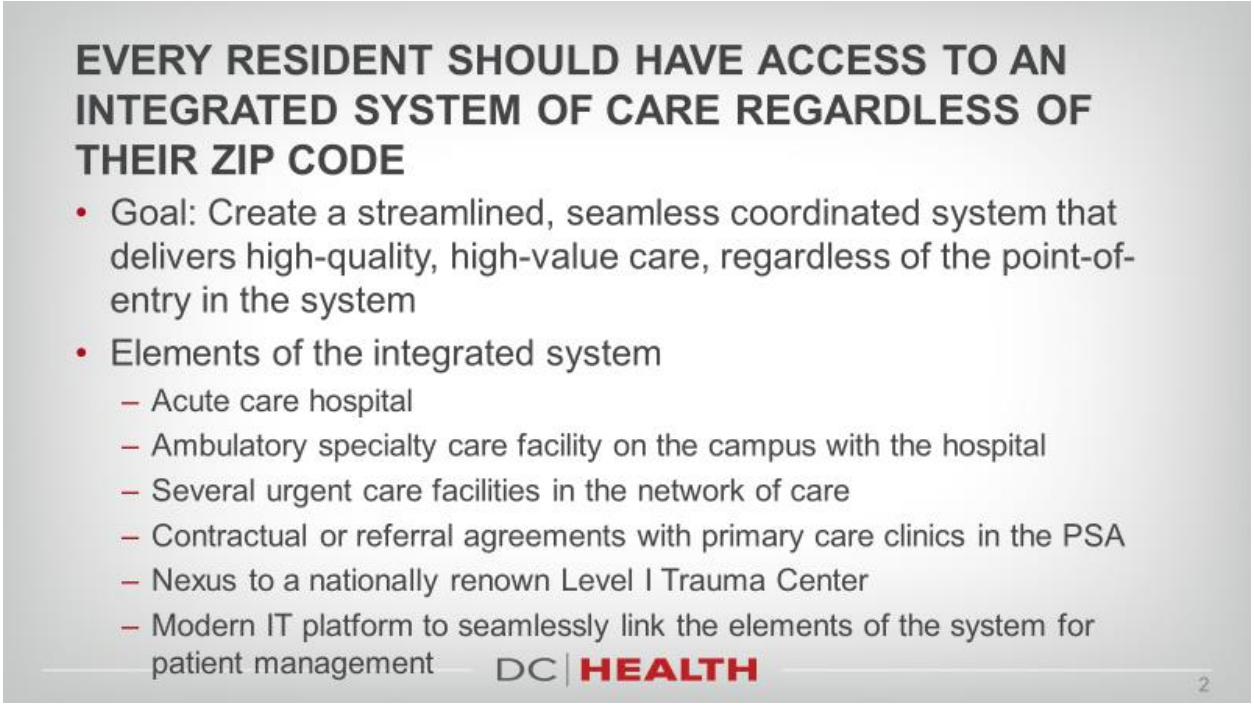
- Co-Chair David Catania called the meeting to order at 10:01 am.
- Co-Chair Sister Carol Keehan arrived at 10:30 am.

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

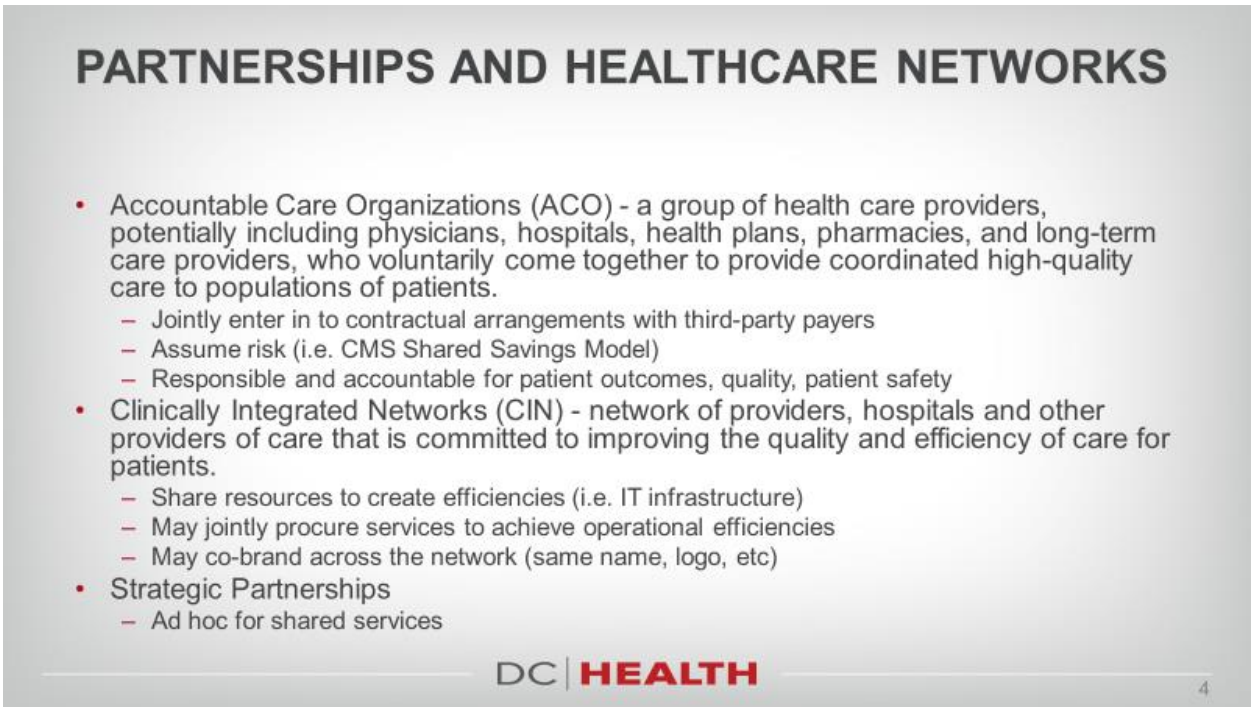
- Co-Chair Catania thanked the Commission and subcommittee members for their continued efforts and acknowledged the depth of discussions and amount of work occurring at the subcommittee level.
- Co-Chair Catania stated that the day's agenda will focus on hearing from several more key partners to inform the discussion of the Commission.

3. Presentation by the Department of Health **Dr. LaQuandra Nesbitt**

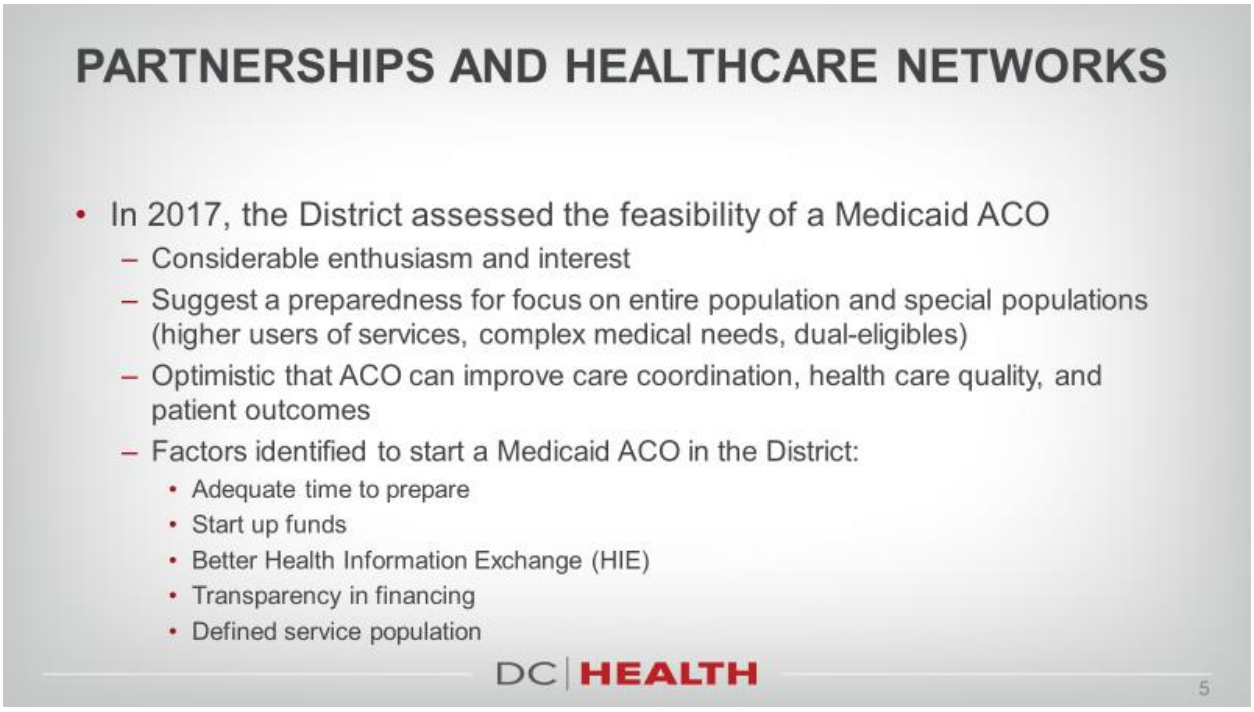
- Dr. LaQuandra Nesbitt, Director, DC Health, introduced her presentation with an overview of the goals of DC Health, focusing on health care system transformation and the work of this Commission.



- Partnerships are key to improving the health care system and are driven by the Federal government, local government and market forces.
- Accountable Care Organizations (ACOs), Clinically Integrated Networks, and ad hoc strategic partnerships among stakeholders are all examples of health care partnerships.



- In 2017, Department of Health Care Finance (DHCF) released a Request for Information (RFI) on the feasibility of forming Medicaid ACOs that resulted in considerable enthusiasm for the concept if certain factors were addressed for health care organizations taking on risk.



- Clinically Integrated Networks (CINs) generally fall into three categories as described in this slide. The District does not require CINs to register with the government and so we do not know the exact number of CINs.

PARTNERSHIPS AND HEALTHCARE NETWORKS

- Clinically Integrated Networks
  - Three typical organization types exist
    - Joint Venture Physician-Hospital Organization (PHO)
    - Health System Subsidiary
    - Independent Practice Association (IPA)
  - The District does not require CINs to register as such the actual number is unknown

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- The District's health care ecosystem is described in this slide. These represent the types of players that would participate in ACOs, CINs and other partnerships.

DC HEALTHCARE ECOSYSTEM

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- Partnerships among health care organizations, working together to share financial risk and financial gain, as well as collaborating to improve the quality of care, can result in more efficient care with better outcomes. Formal partnerships can also help reduce health disparities in the District.

- Population health management refers to how providers and government leaders ensure positive health outcomes for communities and individual groups of patients.

- The District has experienced an overall decline in inpatient visits as care has been shifted to the home and clinics. Some hospitals have seen declines while others have seen increases.

District of Columbia Acute Care Hospital Admissions Comparisons 2017 to 2018

	2017	2018	% Change
Children's National Health System	15,257	15,911	4.3%
The George Washington University Hospital	19,734	20,420	3.5%
Howard University Hospital	7,972	8,110	1.7%
MedStar Georgetown University Hospital Center	15,414	15,390	-0.2%
MedStar Washington Hospital Center	33,144	32,548	-1.8%
Providence Hospital-Ascension	9,562	4,878	-49%
Sibley Memorial Hospital-Johns Hopkins Medicine	11,998	12,182	1.5%
United Medical Center	5,230	5,256	-0.5%
Acute Total	118,311	114,695	-3.1%

*Admissions at Saint Elizabeths Hospital decreased 7.5% and Psychiatric Institute of Washington increased 19.9%
Source: District of Columbia Hospital Association Utilization Indicators Calendar Year 2018 Report, Issued March 2019

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- The causes for inpatient visits and the cause of deaths do not always align as seen in the following two slides.

2018 Top 10 Leading Causes of Death, District of Columbia

Rank	Leading Cause of Death	Frequency	Percent
1	DISEASES OF THE HEART	1,113	26.85
2	MALIGNANT NEOPLASMS	893	21.54
3	ACCIDENTS (UNINTENTIONAL INJURIES)	349	8.42
4	CEREBROVASCULAR DISEASES	198	4.78
5	CHRONIC LOWER RESPIRATORY DISEASES	133	3.21
6	ASSAULT (HOMICIDE)	117	2.82
7	DIABETES MELLITUS	116	2.80
8	ALZHEIMER'S DISEASE	89	2.15
9	ESSENTIAL (PRIMARY) HYPERTENSION	66	1.59
10	INFLUENZA AND PNEUMONIA	64	1.54

Data Source: 2018 DC Mortality File as of 8/26/2019; Vital Records Division, DC Department of Health.

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LEADING DIAGNOSES AMONG DC-RESIDENT INPATIENT HOSPITALIZATIONS, CALENDAR YEAR 2018

	Hospital									
	WHC	GWUH	HUH	SIBLEY	UMC	GTUH	CNMC	PROV	NRH	Total
Leading Cause Categories[1]	N	N	N	N	N	N	N	N	N	N
Diseases of the Circulatory System	3,408	1,967	840	364	764	477	50	675	237	8,782
Complications of Pregnancy, Childbirth, and Puerperium	2,388	2,616	1,201	2,012	4	542	0	3	0	8,766
Mental Disorders	1,991	756	601	341	1,007	276	510	72	0	5,554
Injury and Poisoning	1,545	1,068	821	306	252	399	210	216	110	4,927
Diseases of the Digestive System	1,393	948	574	448	441	407	189	463	0	4,863
Diseases of the Respiratory System	1,029	672	419	228	483	241	1,284	466	0	4,822
Infectious and Parasitic Diseases	1,184	749	565	315	505	343	146	487	0	4,294
Diseases of the Musculoskeletal System and Connective Tissue	662	557	198	401	95	406	84	240	12	2,655
Diseases of the Genitourinary System	651	562	259	183	305	152	74	246	0	2,432
Endocrine, Nutritional and Metabolic Diseases, and Immunity	674	585	330	123	0	156	171	299	1	2,339
Neoplasms	668	544	158	285	40	318	45	115	1	2,174
Symptoms, Signs, and Ill-Defined Conditions	523	347	234	51	108	150	131	90	65	1,699
Diseases of the Nervous System and Sense Organs	307	396	187	67	160	181	170	96	80	1,644
Diseases of the Blood and Blood-Forming Organs	292	210	285	49	97	96	225	55	0	1,309
Supplementary Classifications	172	216	88	53	27	87	73	6	238	960
Diseases of the Skin and Subcutaneous Tissue	220	247	104	88	102	73	66	56	0	956
Certain Conditions Originating in the Perinatal Period	4	0	0	4	0	30	228	0	0	266
Congenital Anomalies	18	20	3	0	0	16	140	2	0	199
Ungroupable Diagnoses	38	38	13	2	2	12	25	1	0	131
Encounter for full-term uncomplicated delivery	42	27	32	11	0	6	0	0	0	118
Missing primary diagnosis code	29	0	14	0	0	3	2	2	0	50
Total	**17,238**	**12,525**	**6,926**	**5,331**	**4,392**	**4,371**	**3,823**	**3,590**	**744**	**58,940**

[1] Leading cause categories are based on primary diagnoses. To reduce double-counting for delivery hospital stays, newborns are excluded from this table. The total number of inpatient hospitalizations will not match the overall total number of inpatient hospitalizations, which includes delivery and newborn hospitalizations.

Data Source: Preliminary 2018 Hospital Discharge Data, DC Hospital Association. Results are preliminary as of August 23, 2019. **Compiled by:** State Health Planning and Development Agency (SHPDA), Center for Policy, Planning and Evaluation, DC Department of Health.

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- DC Fire Emergency Medical Service (FEMS) data also shows that emergency department transports have decreased for some hospitals and increased for others. Overall it has decreased between 2017 and 2018.

District of Columbia DC EMS Transports by Hospital FY2017 to FY2018

	FY2017	FY2018	% Change
Children's National Health System	4,453	4,817	8.2%
The George Washington University Hospital	18,852	19,596	3.9%
Howard University Hospital	14,830	14,409	-2.8%
MedStar Georgetown University Hospital Center	3,374	3,125	-7.4%
MedStar Washington Hospital Center	22,129	24,945	12.7%
Providence Hospital-Ascension	13,483	13,047	-3.2%
Sibley Memorial Hospital-Johns Hopkins Medicine	3,254	3,182	-2.2%
United Medical Center	15,300	16,337	6.8%
Children's National @ UMC	2,378	893	-62.4%
Other/Unknown	8,819	3,144	-64.3%
Acute Total	106,872	103,495	-3.2%

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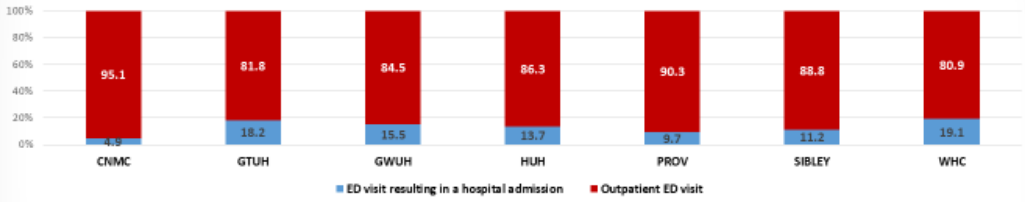
- Among emergency department (ED) admissions, 80-95% resulted in a discharge to outpatient care, including to home.

DATA CAVEAT: DC HEALTH DOES NOT RECEIVE OUTPATIENT DATA FROM UNITED MEDICAL CENTER

DISTRIBUTION OF TOTAL ADMISSIONS TO EMERGENCY DEPARTMENTS BY TYPE OF ADMISSION AND HOSPITAL AMONG HOSPITALS WITH COMPLETE INPATIENT AND OUTPATIENT DATA, CALENDAR YEAR 2018



➢ ***Among District of Columbia hospitals with complete Outpatient and Inpatient data available, 80% - 95% of total emergency department admissions are Outpatient.***

Data Source: Preliminary 2018 Inpatient and Outpatient Hospital Discharge Data, DC Hospital Association, DC Hospital Association. Results are preliminary as of August 23, 2019. **Compiled by:** State Health Planning and Development Agency (SHPDA), Center for Policy, Planning and Evaluation, DC Department of Health. The Outpatient Emergency Department (ED) data file excludes patients admitted to the hospital from the ED. The Inpatient data file include records from all patients admitted to inpatient services. ED records for this analysis include 1) Outpatient ED Records for all patients in the Outpatient ED file, and 2) Inpatient records for all patients who presented at the ED, based on an indicator flag located on the Inpatient file.

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- Leading diagnoses for ED admissions are presented in this slide. The leading diagnosis is for symptoms or signs that are ill-defined, meaning there is no primary diagnosis. This indicates that many ED visits may not be necessary and could be addressed at other sites.

LEADING DIAGNOSES AMONG DC-RESIDENT TOTAL ADMISSIONS TO EMERGENCY DEPARTMENTS, CALENDAR YEAR 2018

	Hospital								
	WHC	CNMC	GWUH	HUH	PROV	SIBLEY	GTUH	UMC	TOTAL
Leading Cause Categories[1]	N	N	N	N	N	N	N	N	N
Symptoms, Signs, and Ill-Defined Conditions	14,895	7,989	11,126	6,089	5,294	4,367	3,629	106	53,495
Injury and Poisoning	9,637	12,132	8,337	6,505	6,076	5,734	2,667	243	51,331
Diseases of the Respiratory System	4,721	16,539	3,743	3,304	3,846	1,869	1,186	481	35,689
Diseases of the Musculoskeletal System and Connective Tissue	7,637	1,907	5,722	4,123	3,710	1,731	1,672	91	26,593
Diseases of the Digestive System	4,099	3,154	2,904	2,780	2,457	1,746	905	435	18,480
Mental Disorders	4,749	1,069	3,605	2,848	1,874	1,165	827	938	17,075
Diseases of the Genitourinary System	3,415	1,304	2,932	1,896	2,038	1,442	851	300	14,178
Infectious and Parasitic Diseases	1,753	6,649	1,711	1,184	1,048	629	506	502	13,982
Diseases of the Circulatory System	4,481	134	2,660	1,359	1,475	951	656	753	12,469
Other Diagnoses	1,367	5,576	982	995	657	443	330	2	10,352
Diseases of the Skin and Subcutaneous Tissue	1,745	2,977	1,701	1,084	1,100	775	462	100	9,944
Supplementary Classifications	1,384	2,696	1,213	1,219	848	637	223	25	8,245
Complications of Pregnancy, Childbirth, and Puerperium	2,243	58	1,571	1,065	613	544	341	4	6,439
Diseases of the Nervous System and Sense Organs	988	771	1,184	1,024	951	628	293	157	5,996
Endocrine, Nutritional and Metabolic Diseases, and Immunity	1,213	438	1,103	982	962	352	252	0	5,302
Diseases of the Blood and Blood-Forming Organs	531	485	440	729	135	163	151	97	2,731
Neoplasms	494	62	370	129	176	223	196	36	1,686
Certain Conditions Originating in the Perinatal Period	1	453	4	5	1	4	19	0	487
Congenital Anomalies	14	77	15	4	11	4	6	0	131
Total	**65,367**	**64,470**	**51,323**	**37,324**	**33,272**	**23,407**	**15,172**	**4,270**	**294,605**

[1] Leading cause categories are based on primary diagnoses.

Data Source: Preliminary 2018 Inpatient and Outpatient Hospital Discharge Data, DC Hospital Association. Results are preliminary as of August 23, 2019. **Compiled by:** State Health Planning and Development Agency (SHPDA), Center for Policy, Planning and Evaluation, DC Department of Health. The Outpatient Emergency Department (ED) data file excludes patients admitted to the hospital from the ED. The Inpatient data file include records from all patients admitted to inpatient services. ED records for this analysis include 1) Outpatient ED Records for all patients in the Outpatient ED file, and 2) Inpatient records for all patients who presented at the ED, based on an indicator flag located on the Inpatient file. DC Health does not receive outpatient data from United Medical Center; United Medical Center data in this presentation is based on inpatient hospital discharge data only. Data from National Rehabilitation Hospital are excluded (n=19).

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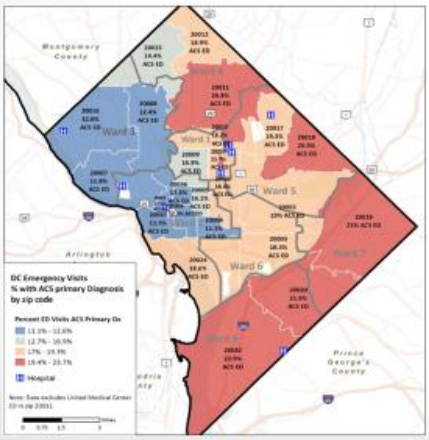
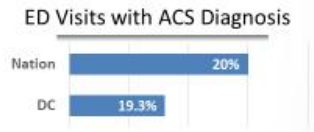
- This map depicts the number of ED visits that may be less acute and could be addressed at other sites, by Ward. The highest rates of low acuity ED visits occurred in Wards 5, 7 and 8.

Emergency Departments (ED) Ambulatory Care Sensitive (ACS) Visits

Emergency Department Visits with ACS Primary Diagnosis by Zip Code (2014)



Overall, the District is slightly below the national average of ED visits falling into the ACS diagnostic categories (e.g. asthma, severe Ear, Nose, Throat infections, and iron deficiency anemia).



Almost all of Ward 7 & 8, and parts of Ward 4 & 5 have higher rates of utilizing the ED for ACS conditions.

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Source: District of Columbia. DC Department of Health. Primary Care Office. *District of Columbia Primary Care Needs Assessment. By* John Snow, Inc. 2018. pp. 66 - 67. Print.

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- The District should identify critical disease processes and population types that represent the best opportunities to reduce unnecessary utilization and improve outcomes.

POPULATION HEALTH MANAGEMENT

- Effective population health management is critical to the success of value based payment and health system transformation initiatives
- Public health and clinical care collaboration increases the likelihood of success of population health management initiatives

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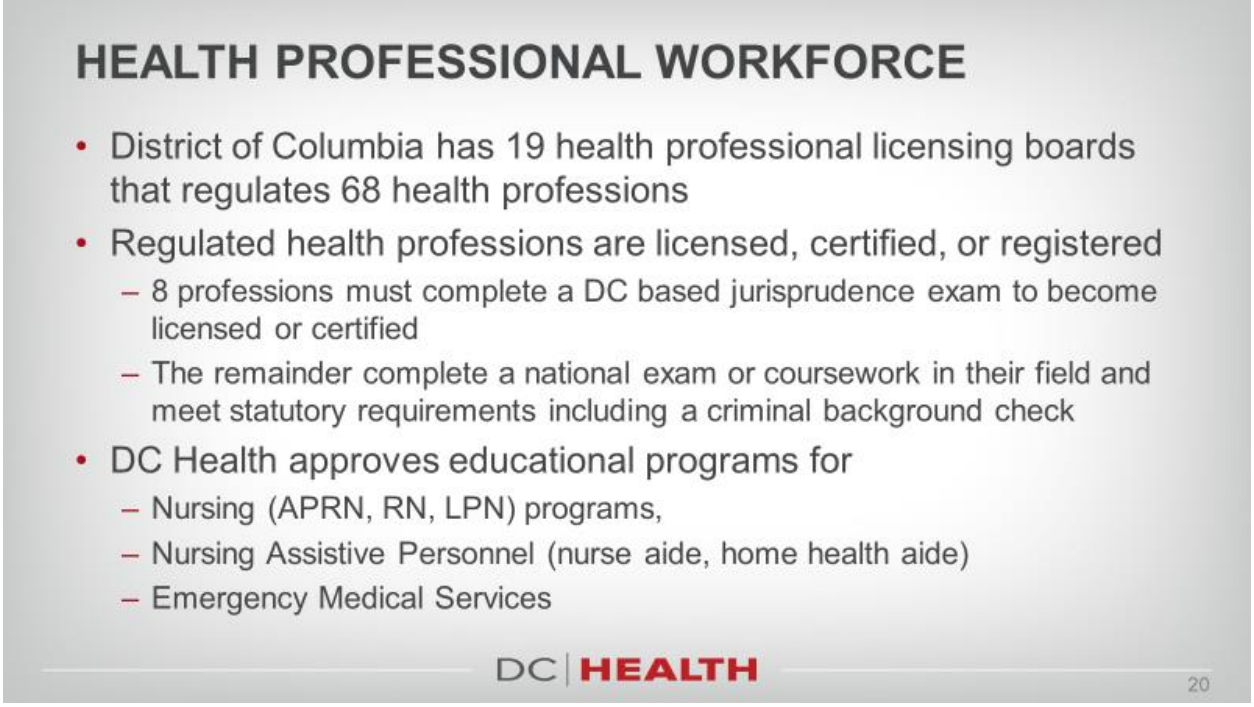
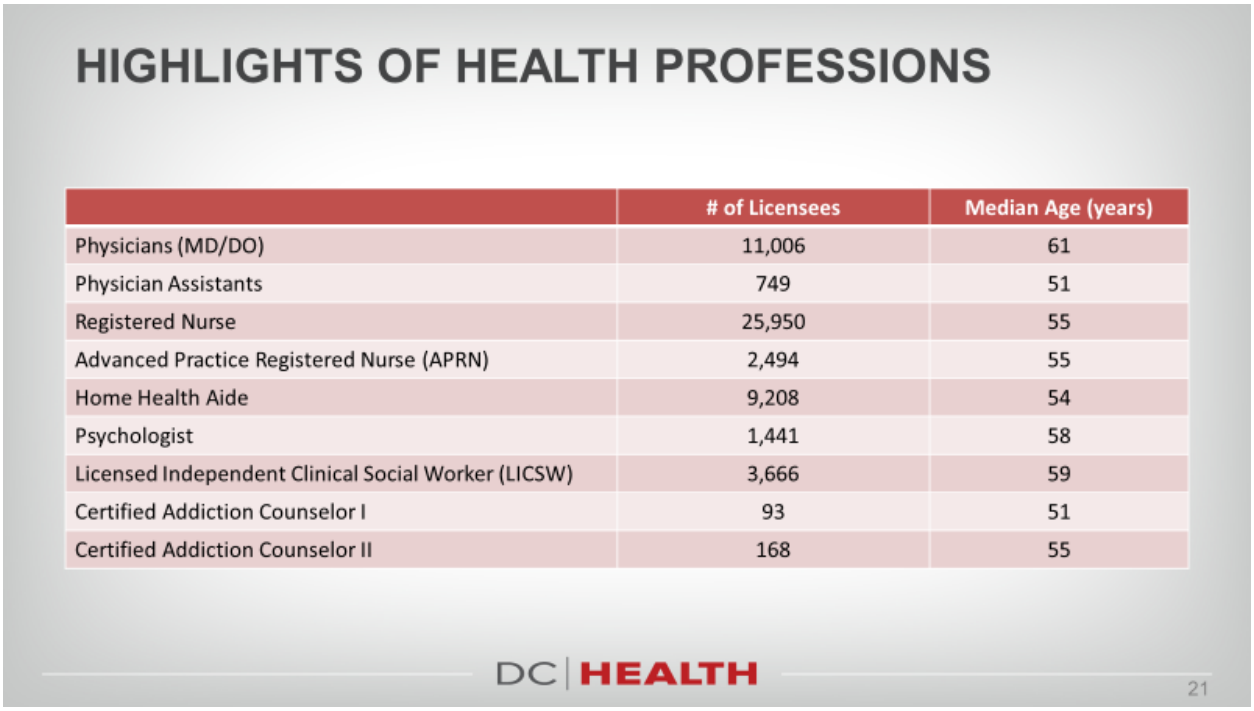
- Dr. Nesbitt introduced DC Health's role in ensuring the availability and training of the health care workforce.

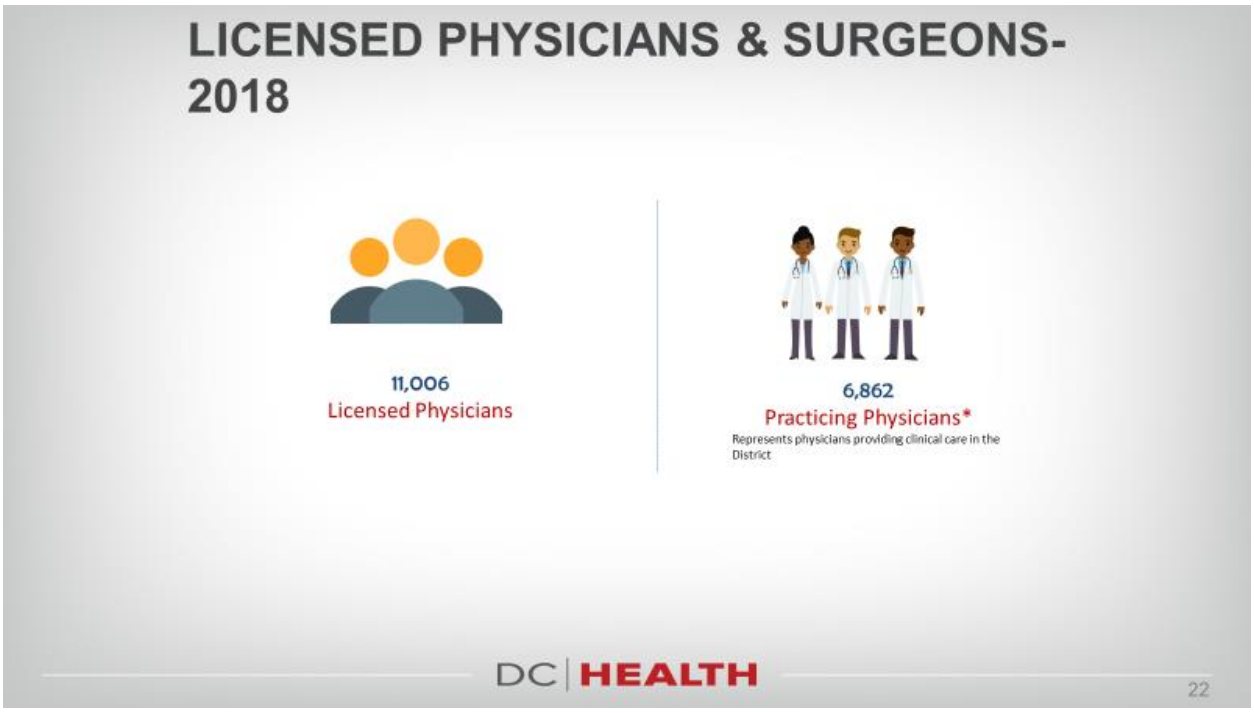


- The District's licensed health professionals trend toward higher ages, which may represent a risk for the health system.

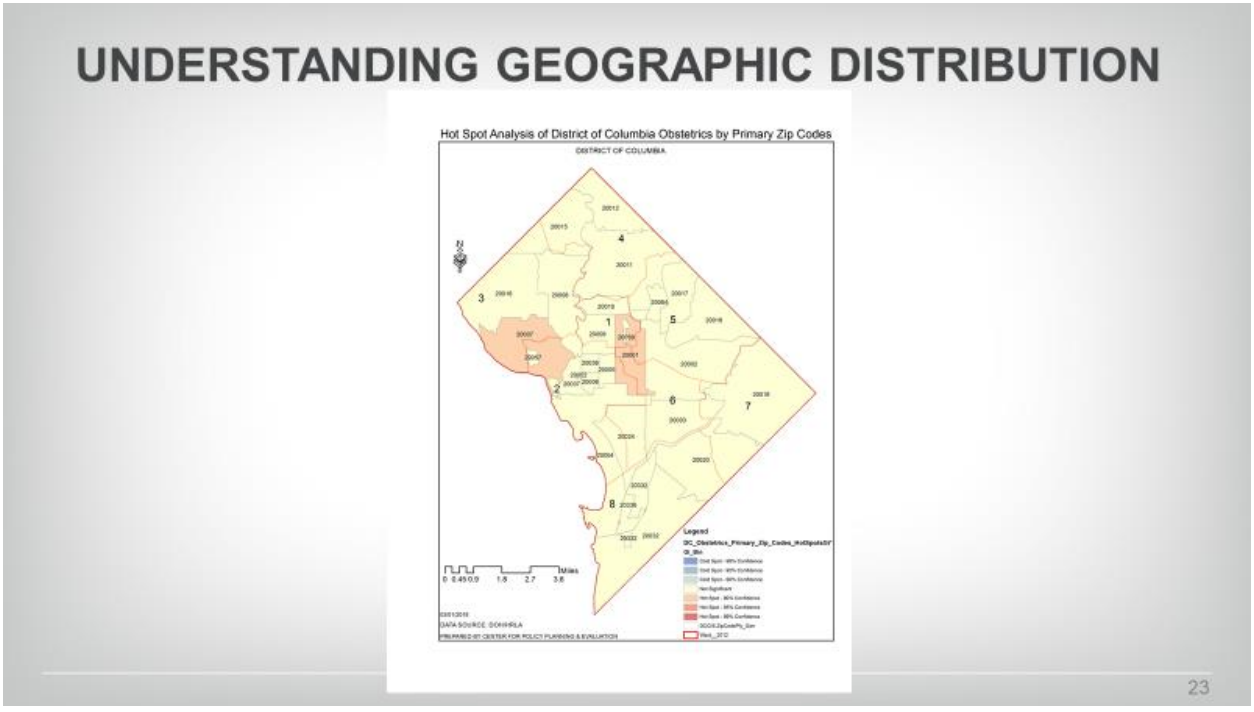


	# of Licensees	Median Age (years)
Physicians (MD/DO)	11,006	61
Physician Assistants	749	51
Registered Nurse	25,950	55
Advanced Practice Registered Nurse (APRN)	2,494	55
Home Health Aide	9,208	54
Psychologist	1,441	58
Licensed Independent Clinical Social Worker (LICSW)	3,666	59
Certified Addiction Counselor I	93	51
Certified Addiction Counselor II	168	55

- There is a distinction between providers who are licensed by the District and those who practice in the District full-time.



- The following three slides depict hot spots and cold spots of the distribution of different types of health professionals (Obstetrics, Cardiologists, and Oncologists). There are several hot spots, but no cold spots for these types of providers in the District.



UNDERSTANDING GEOGRAPHIC DISTRIBUTION

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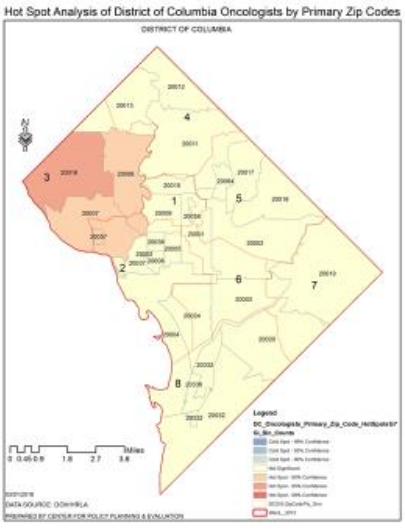
UNDERSTANDING GEOGRAPHIC DISTRIBUTION



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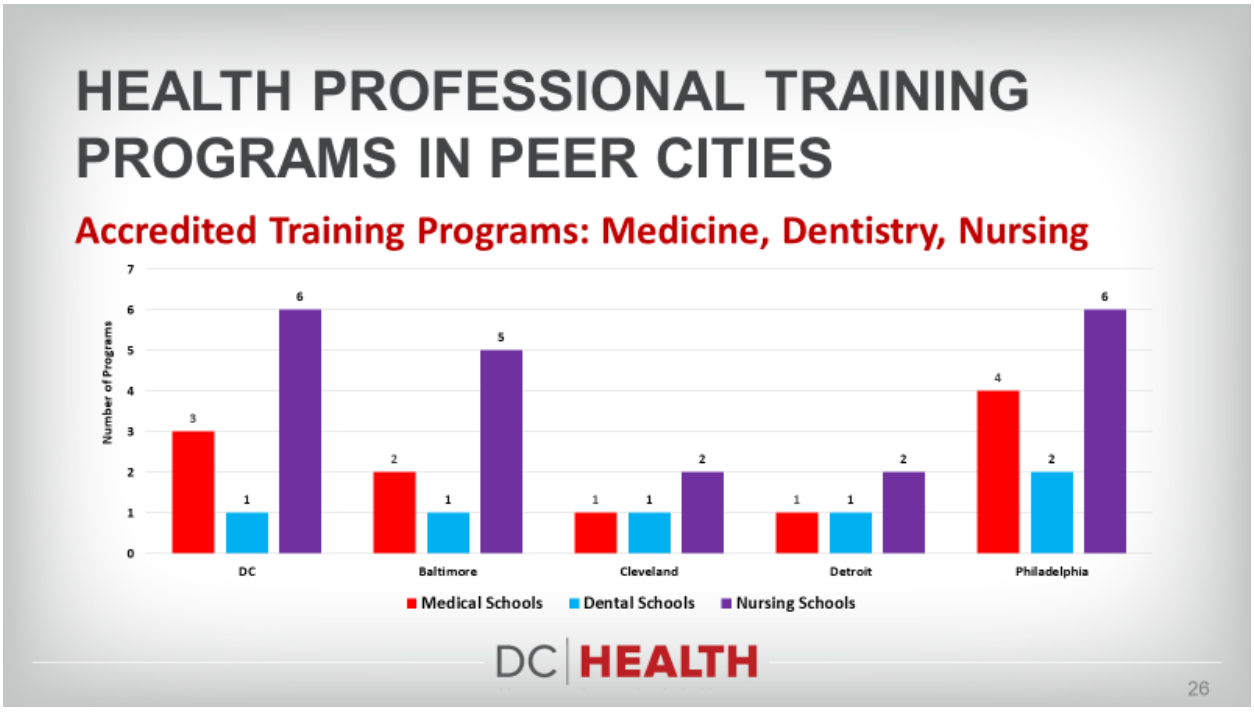
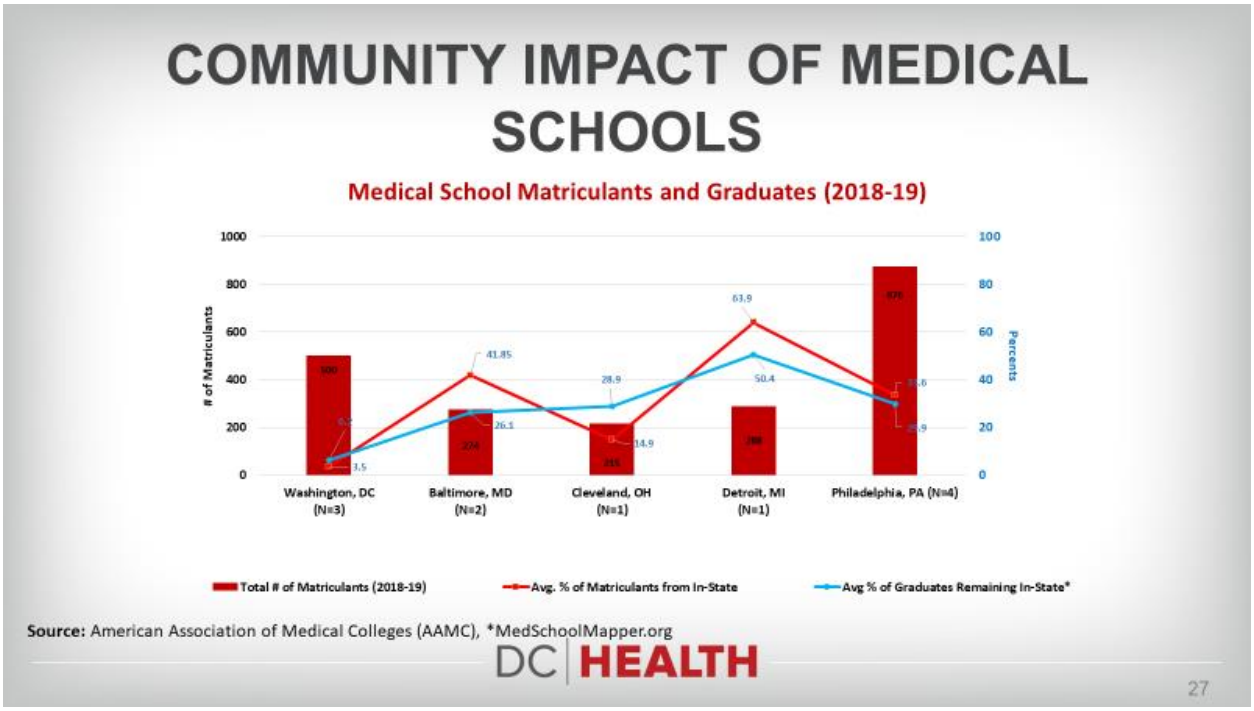
- Dr. Nesbitt noted that many organizations, such as Kaiser Permanente, require their providers to be licensed in DC, Maryland and Virginia.
- Kim Horn stated that Kaiser Permanente requires this because of the opportunity to provide telehealth services to members in different states.

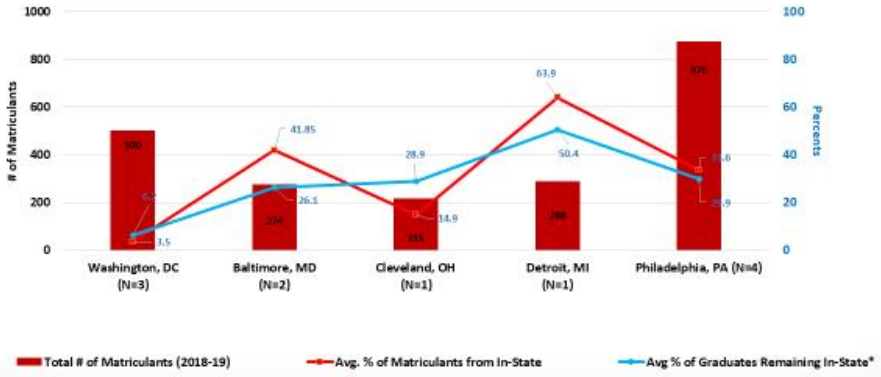
- The following two slides depict how the District compares to several peer cities regarding the number of accredited training programs in medicine, dentistry and nursing. The four following slides depict how the District does not retain as many providers who trained here as other cities.





COMMUNITY IMPACT OF MEDICAL SCHOOLS

Medical School Matriculants and Graduates (2018-19)



Source: American Association of Medical Colleges (AAMC), *MedSchoolMapper.org

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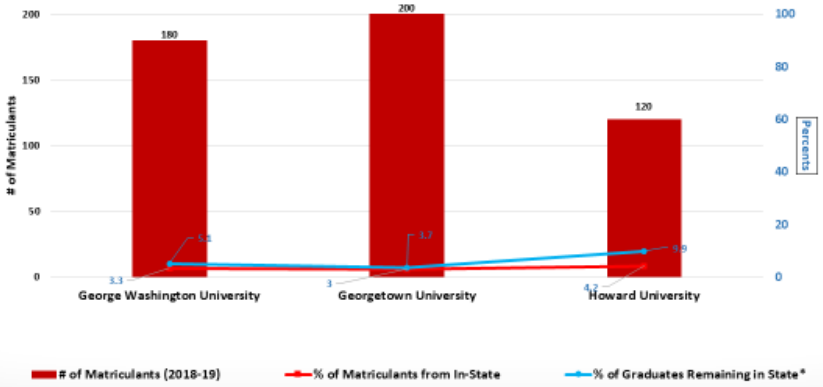
COMMUNITY IMPACT OF DC MEDICAL SCHOOLS

DC Medical Schools (2018-19)



Sources: American Association of Medical Colleges (AAMC); *MedSchoolMapper.org

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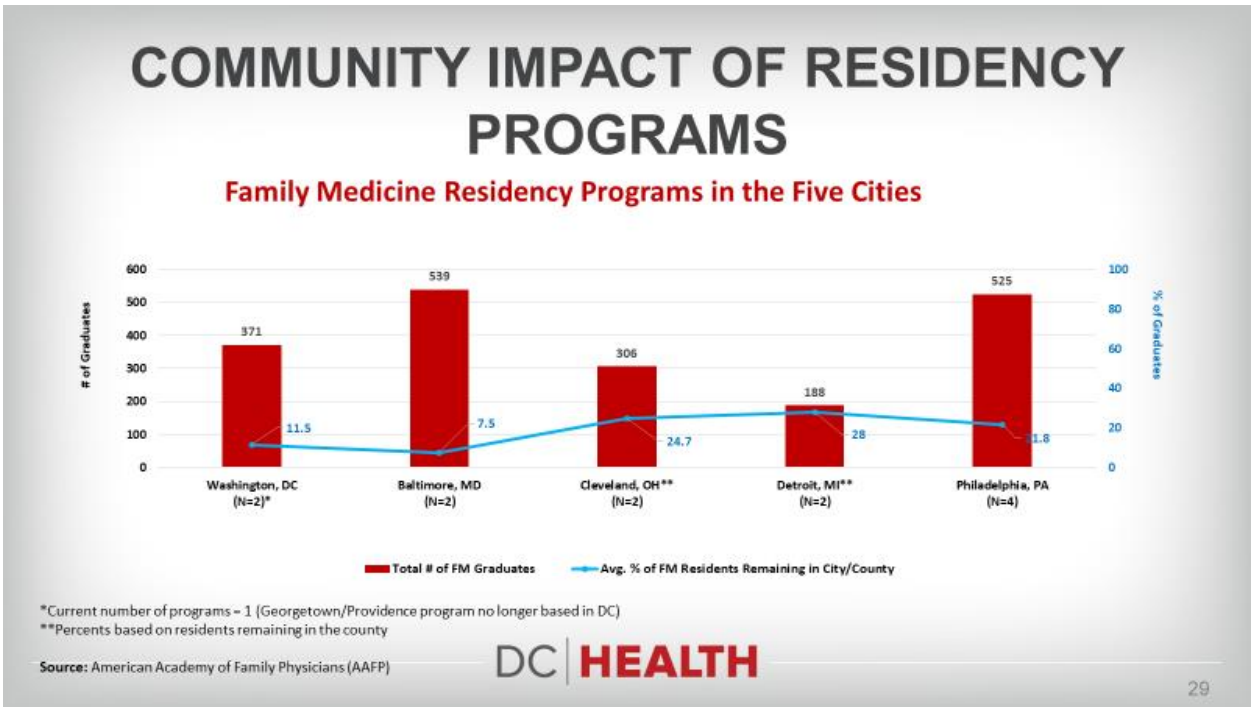
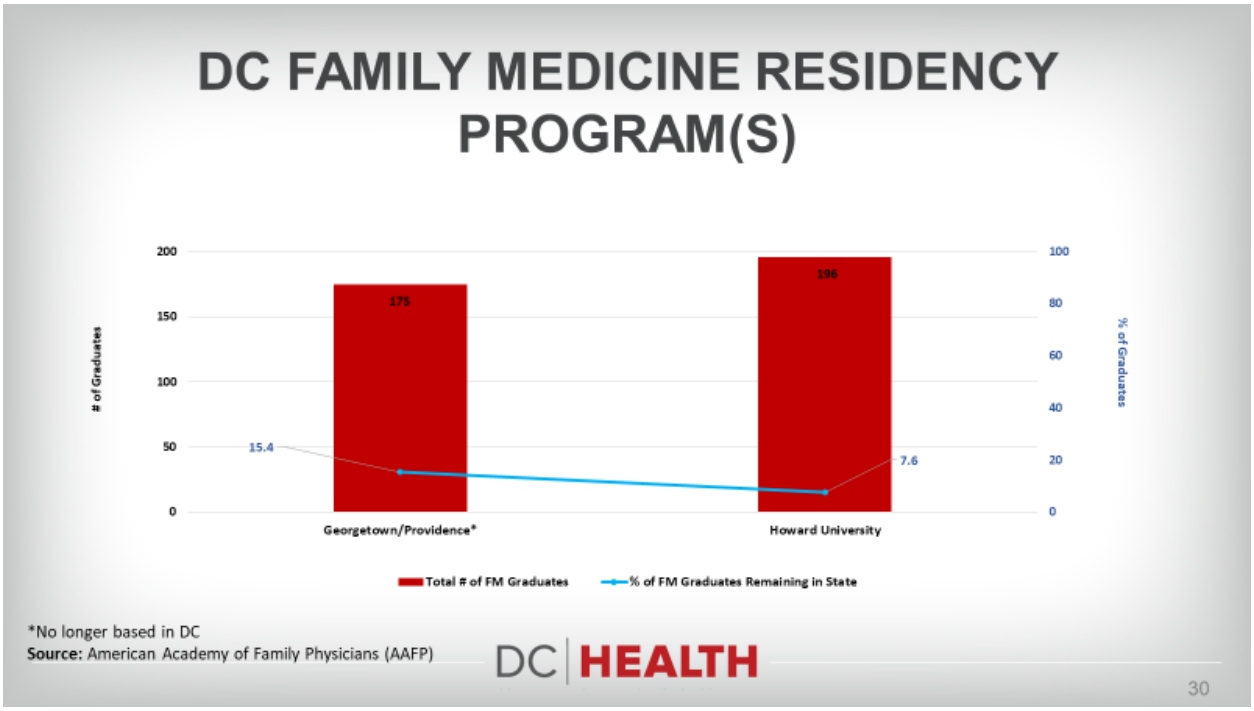
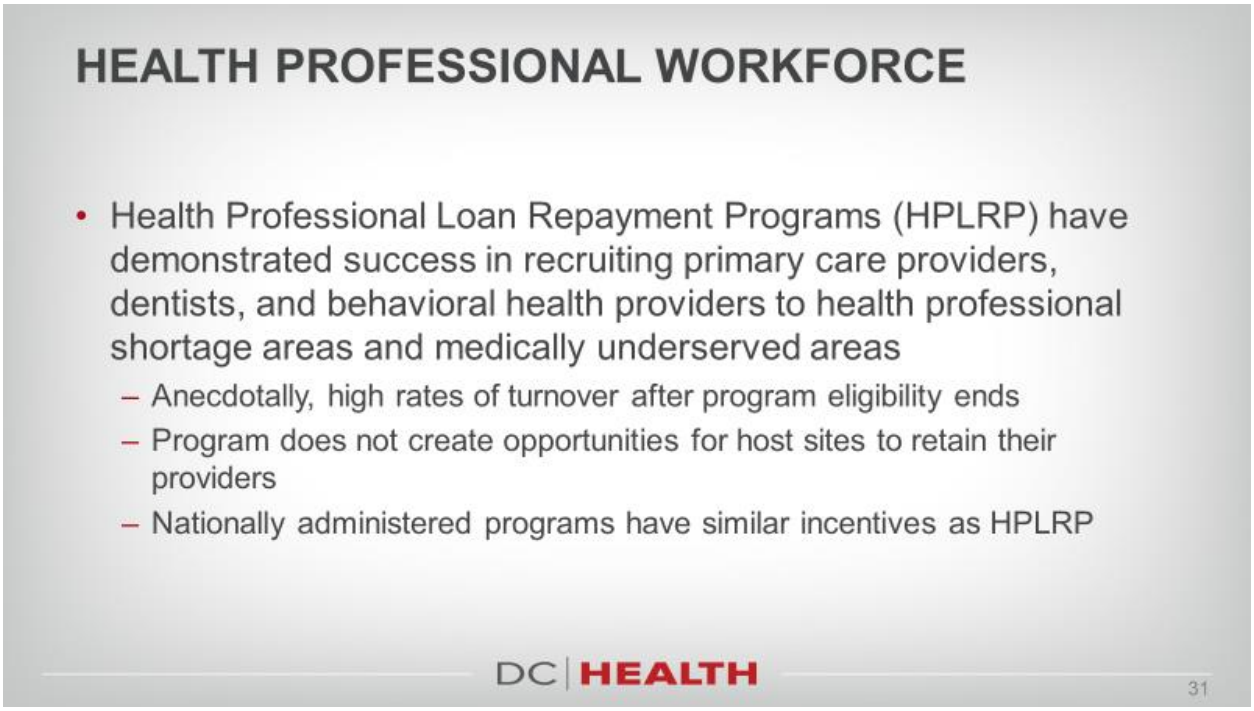


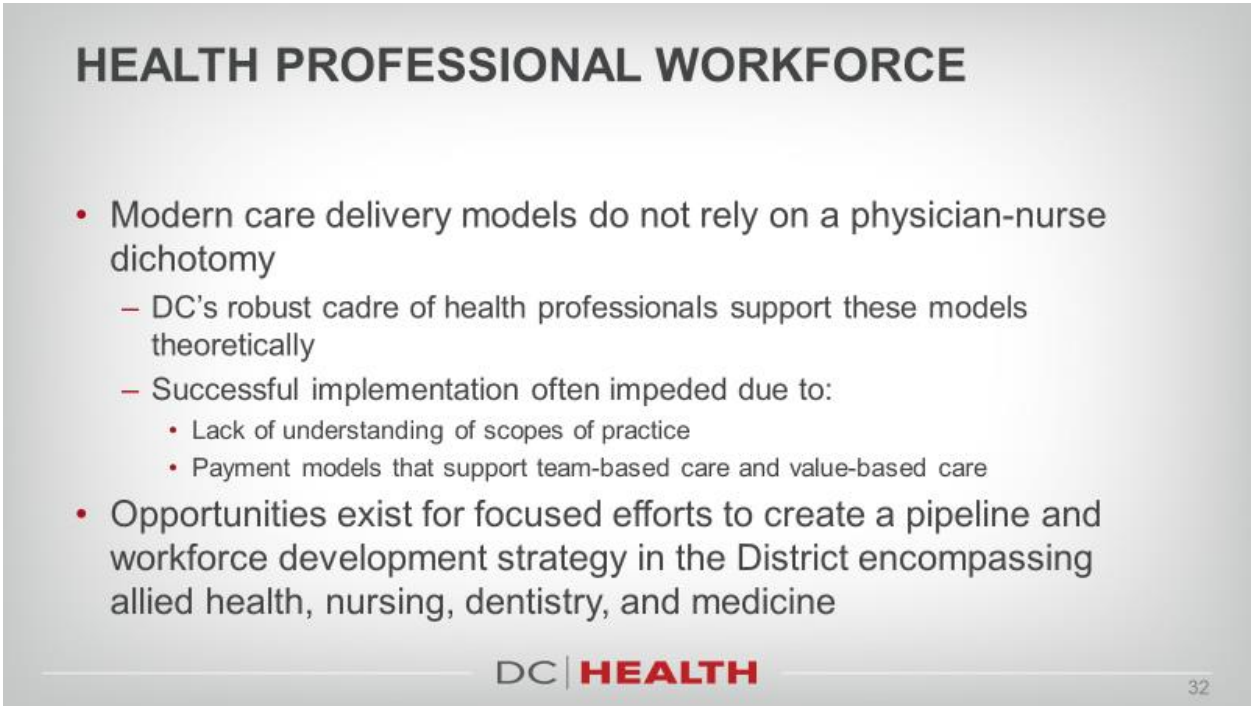


- Dr. Mighty and Vince Keane stated that Unity's family medicine residency program may not be included in the DC Health data.

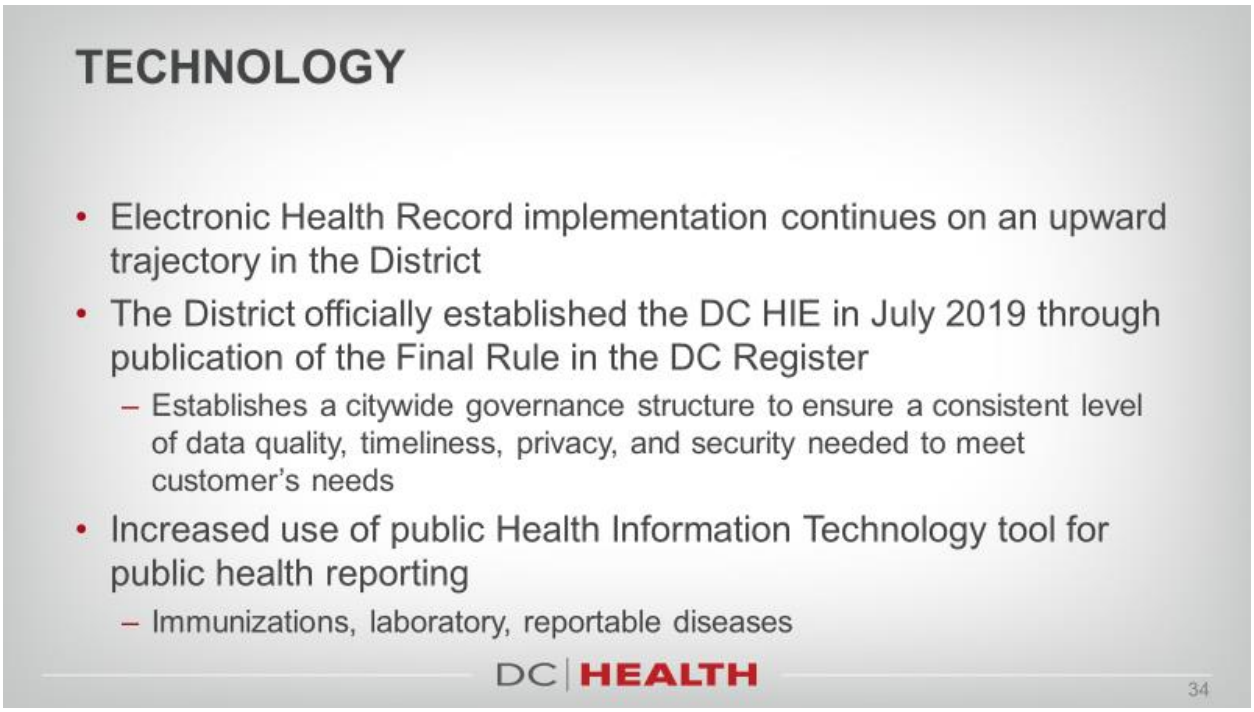
- The Health Professional Loan Repayment Program has successfully recruited primary care providers to serve in the District's health shortage areas, but anecdotally those providers often do not stay beyond the time that is incentivized by the program.



- Dr. Nesbitt described how there are many opportunities to create a pipeline for health professionals to be trained and practice for long periods of time in the District.



- The District has invested heavily in the foundations of health information exchange, including electronic health record (EHR) incentives through DHCF.
- DHCF also recently published a final rule to govern the DC HIE to ensure consistent access to high-quality patient information is available to all providers.



- Telehealth remains a major opportunity to help residents avoid EMS and ED utilization.

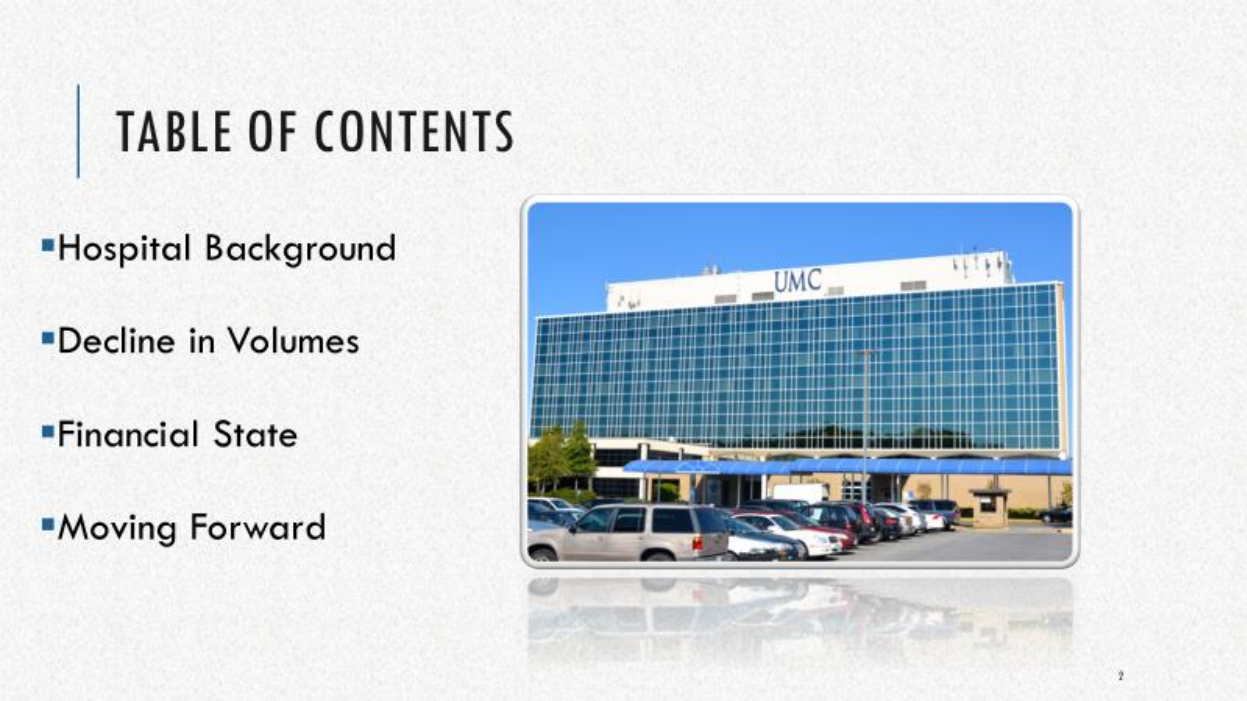
- New technology, such as personalized medicine and new approaches to care.

- The following two slides summarize Dr. Nesbitt's presentation. DC Health is prioritizing approaches that reduce reliance on inpatient services and increase the use of more efficient, technology enabled, solutions to health system transformation.

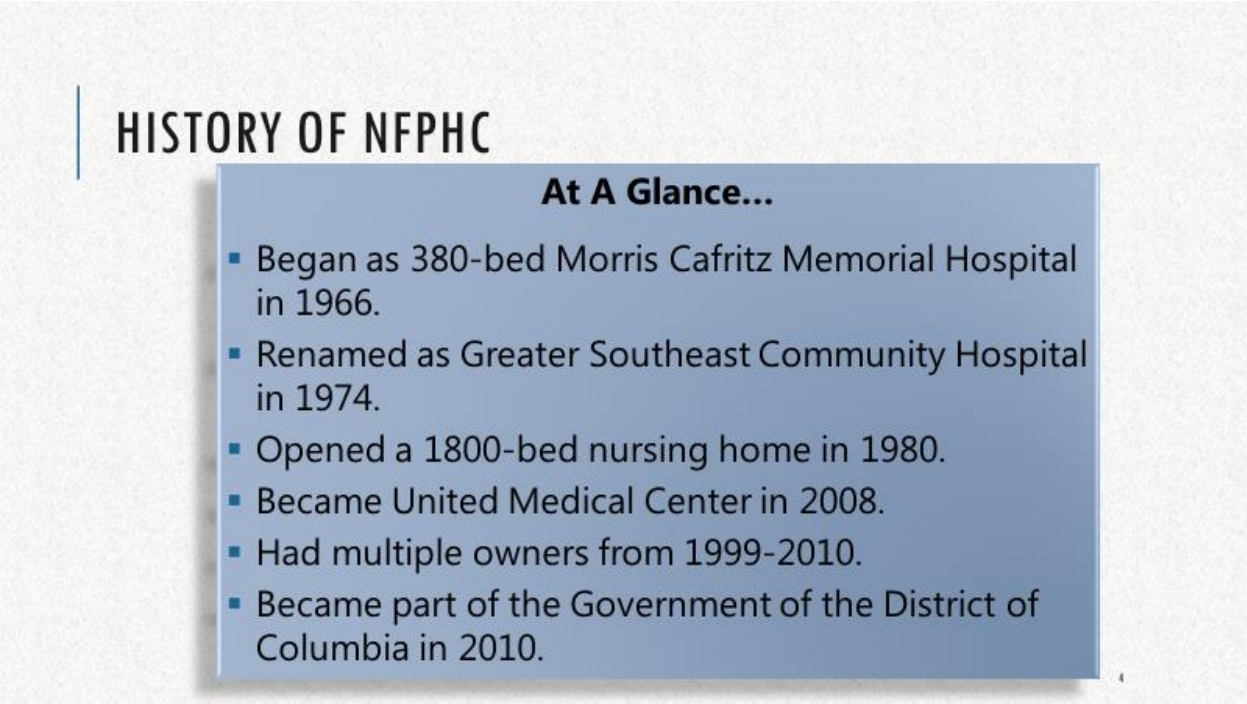
- Co-Chair Catania thanked Dr. Nesbitt for her presentation and the efforts of her team at the DC Health. Co-Chair Catania lauded the health care leadership of the city today and stated that he is confident that should this Commission provide thoughtful recommendations to the Mayor, she has the team in place to implement them effectively.
- Co-Chair Catania requested that at the next meeting DC Health, DHCF and Department of Behavioral Health (DBH) each present 5 minutes on the landscape of rules, reimbursement and utilization of telemedicine as well as the District's participation in interstate compacts to help facilitate telemedicine.

4. Presentation by United Medical Center **Dr. Malika Fair**

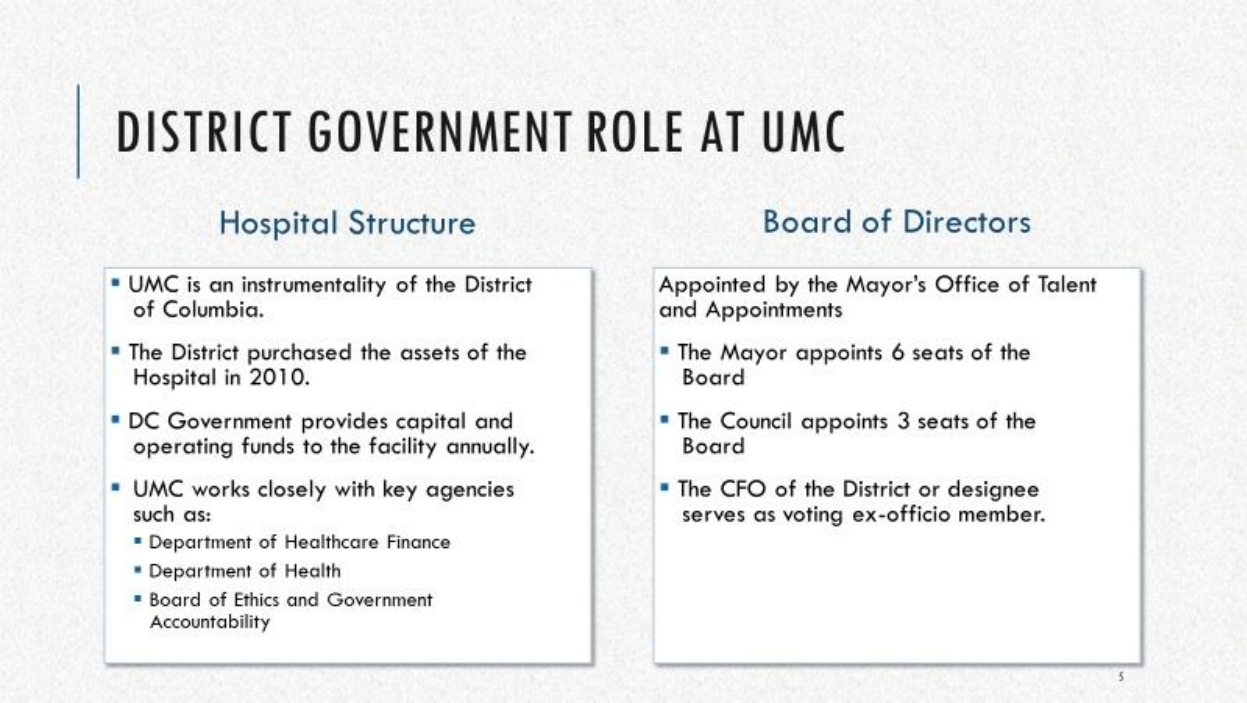
- Co-Chair Catania introduced Dr. Malika Fair, an emergency physician at the George Washington University Medical Faculty Associates and a member of the Board of Directors at United Medical Center (UMC).
- Dr. Fair introduced herself and offered regrets from LaRuby May, Chair of the Board of Directors at UMC who was unable to attend today.
- Dr. Fair is a Ward 7 resident and recognizes a difference between the stories she hears about UMC from her neighbors and those from hospital staff.
- Dr. Fair said she will present information today that is often not heard in media reports, including the decline in encounter volume at the hospital, the financial state of the hospital and the path forward under the leadership of the District government and the hospital operator.



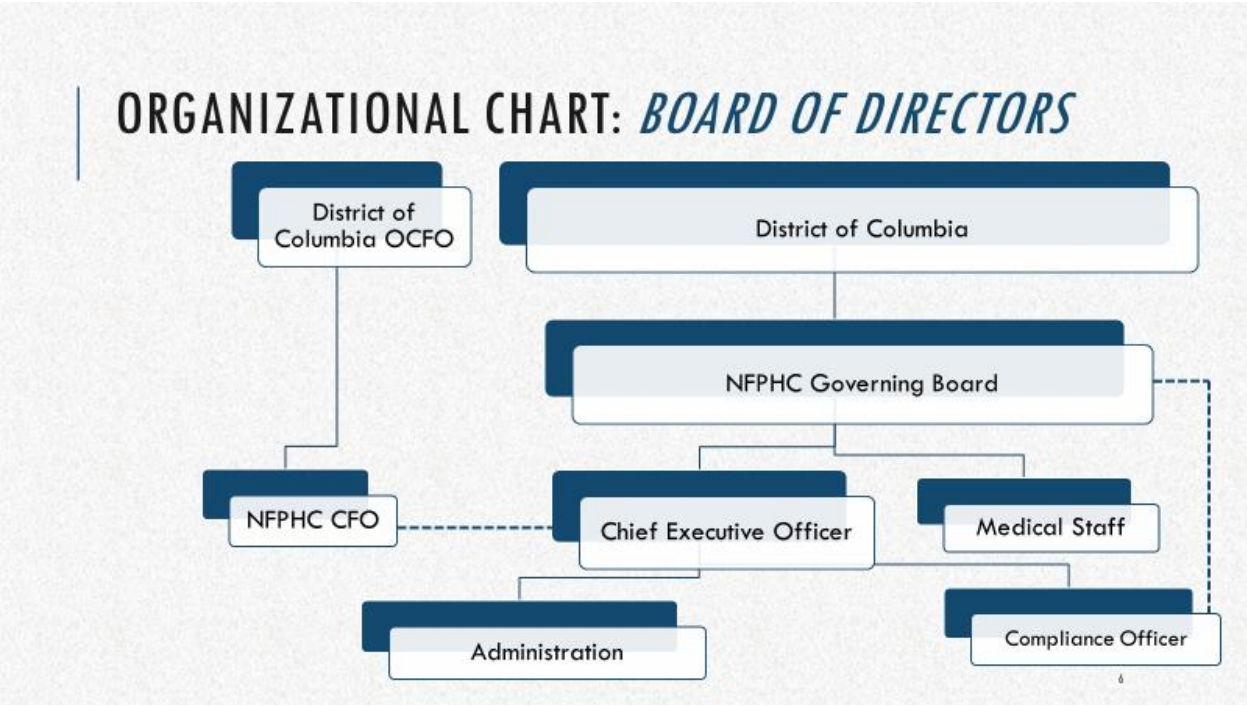
- Dr. Fair presented the history of the hospital at the site of UMC.



- UMC's governance structure is unique, including how it is an instrumentality of the District of Columbia.



- Dr. Fair presented the organization chart for UMC.



- UMC has had several operators throughout its history and today is operated by Mazars USA, who provides a full compliment of C-Suite leaders for the hospital.

UMC MANAGEMENT CONTRACT

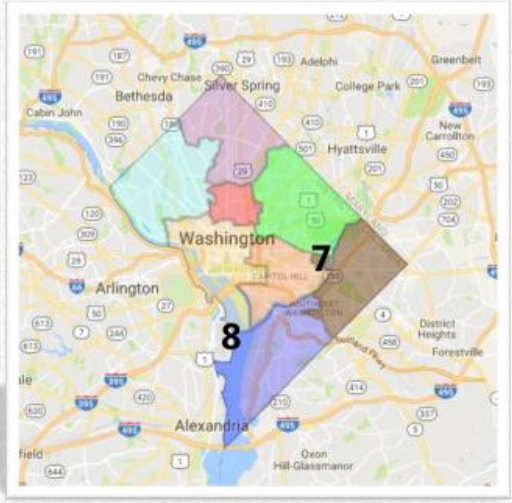
- Mazars USA joined the United Medical Center team in February 2018 as the administrative group charged with the executive oversight of the Hospital
- Mazars contract fills key leadership roles: Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Information Officer, Chief Purchasing Officer, and Associate Administrator
- Mazars USA comes to UMC with over 150 years of collective experience providing quality, hands on expertise to Healthcare organizations across the country

7

- UMC's primary service area includes Wards 7 and 8 as well as western and southern Prince George's County. UMC's market share within that primary service area is 17%.

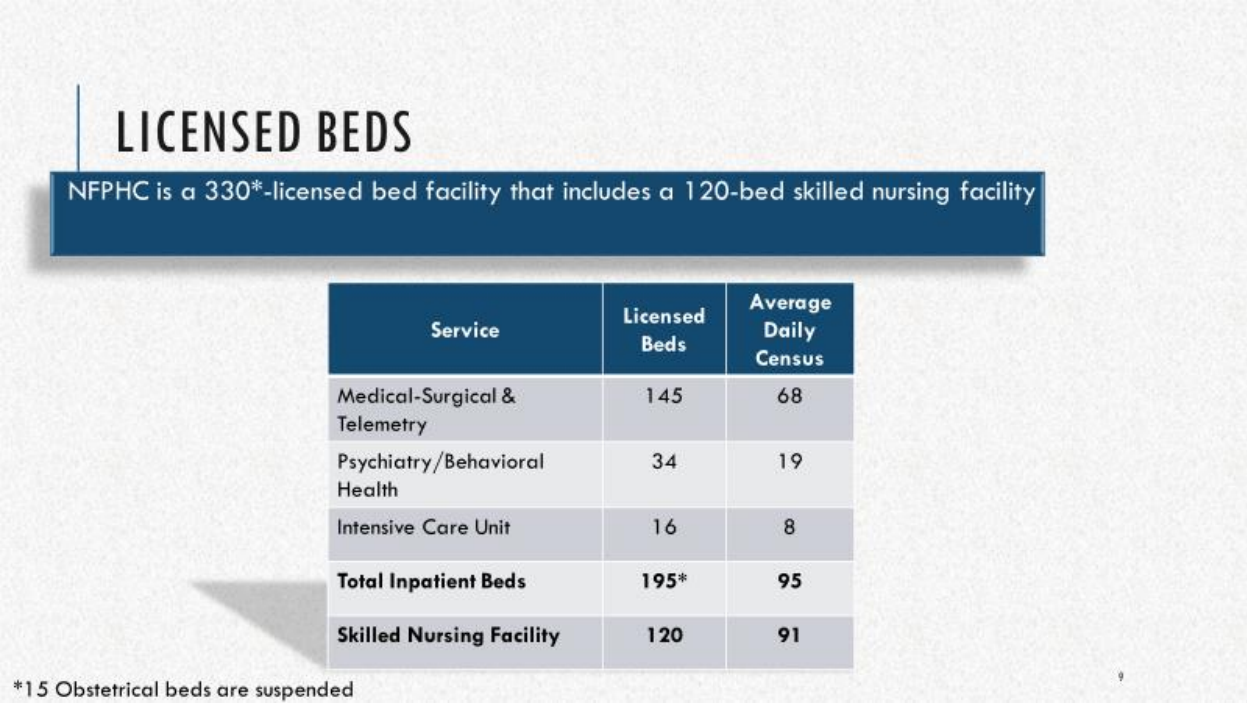
PRIMARY SERVICE AREA

- UMC predominantly provides service to residents of Ward 7, Ward 8 and Southern Prince George's County.
- The primary service area includes over 200,000 residents.
- The current district primary service area market share for admissions is approximately 13%.



8

- The average daily census is approximately 50% for inpatient beds and 70% for the Skilled Nursing Facility (SNF) affiliated with UMC.



LICENSED BEDS

NFPHC is a 330*-licensed bed facility that includes a 120-bed skilled nursing facility

Service	Licensed Beds	Average Daily Census
Medical-Surgical & Telemetry	145	68
Psychiatry/Behavioral Health	34	19
Intensive Care Unit	16	8
Total Inpatient Beds	**195***	**95**
Skilled Nursing Facility	**120**	**91**

*15 Obstetrical beds are suspended

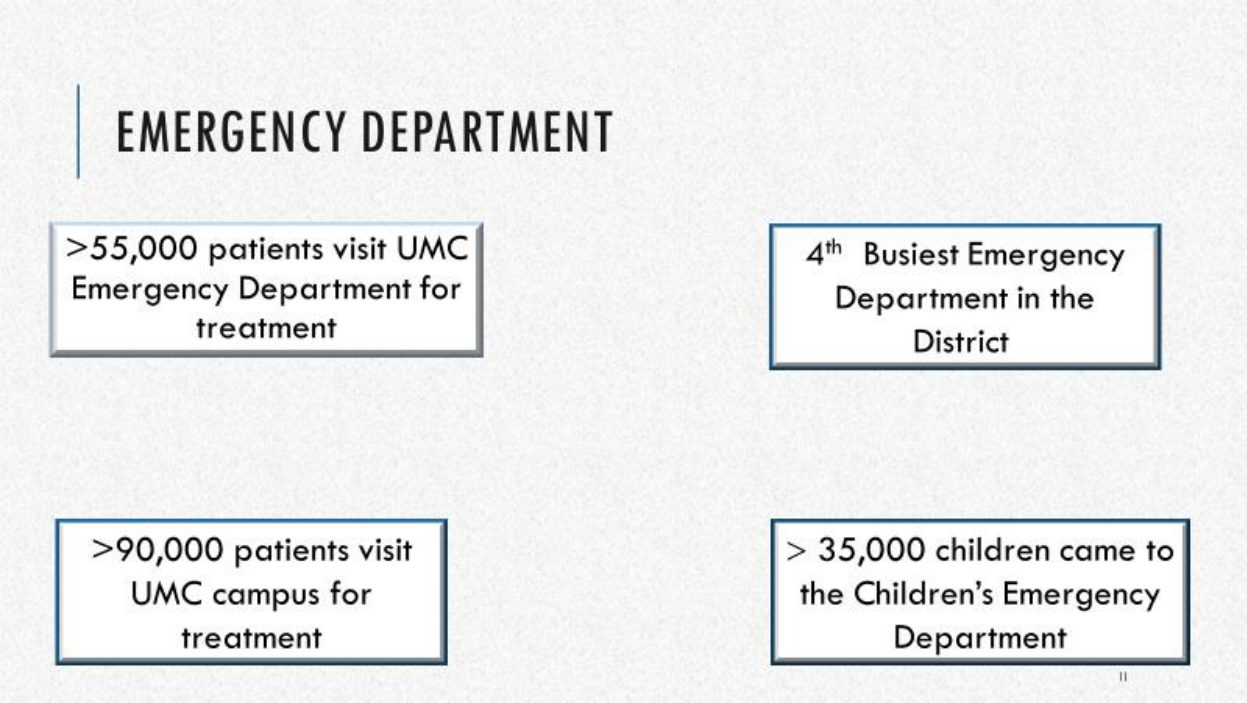
- UMC has over two dozen specialties available, including ED and hospitalist care provided by GW MFA under contract.

SERVICES & SPECIALTIES

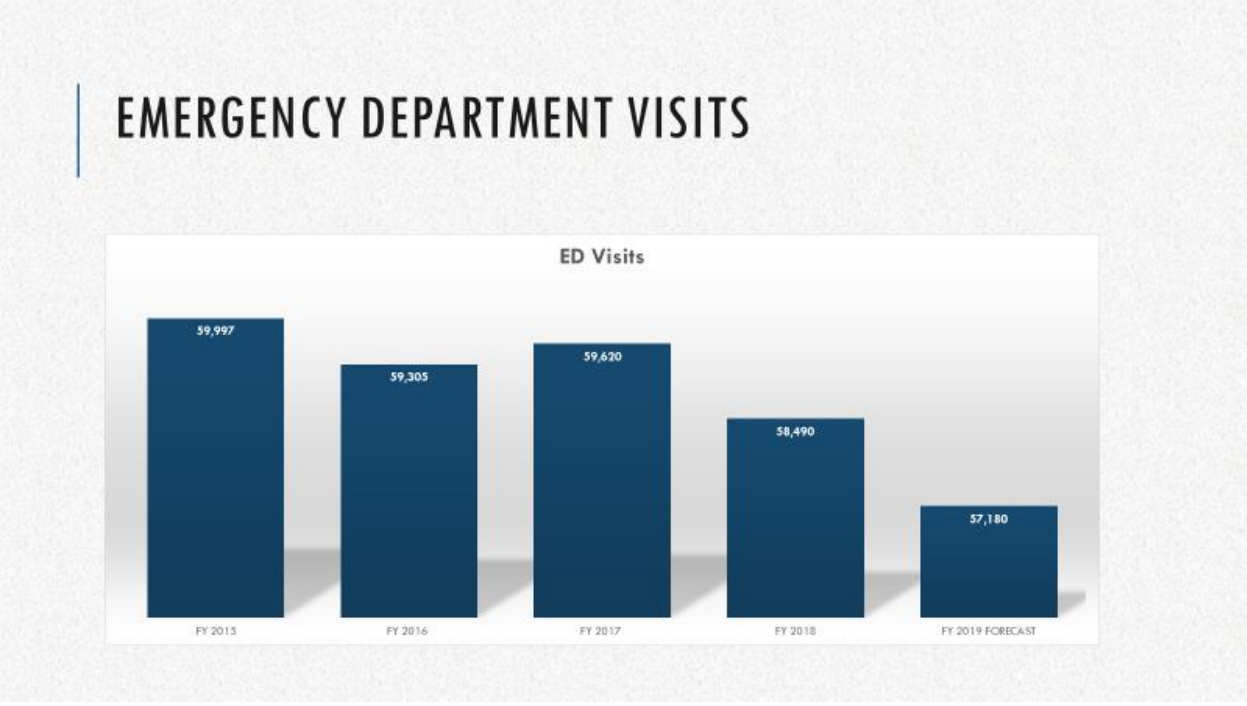
Campus Programs and Services		
Infectious Disease & HIV Program	Diabetes Management	Wound Care & Hyperbaric Medicine
Rehabilitation Medicine	Mobile Health Clinics	Laboratory& Pathology Services
Dedicated Pediatric Emergency Room	Opioid Response Medication-Assisted Treatment	Outpatient Pharmacy
Diagnostic & Outpatient Services	Women's Health	Sleep Center

Specialties	
Anesthesiology	Rehabilitation Medicine
Cardiology	Rheumatology
Endocrinology	Radiation Oncology
Family Practice	Radiology
Gastroenterology	Dentistry
Geriatrics	General Surgery
Infectious Disease	Orthopedics
Internal Medicine	Otolaryngology
Nephrology	Plastic Surgery
Neurology	Podiatry
Oncology	Thoracic Surgery
Pediatrics	Urology
Pulmonology	Vascular Surgery

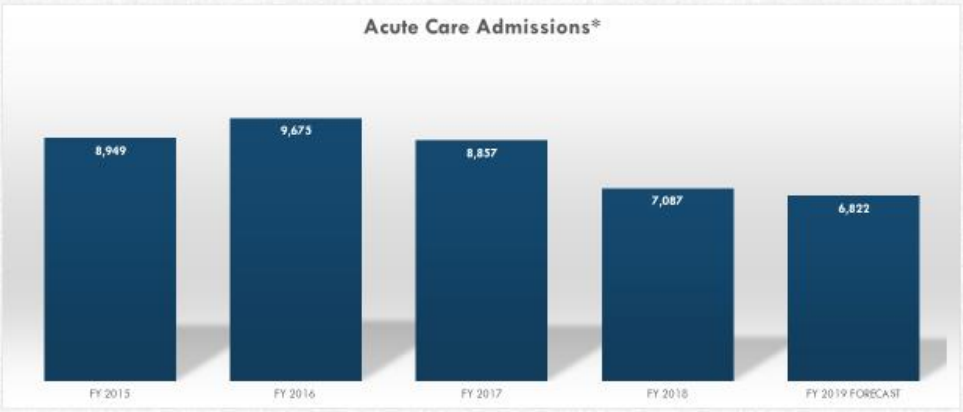
- UMC has the 4th busiest ED in the city, including a stand-alone pediatric ED operated by Children's National Health System (CNHS).



- The following four slides depict the reduction in hospital volumes over several years. There has been a slight increase in surgical cases due to referrals from GW physicians.

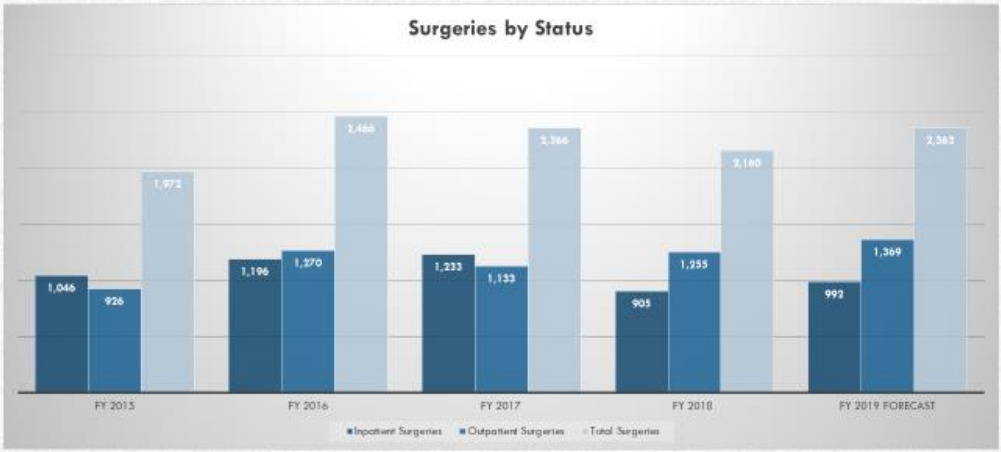


ACUTE CARE ADMISSIONS



*Includes observation admissions

SURGERIES BY STATUS

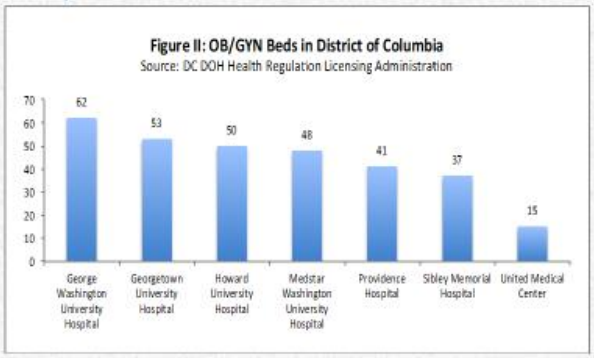


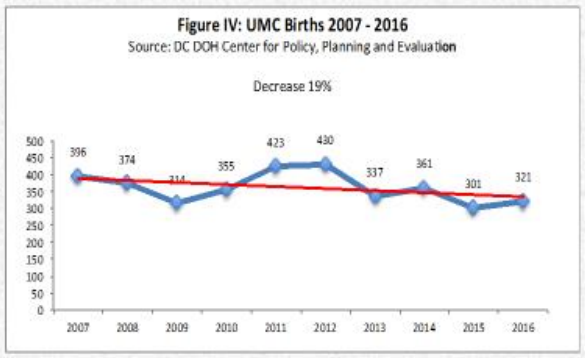
CLINIC VISITS

Hospital Based Specialty Clinics:

- Cardiology
- Urology
- Gastroenterology
- Obstetrics and Gynecology
- Orthopedic
- Infectious Disease
- Primary Care
- General Surgery

OB/GYN BACKGROUND

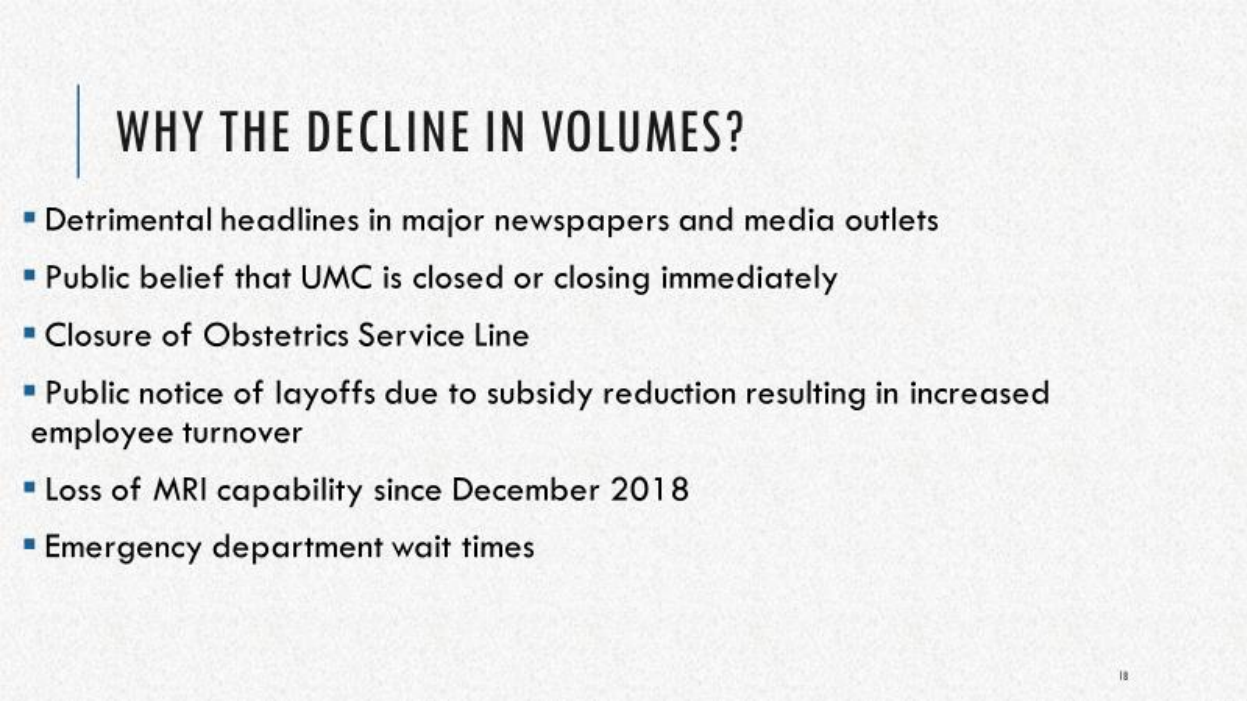




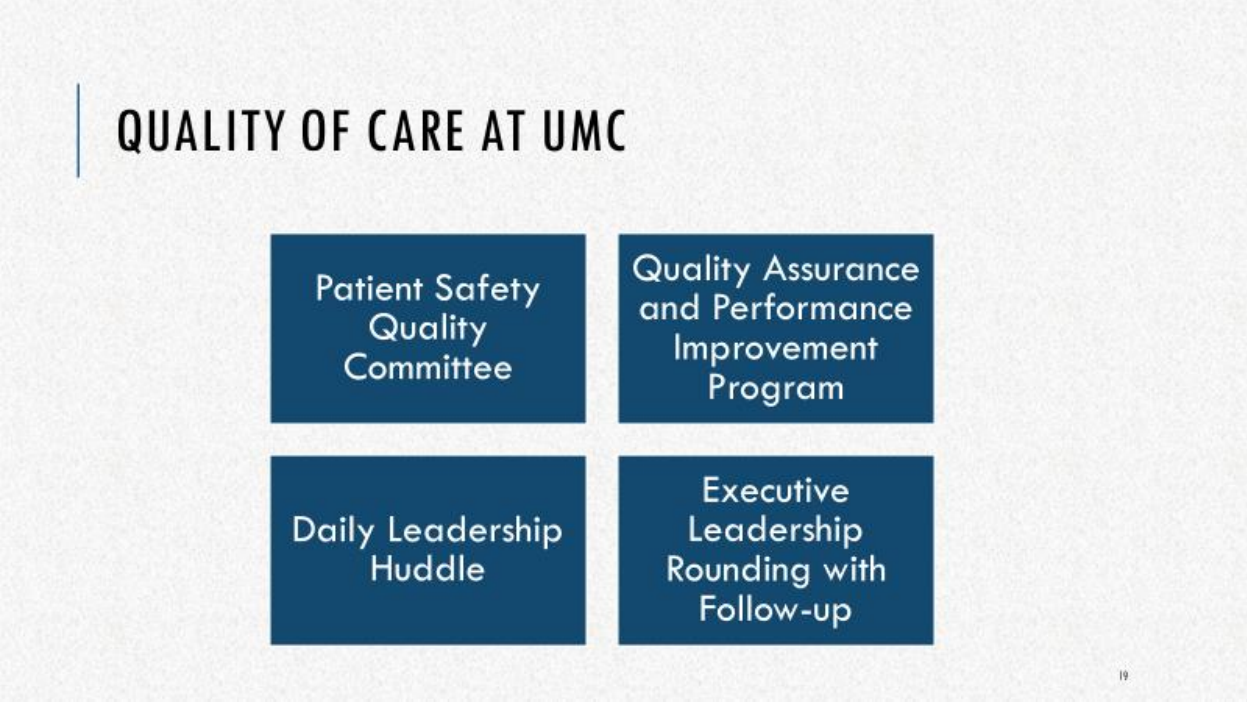
2007- 2017, births at UMC decreased 19%

- 2015 and 2016, UMC had 10% of total births to Wards 7 and Ward 8 residents
- In 2017, (partial year) to Wards 7 and 8 residents, only 9% delivered at UMC

17



- Day-to-day quality improvement has become the norm at UMC.

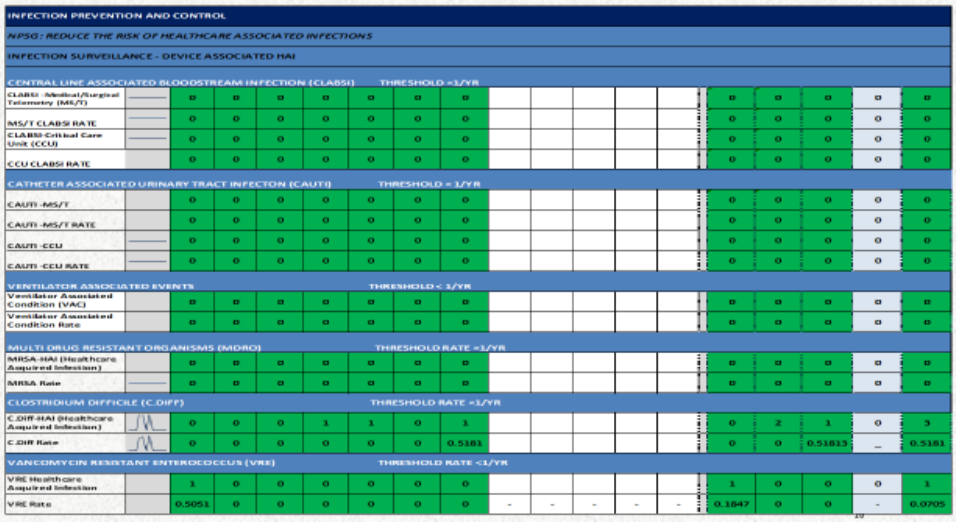


- UMC's quality dashboard is depicted here. The hospital has lower than average rates of hospital-acquired infections and increasing patient satisfaction scores.

QUALITY

INFECTION PREVENTION AND CONTROL

UMC has maintained GREEN (below national average) hospital acquired infection rates



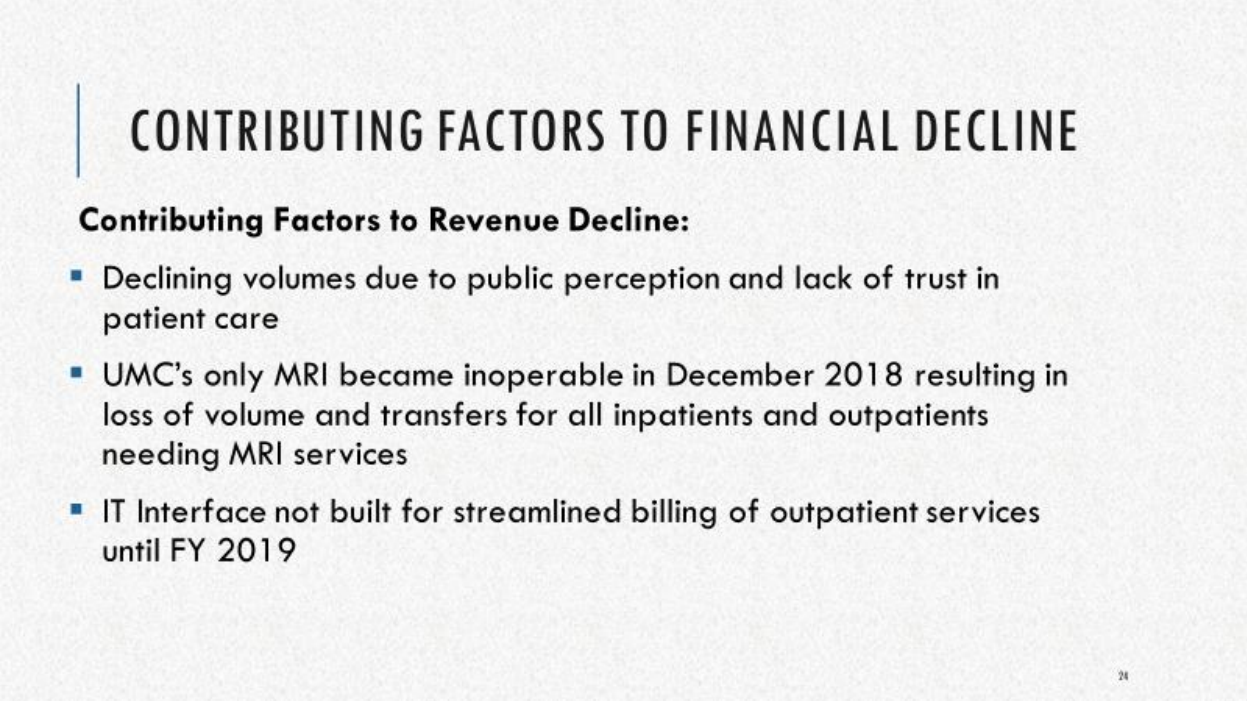
INFECTION PREVENTION AND CONTROL																	
NPSG: REDUCE THE RISK OF HEALTHCARE ASSOCIATED INFECTIONS																	
INFECTION SURVEILLANCE - DEVICE ASSOCIATED HAI																	
CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION (CLABSI) THRESHOLD =1/YR																	
CLABSI - Medical/Surgical Telemetry (MS/T)		0	0	0	0	0	0	0						0	0	0	0	0
MS/T CLABSI RATE		0	0	0	0	0	0	0						0	0	0	0	0
CLABSI-Critical Care Unit (CCU)		0	0	0	0	0	0	0						0	0	0	0	0
CCU CLABSI RATE		0	0	0	0	0	0	0						0	0	0	0	0
CATHETER ASSOCIATED URINARY TRACT INFECTON (CAUTI) THRESHOLD = 1/YR																	
CAUTI -MS/T		0	0	0	0	0	0	0						0	0	0	0	0
CAUTI -MS/T RATE		0	0	0	0	0	0	0						0	0	0	0	0
CAUTI -CCU		0	0	0	0	0	0	0						0	0	0	0	0
CAUTI -CCU RATE		0	0	0	0	0	0	0						0	0	0	0	0
VENTILATOR ASSOCIATED EVENTS THRESHOLD < 1/YR																	
Ventilator Associated Condition (VAC)		0	0	0	0	0	0	0						0	0	0	0	0
Ventilator Associated Condition Rate		0	0	0	0	0	0	0						0	0	0	0	0
MULTI-DRUG RESISTANT ORGANISMS (MDRO) THRESHOLD RATE =1/YR																	
MRSA-HAI (Healthcare Aquired Infection)		0	0	0	0	0	0	0						0	0	0	0	0
MRSA Rate		0	0	0	0	0	0	0						0	0	0	0	0
CLOSTRIDIUM DIFFICILE (C.DIFF) THRESHOLD RATE =1/YR																	
C.DIff-HAI (Healthcare Aquired Infection)		0	0	0	1	1	0	1						0	2	1	0	3
C.DIff Rate		0	0	0	0	0	0	0.5181						0	0	0.51813	_	0.5181
VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE) THRESHOLD RATE <1/YR																	
VRE Healthcare Aquired Infection		1	0	0	0	0	0	0						1	0	0	0	1
VRE Rate		0.5051	0	0	0	0	0	0	-	-	-	-	-	0.1847	0	0	-	0.0705

PATIENT SATISFACTION

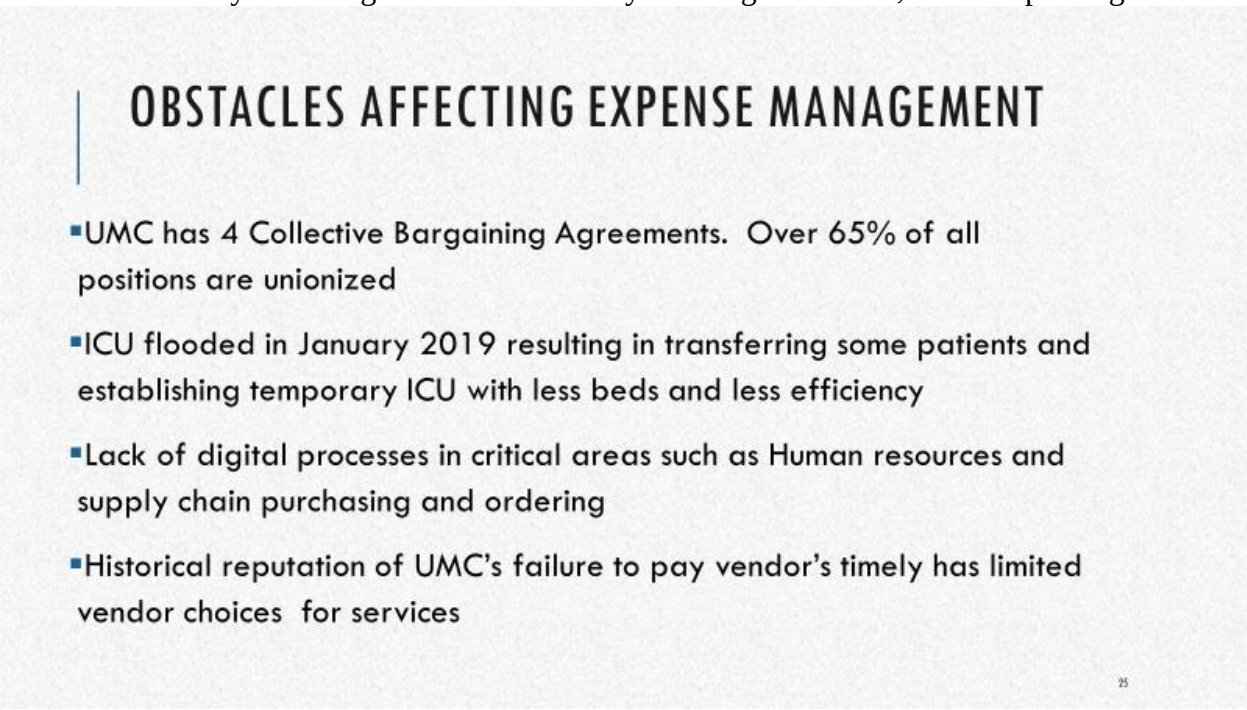
CAHPS	2016	2017	2018	2019 YTD
	Top Box	Top Box	Top Box	Top Box
Rate hospital 0-10	43.9	45.1 ▲	39.3 ▼	47.0 ▲
Recommend the hospital	39.5	31.3 ▼	28.1 ▼	34.1 ▲
Cleanliness of hospital environment	54.5	58.5 ▲	54.5 ▼	65.9 ▲
Quietness of hospital environment	54.6	52.4 ▼	49.5 ▼	45.0 ▼
Comm w/ Nurses	65.8	63.6 ▼	59.2 ▼	65.6 ▲
Response of Hosp Staff	39.5	41.6 ▲	37.3 ▼	44.5 ▲
Comm w/ Doctors	72.8	72.0 ▼	62.6 ▼	67.8 ▲
Hospital Environment	54.6	55.5 ▲	52.0 ▼	55.4 ▲
Communication About Pain	-	-	40.8	45.1 ▲
Pain Management	60.8	54.2 ▼	-	-
Comm About Medicines	50.4	52.3 ▲	46.5 ▼	50.0 ▲
Discharge Information	67.2	68.4 ▲	68.8 ▲	75.9 ▲

Displayed by Discharge Date

- The primary factor leading to the financial decline at UMC is a reduction in patient volume over the last several years. The loss of UMC's only MRI machine in late 2018 also resulted in a reduction in volume.



- Several factors contribute to higher expenses at UMC, including collective bargaining agreements and high staff turnover.
- Revenue cycle management remains a key challenge for UMC, but is improving.



OPERATING MARGIN PERFORMANCE

	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July	Aug	Sep
FY19 Actual	-3.0%	-12.4%	-8.2%	-7.6%	-4.5%	-4.9%	-2.5%	-1.1				
FY19 Budget	-34.2%	6.6%	6.8%	6.8%	6.6%	6.6%	6.6%	6.6				
FY18 Actual	-6.7%	-13.3%	-18.2%	-18.8%	-19.4%	-19.4%	-17.6%	-13.5				

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Operating margin has improved over by focused effort on achieving GAP measures such as:

- Improving behavioral health patient throughput
- Management of Overtime
- Agency Cost reduction
- Organizational Staffing Realignment
- Improved Revenue Cycle
- Improved Contract Management

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- Recently adopted legislation has resulted in an increase in the subsidy to UMC and also required that the hospital develop a balanced budget in FY2020, 2021 and 2022.

RECENT LEGISLATION

Recent Legislation:

- Mayor Bowser put 40 million for UMC subsidy in FY 2020 District budget
- City Council reduced subsidy to 15 million in the "Not-for-Profit Hospital Corporation Fiscal Oversight and Transition Planning Act of 2019"
- City Council also approved a one time allotment of 7.1 million for FY 2020
- UMC requested to develop balanced budget for FY 2020, FY 2021, FY 2022 with reduced subsidy

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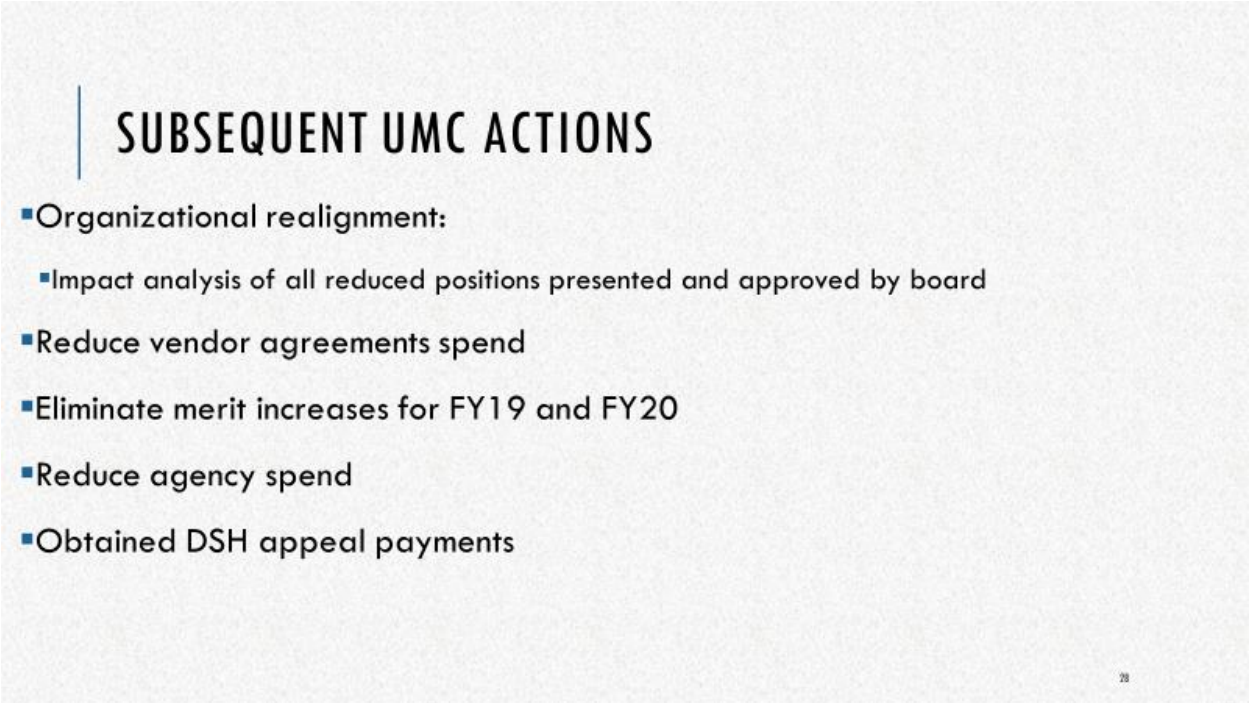
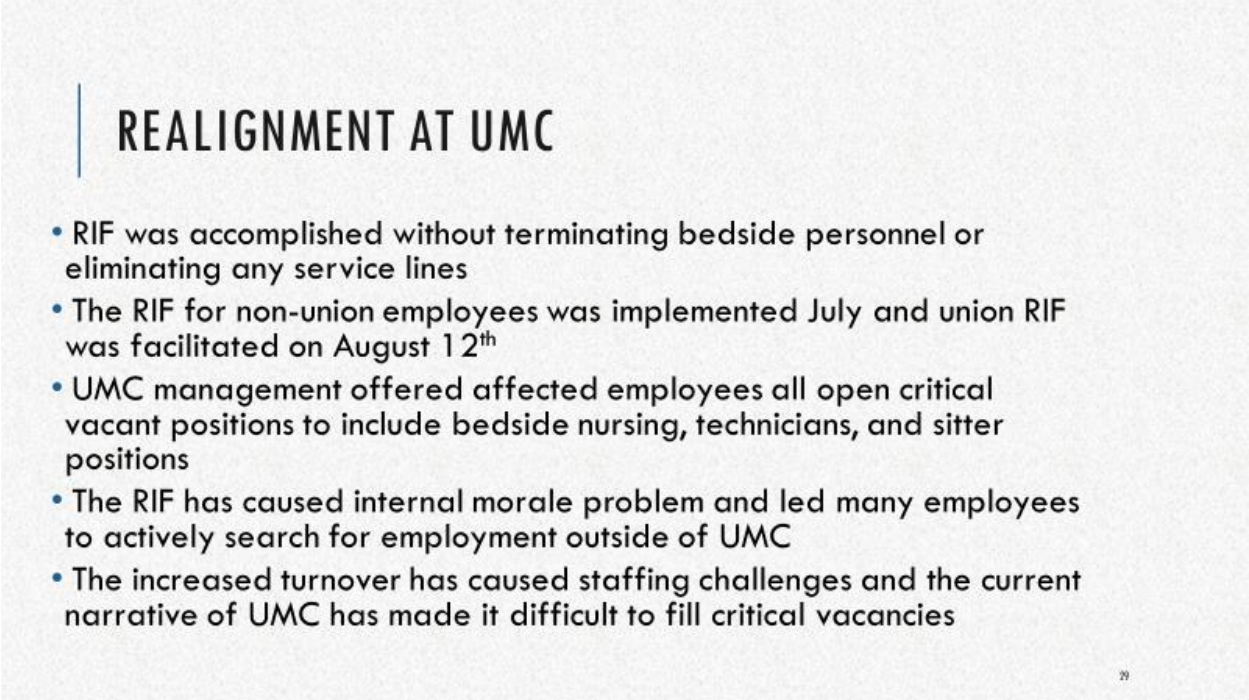
- Balancing the budget has resulted in a realignment and reductions in force at UMC.





- There are several current efforts to ensure the quality of care at UMC, particularly while facing a reduction in force.

- UMC is focusing on expanding community partnerships, internal workforce development and contributing more concretely to the development of a health care system east of the river.

- Dr. Bramble described the pediatric emergency department at UMC and asked how CNHS can work with the UMC Board to ensure adequate supplies are available for the ED and the HVAC system is more reliable.
- Dr. Fair offered that UMC is reviewing every contract to improve logistics and supply management. Dr. Fair asked to engage directly with CNHS at a future Board meeting.
- Dr. Tu stated that UMC is a classic example of how two different organizations (UMC and CNHS) at the same location can have very different reputations, brands and revenue cycle management. Dr. Tu recommended that UMC look closely at improving revenue cycle management.
- Co-Chair Catania inquired about the loss of the MRI at UMC.
- Dr. Tu, who chairs the radiology department at UMC, responded that late last year the mobile, temporary building housing the MRI machine reached its shelf-life and experienced water penetration. While the leak was fixed quickly, a mold issue emerged, and the MRI machine had to be taken out of service. A replacement machine and building is scheduled to open this year.
- Dr. Gloria Wilder from Core Health and Wellness Center and a member of the public offered that physicians who lease space at UMC ambulatory care center are concerned about the ending of a program to divert non-acute patients from the ED to clinics on the UMC campus. The program was a partnership between physicians groups and AmeriHealth. Dr. Wilder requested that the Commission consider recommending a similar program at UMC and other hospitals.

5. Presentation by the DC Hospital Association **Jacqueline Bowens**

- Jacqueline Bowens, Executive Director of the DC Hospital Association, thanked the Co-Chairs as well as DM Turnage and Dr. Nesbitt for setting the stage for her presentation.
- Ms. Bowens described the DC Hospital Association (DCHA) membership, which includes the acute care hospitals mentioned by Dr. Nesbitt, as well as the Veterans Administration Hospital.
- Hospitals are licensed within specific categories as described in the first slide.

DC Hospitals and Types of Beds

DC Has 14 Hospitals

- 8 General Acute Care
- 2 Long-Term Care Acute Care
- 2 Psychiatric
- 1 Rehabilitation
- 1 Pediatric Acute Care
- 1 Pediatric Specialty
- 4 Level One Trauma Centers (1 Pediatric/3 Adult)

Licensed Hospital Bed Categories/Types

1. Med-Surge
2. OB/GYN
3. Pediatrics
4. ICU
6. NICU
7. Psychiatric
8. Detox Beds
9. Sub Acute Care (Nursing Home Beds)

- Hospitals play an important role in the economy of the District of Columbia. Hospitals represent the second largest employer in the District.

DC Hospitals: A Snapshot

Hospital Economic Drivers	Impact
Hospital Employees	27,922
Total Employment Supported by Hospital	39,102 or 4.92%
Hospital Payroll	$2.3 Billion
Total Payroll Income from Hospitals	$2.9 Billion
Hospital Spending	$4.5Billion
Total Effect of Hospitals on Economic Output	$5.8 Billion

Community Benefits Calculator	Total
Community Health Improvement	$ 9,894,915.81
Health Professions Education	$168,431,607.66
Subsidized Health Services	$28,030,028.25
Research	$11,239,464.49
Cash and In-Kind Contributions	$1,512,748.64
Total Community Benefit	$219,108,764.86

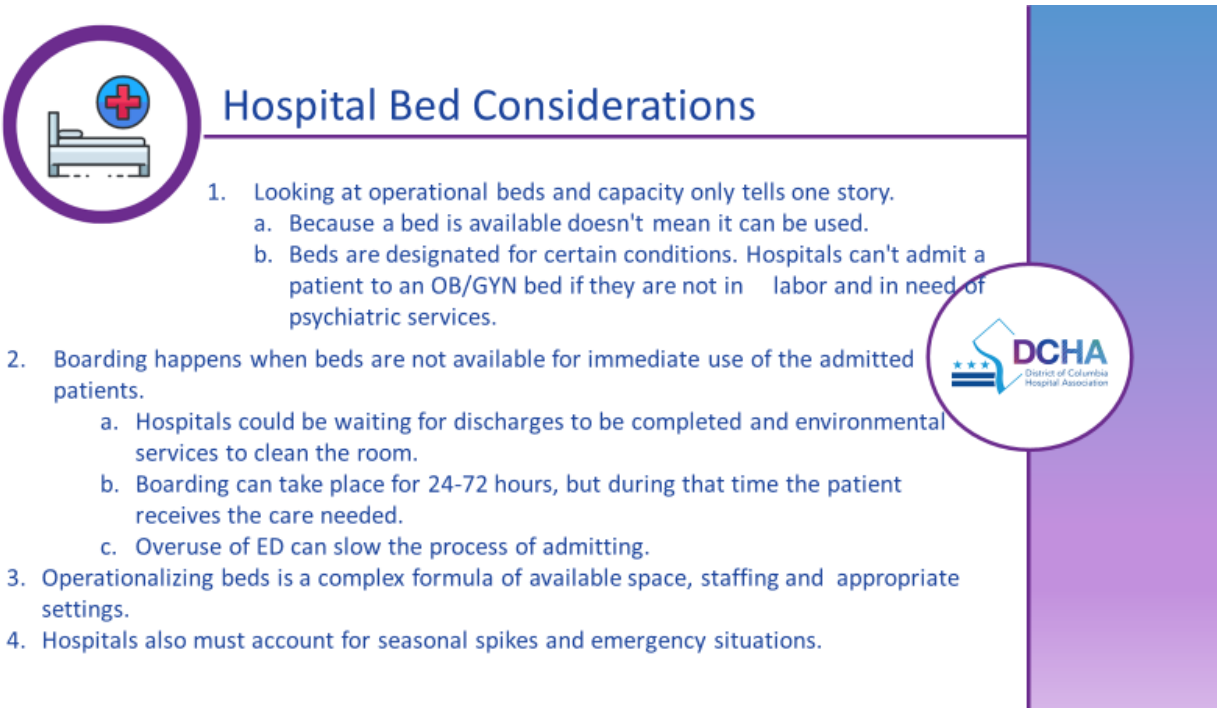
$95.3 Million Uncompensated Care

$41 Million To District Residents

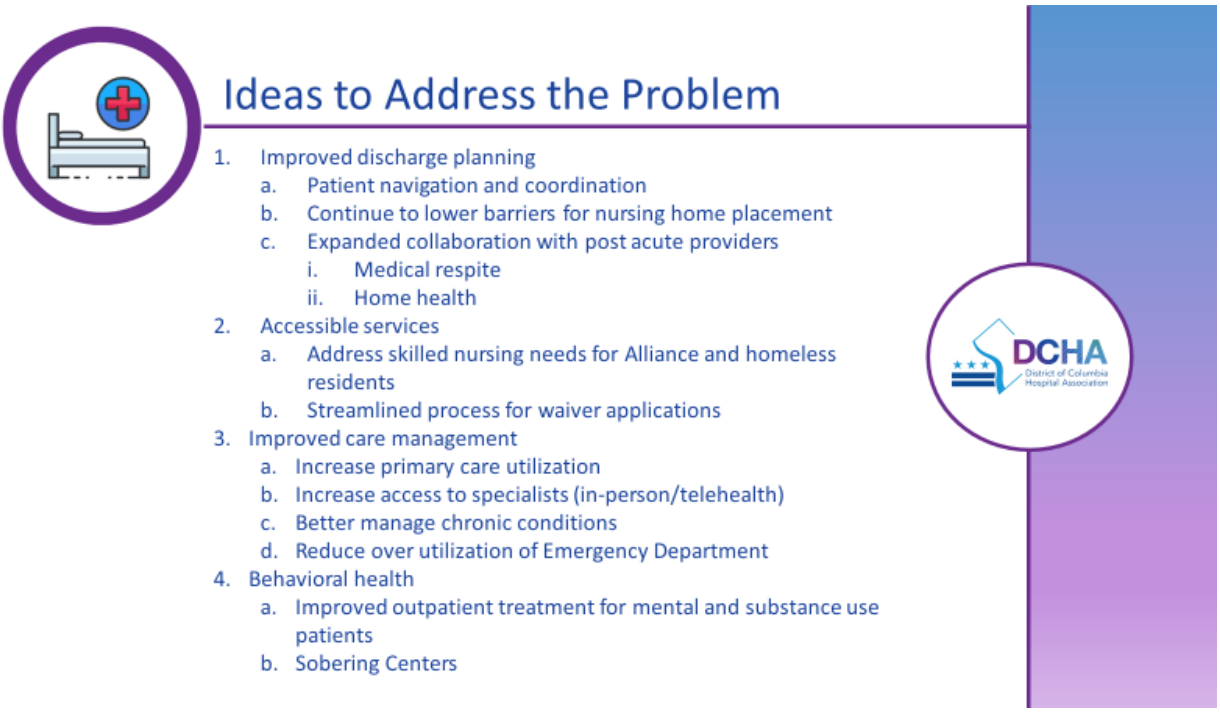
$28.8 Million Charity Care

$66.4 Million Bad Debt

- Ms. Bowens described several considerations when addressing the number of licensed beds in District hospitals. There are key differences between the number of licensed beds that a hospital may have and the number of beds that are available for patients.



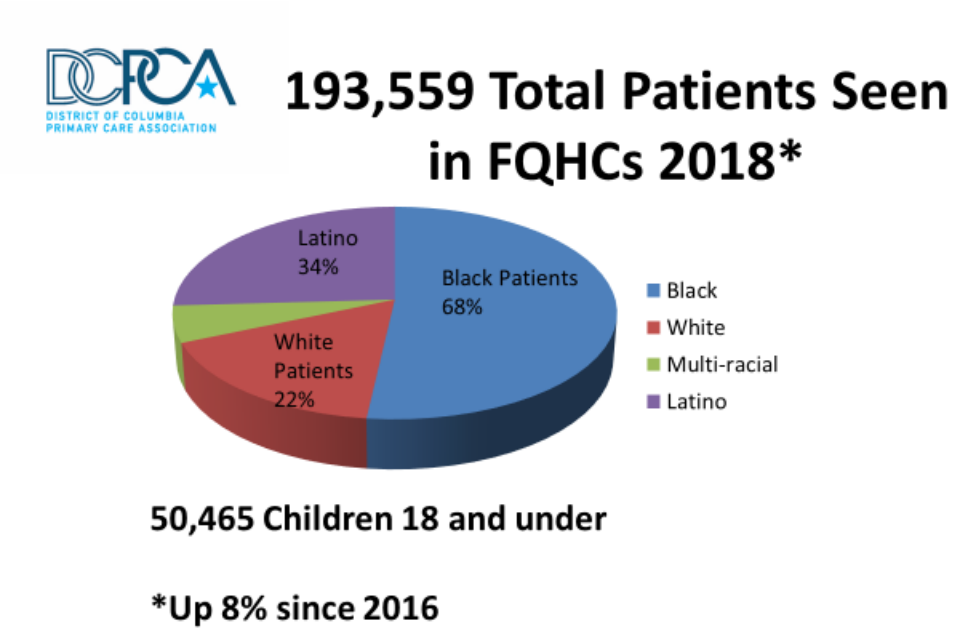
- There are many opportunities for hospitals to work in partnership with the health system to improve outcomes for District residents.
- DCHA is working on a grant from DHCF to improve and standardize discharge planning. Results from that grant will be available this year.



- DCHA is working with the city on realigning the number of licensed hospital beds among District hospitals that are experiencing increases and decreases in patient volume.
- Questions and discussion were held until after the presentation by the DC Primary Care Association.

6. Presentation by the DC Primary Care Association **Tamara Smith**

- Tamara Smith, Executive Director of the DC Primary Care Association, offered a response to several questions that have come up in the last few meetings about primary care capacity and why patients seek care at emergency departments.
- Ms. Smith provided an overview of the Federal Qualified Health Care (FQHC) system in the District.



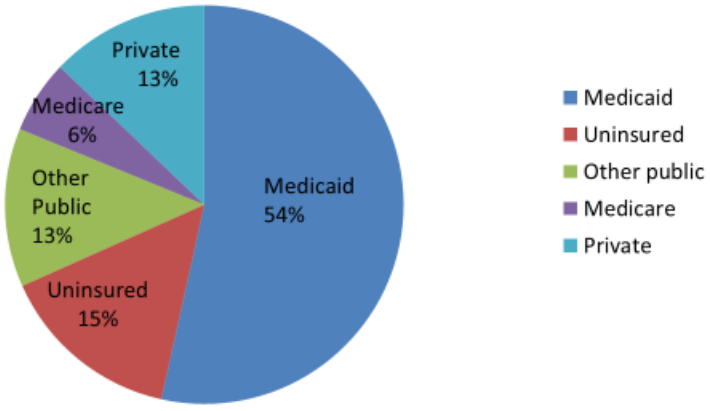
- Ms. Smith presented the following slides on behalf of DC Primary Care Association (DCPCA).

2018 Prenatal Patients

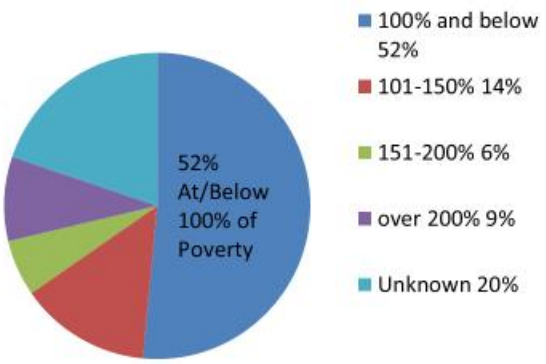
Increased Prenatal Patients by 30% since 2016

Prenatal				
Number of Prenatal Patients[4]	5,898	7,611	7,817	
Number of Prenatal Patients who Delivered	3,661	3,686	3,827	
Quality of Care Measures				
Perinatal Health				
Percentage of Prenatal Patients with Access to Prenatal Care (First Prenatal Visit in 1st Trimester)	64.92%	63.42%	61.25%	
Number of Access to Prenatal Care (First Prenatal Visit in 1st Trimester)	3,829	4,827	4,788	
Percentage of Newborns with Low and Very Low Birth Weight	10.50%	8.43%	8.66%	
Number of Newborns with Low Birth Weight	301	227	287	

FQHC Payers



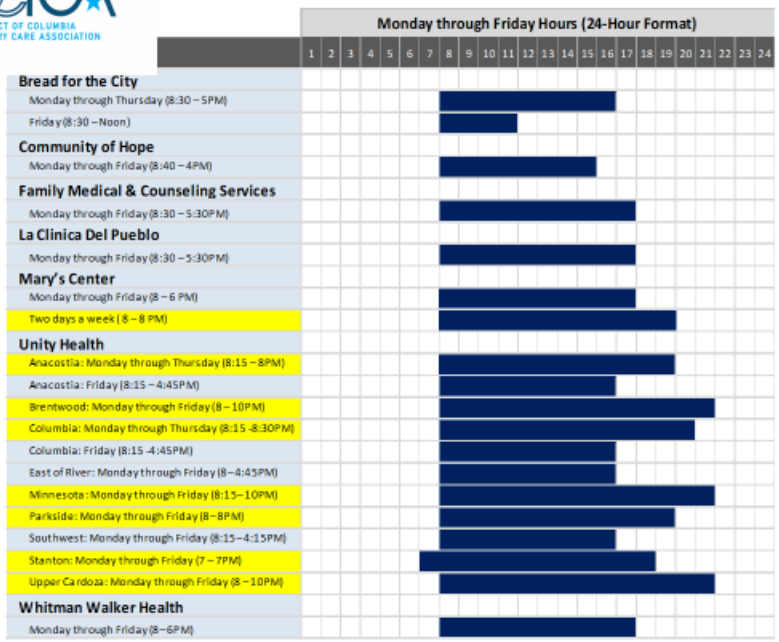
Patient Income



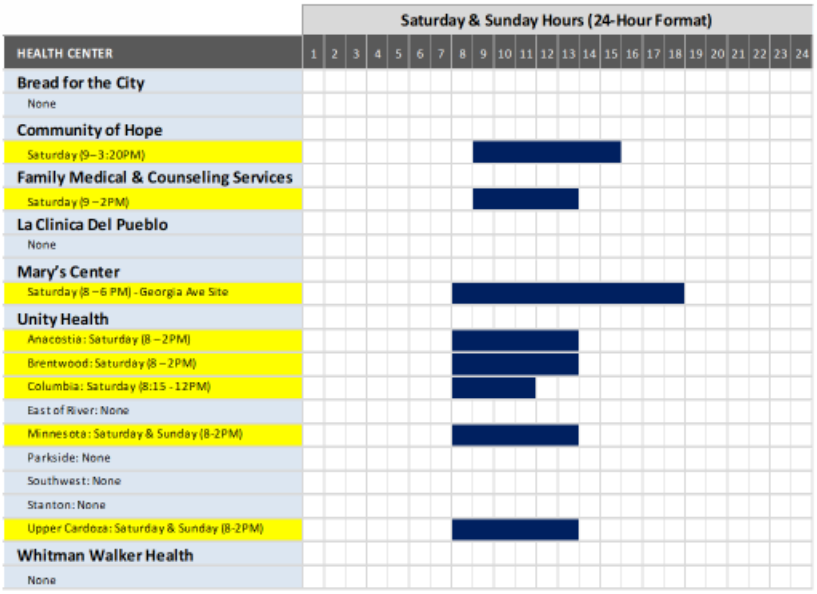
2018 Selected Workforce Data

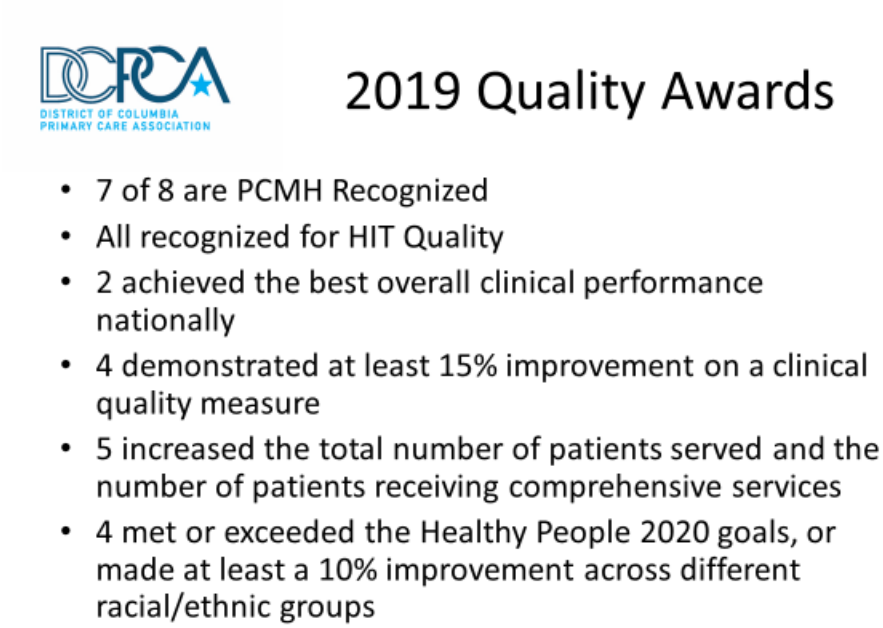
- Average Tenure for Physicians 6 Years
- Average Tenure for NPs, PAs, CNM 4.5 Years
- Average Tenure Mental Health 4.4 Years
- Average Tenure CEOs 24 Years

Expanded After-Hours Access

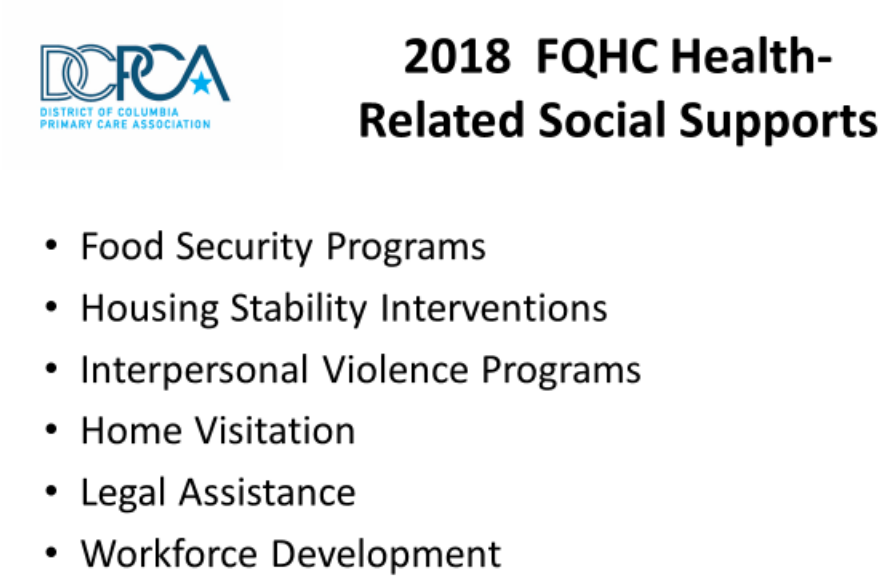


Expanded Weekend Access

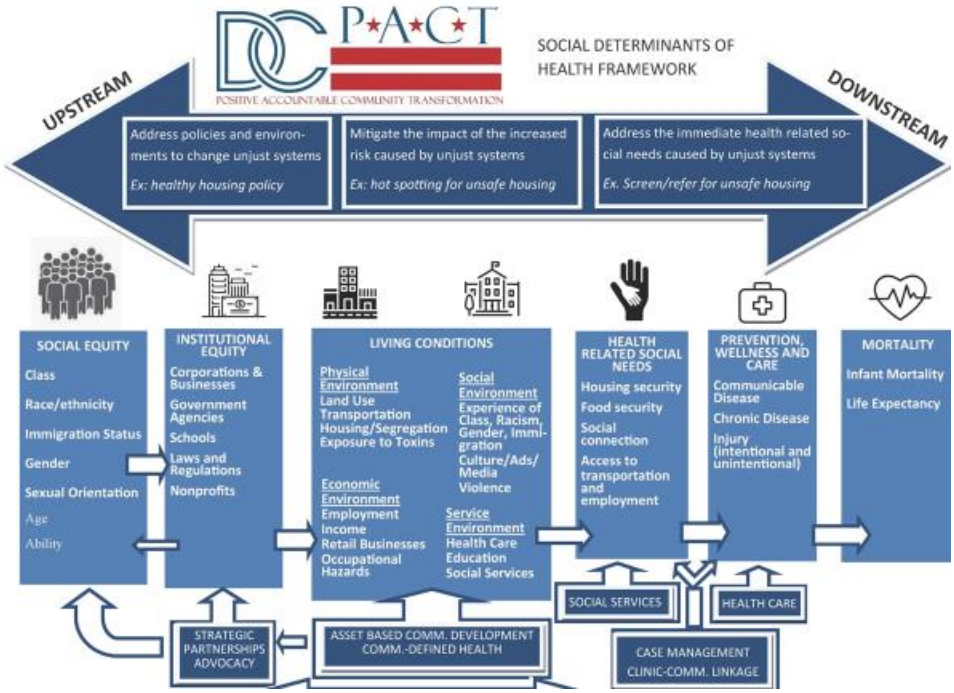




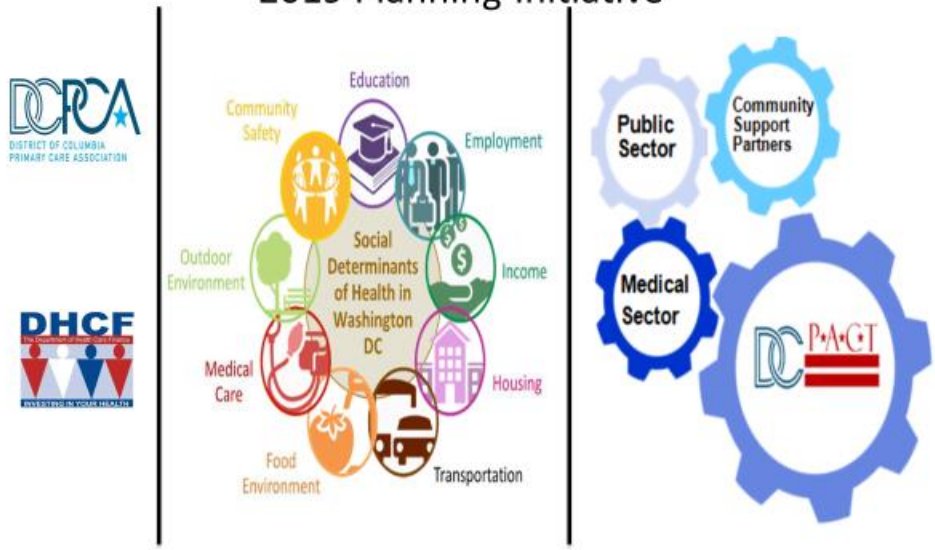
- Health centers provide comprehensive services, including non-traditional health services such as food security program and housing stability interventions.

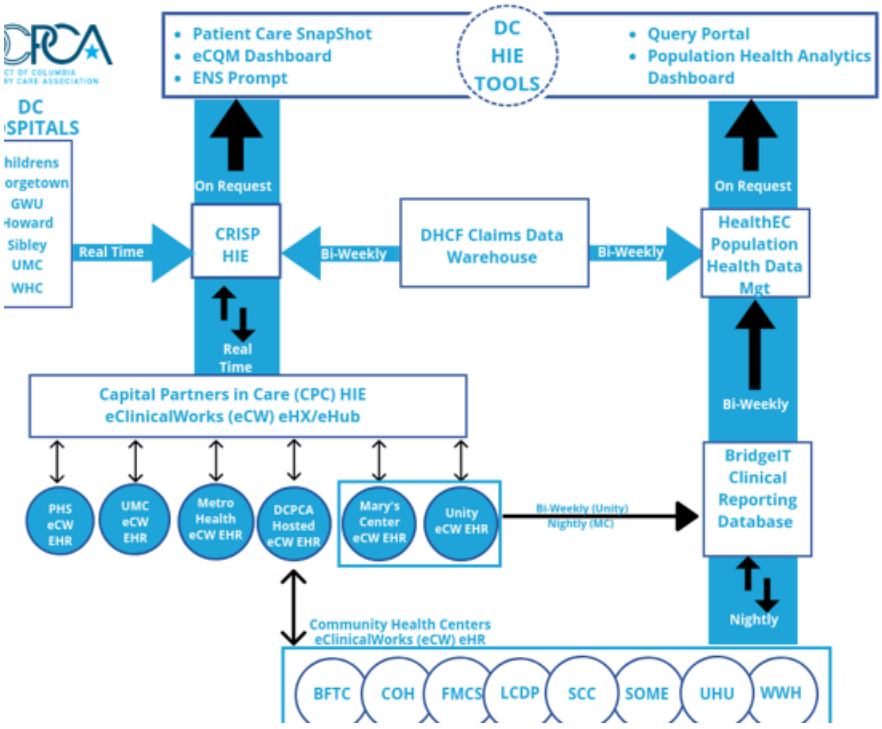


- The following three slides describe a project led by DC Positive Accountable Community Transformation (DC PACT) and managed by DCPCA to standardize the screening and referral of social determinants of health (SDOH) needs at clinics in the District. This work is funded by a grant from DHCF.
- Under the DHCF grant, DCPCA and its partners are developing an *electronic community resource inventory* and designing a technical solution for exchanging SDOH screening results and to refer patients to community-based organizations via the HIE.



Community Resource Information Exchange (CoRIE) 2019 Planning Initiative





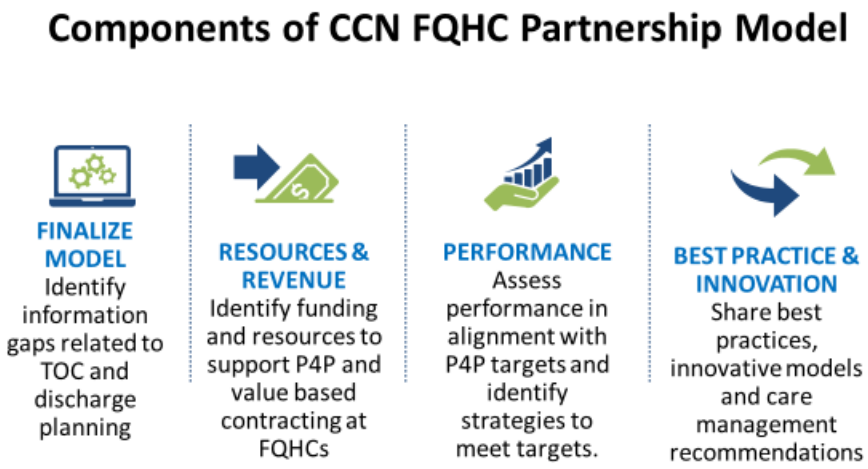
- In the last few years the FQHCs have organized into a clinically integrated network that is a separate governing body from the individual FQHCs. The objective of the Connected Care Network (CCN) is to increase quality of care and decrease costs for the city.

- Key interventions by the clinically integrated network are described below.

CCN Core Interventions

- **Health information technology and data analytics**: Optimize the use of EHRs in patient care; and utilize population health analytics to drive care strategies and network performance.
- **Emergency Department Care Transitions & Diversion Program**: hospital based ED liaisons to foster transition to primary care, reduce inappropriate ED use and increase awareness of primary care services in Network.
- **Hospital-based transition of care**: Nurse-led transition of care program for priority group focusing on discharge follow-up with PCP and specialists, transmission of discharge plan, home health coordination, and medication reconciliation.
- **Expanded clinic access**: nurse triage and expanded access to same, next day, weekend appointments, and patient education campaigns on primary care and network services.
- **Standardized care management for complex health and social needs**: Clinic-based teams that implement standardized assessment and care plan approach.

- The FQHC partnership model is focused on sharing information and best practices among the health centers.



- Ms. Smith described DCPCA's qualitative research on human-centered design and maternal health. The primary barrier to receiving high-quality health services is a lack of awareness on the part of patients about what services are available to them and how/when they can be accessed.
- Patients do not always understand what services are available in their communities. There is an opportunity to help providers educate patients about the services available to them.
- Ms. Smith closed by applauding the work of the Commission, particularly around reducing the reliance on ED care when the primary care system is so robust in the city. The health centers are ready to work together with other system stakeholders to address the challenges identified by this Commission.

- Co-Chair Catania opened the meeting for questions and general discussion by members.
- Deputy Mayor Turnage asked Ms. Bowens about the reallocation of licensed hospital beds. There is a surplus of approximately 1000 licensed hospital beds in the city, but they are not evenly distributed. Some hospitals are operating at capacity and others are not.
- Ms. Bowens responded that the hospitals are entering discussions with DC Health about that issue, including utilization, facilities, and future growth. That discussion will occur with DC Health by September 30th.

- Karen Dale addressed the Commission about the impact of violence on the residents and communities each of us serve. The impact is particularly devastating on children who are experiencing extreme psychological traumas in their communities. There are health impacts to the violence and trauma. AmeriHealth staff regularly review news reports and nearly every week a member is involved in violence.
- Ms. Bowens agreed and said that violence often follows the victim to the hospital where the physical and psychological impacts are felt by providers, which contributes to burnout.

- Dr. Bazron also agreed with Ms. Dale and offered that DBH is implementing new trauma-informed care programs, including funding school-based mental health care at 119 DCPS schools this year.
- Ms. Gomez said that more collaboration is needed between school nurses and behavioral health providers who have the same patients but are not always working together.
- Dr. Argyros and Ms. Russo agreed that daily lives at hospitals are changing rapidly because of violence that often follows patients into hospitals. Violence is prevalent between patients, families and staff. There is a real impact to staffing shortages due to physical and emotional violence.
- Dr. Tu offered that the areas surrounding hospitals are also potentially dangerous for hospital staff, including traffic safety concerns.

- At September 24th meeting, Co-Chairs Catania and Keehan requested a 20-minute presentation from City Administrator Young and Deputy Mayor Turnage about the proposed new hospital and St. Elizabeths. This will be the last major presentation to the Commission.

7. Subcommittee Updates **Subcommittee Chairs**

- Co-Chair Catania recognized that subcommittees were working diligently to produce recommendations.
- Co-Chair Keehan offered that subcommittees may have overlapping or contradictory recommendations, which is positve and will lead to productive conversations at the Commission.
- The Value-Based Purchasing Subcommittee will likely produce its recommendations after it reviews the draft recommendations of other subcommittees.

- Subcommittee co-chairs will provide an update on their draft recommendations at the September 24th meeting for discussion. Final draft recommendations are due to the Commission staff on September 27th.

8. Public Comments **Public**

- Dr. Gloria Wilder asked that the Commission review data on the number, types and locations of independent physicians working in the District.

9. Adjournment **Commission Co-Chairs**

- Maria Gomez discussed the proposed Federal detention center in Ward 4 to hold 200+ children that Mayor Bowser is opposing. Ms. Gomez applauded the Mayor for opposing the new detention center and noted that while the children will be housed there, they will have to interact with the District's health system.
- The meeting was adjourned at 11:58 am.