COMMISSION ON HEALTHCARE SYSTEMS TRANSFORMATION  
August 27, 2019  
1152 15th Street NW, Suite 900  
10:00 am – 12:00 pm

### Commission Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation/Designation</th>
<th>Attendance</th>
<th>Designee</th>
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<tbody>
<tr>
<td>David Catania</td>
<td>Co-Chair</td>
<td>Present</td>
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<tr>
<td>Sister Carol Keehan</td>
<td>Co-Chair</td>
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<tr>
<td>Kimberly Russo</td>
<td>George Washington University Hospital</td>
<td>Present</td>
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<tr>
<td>Kevin Sowers</td>
<td>Johns Hopkins Medicine, Sibley Memorial Hospital</td>
<td>Present</td>
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<tr>
<td>Oliver Johnson</td>
<td>MedStar Health</td>
<td>Present</td>
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<tr>
<td>Dr. Malika Fair</td>
<td>United Medical Center</td>
<td>Present</td>
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<tr>
<td>Dean Hugh Mighty</td>
<td>Howard University Hospital</td>
<td>Present</td>
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<tr>
<td>Corey Odol</td>
<td>Psychiatric Institute of Washington</td>
<td>Present</td>
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<tr>
<td>Denise Cora-Bramble, M.D.</td>
<td>Children’s Hospital</td>
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<tr>
<td>Marc Ferrell</td>
<td>Bridgepoint</td>
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<tr>
<td>Don Blanchon</td>
<td>Whitman-Walker Health</td>
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<tr>
<td>Kim Horn</td>
<td>Kaiser Foundation Health Plan</td>
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<tr>
<td>Maria Harris Tildon</td>
<td>CareFirst BlueCross BlueShield</td>
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<tr>
<td>David Stewart</td>
<td>University of Maryland, Family Medicine</td>
<td>Present</td>
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<tr>
<td>Kelly Sweeney McShane</td>
<td>Community of Hope</td>
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<tr>
<td>Maria Gomez</td>
<td>Mary's Center</td>
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<tr>
<td>City Administrator</td>
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<td>Not present</td>
<td>Ben Stutz</td>
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<tr>
<td>Rashad Young</td>
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<tr>
<td>Deputy Mayor Wayne Turnage</td>
<td>Deputy Mayor for Health and Human Services</td>
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<tr>
<td>Dr. LaQuandra Nesbitt</td>
<td>D.C. Health</td>
<td>Present</td>
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<tr>
<td>Dr. Barbara Bazron</td>
<td>Department of Behavioral Health</td>
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<tr>
<td>Melisa Byrd</td>
<td>Department of Health Care Finance</td>
<td>Present</td>
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<tr>
<td>Dr. Faith Gibson Hubbard</td>
<td>Thrive by Five</td>
<td>Present</td>
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<tr>
<td>Chief Gregory Dean</td>
<td>Fire and Emergency Medical Services</td>
<td>Present</td>
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<tr>
<td>Councilmember Vince Gray</td>
<td>Council of the District of Columbia, Committee on Health</td>
<td>Not Present, Eric Goulet, Present</td>
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<tr>
<td>Tamara Smith</td>
<td>D.C. Primary Care Association</td>
<td>Present</td>
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<tr>
<td>Jacqueline Bowens</td>
<td>D.C. Hospital Association</td>
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<tr>
<td>Dr. Gregory Argyros</td>
<td>Washington Hospital Center</td>
<td>Present</td>
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<tr>
<td>Vincent Keane</td>
<td>Unity Health Care</td>
<td>Present</td>
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<tr>
<td>Dr. Raymond Tu</td>
<td>DC Medical Society</td>
<td>Present</td>
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<tr>
<td>Karen Dale</td>
<td>AmeriHealth Caritas</td>
<td>Present</td>
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### Additional District Government

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

EVERY RESIDENT SHOULD HAVE ACCESS TO AN INTEGRATED SYSTEM OF CARE REGARDLESS OF THEIR ZIP CODE

- Goal: Create a streamlined, seamless coordinated system that delivers high-quality, high-value care, regardless of the point-of-entry in the system
- Elements of the integrated system
  - Acute care hospital
  - Ambulatory specialty care facility on the campus with the hospital
  - Several urgent care facilities in the network of care
  - Contractual or referral agreements with primary care clinics in the PSA
  - Nexus to a nationally renown Level I Trauma Center
  - Modern IT platform to seamlessly link the elements of the system for patient management

- 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.

- Considerable enthusiasm and interest
- Suggest a preparedness for focus on entire population and special populations (higher users of services, complex medical needs, dual-eligibles)
- Optimistic that ACO can improve care coordination, health care quality, and patient outcomes
- Factors identified to start a Medicaid ACO in the District:
  - Adequate time to prepare
  - Start up funds
  - Better Health Information Exchange (HIE)
  - Transparency in financing
  - Defined service population
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

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**
- 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.

**PARTNERSHIPS AND HEALTHCARE NETWORKS**

- Opportunities exist for vertical and horizontal integration of existing healthcare providers to achieve the principal goals of ACOs and CINs
  - Can improve quality, cost, and value in healthcare in the District while improving patient outcomes and eliminating health disparities

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

**POPULATION HEALTH MANAGEMENT**

- Defined as managing the health outcomes of a group of individuals, including the distribution of such outcomes within the group
- A critical component of new care delivery models and value based payment strategies
- Requires an understanding of the health systems patients (market share) as well as the community as a whole
  - Differences in health outcomes between patients and community can drive service lines (bi-directionally)
• 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 Elizabeth’s Hospital decreased 7.3% and Psychiatric Institute of Washington increased 19.9%.
Source: District of Columbia Hospital Association Utilization Indicators, Calendar Year 2018 Report, issued March 2019

• 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 | 26.65 |
| 2 | MALIGNANT NEOPLASMS | 893 | 21.54 |
| 3 | ACCIDENTS (UNINTENTIONAL INJURIES) | 340 | 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.
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.
Among emergency department (ED) admissions, 80-95% resulted in a discharge to outpatient care, including to home.

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.
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.

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

### HEALTH PROFESSIONAL WORKFORCE

- District of Columbia has 19 health professional licensing boards that regulates 68 health professions
- Regulated health professions are licensed, certified, or registered
  - 8 professions must complete a DC based jurisprudence exam to become licensed or certified
  - The remainder complete a national exam or coursework in their field and meet statutory requirements including a criminal background check
- DC Health approves educational programs for
  - Nursing (APRN, RN, LPN) programs
  - Nursing Assistive Personnel (nurse aide, home health aide)
  - Emergency Medical Services

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

### HIGHLIGHTS OF HEALTH PROFESSIONS

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

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<tr>
<th>City</th>
<th>Matriculants</th>
<th>Graduates</th>
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<tr>
<td>Washington, DC</td>
<td>350</td>
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<td>Baltimore, MD</td>
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<td>10</td>
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<tr>
<td>Georgetown, D.C.</td>
<td>189</td>
<td>120</td>
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<td>Detroit, MI</td>
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<td>60</td>
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<tr>
<td>Philadelphia, PA</td>
<td>126</td>
<td>80</td>
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Source: American Association of Medical Colleges (AAMC), *MedSchoolMapper.org

COMMUNITY IMPACT OF DC MEDICAL SCHOOLS

DC Medical Schools (2018-19)

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<tr>
<th>University</th>
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<tr>
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<td>100</td>
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<tr>
<td>Georgetown</td>
<td>200</td>
</tr>
<tr>
<td>Howard University</td>
<td>120</td>
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</tbody>
</table>

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

**HEALTH PROFESSIONAL WORKFORCE**

- Health Professional Loan Repayment Programs (HPLRP) have demonstrated success in recruiting primary care providers, dentists, and behavioral health providers to health professional shortage areas and medically underserved areas
  - Anecdotally, high rates of turnover after program eligibility ends
  - Program does not create opportunities for host sites to retain their providers
  - Nationally administered programs have similar incentives as HPLRP

• 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.

**HEALTH PROFESSIONAL WORKFORCE**

- Modern care delivery models do not rely on a physician-nurse dichotomy
  - DC’s robust cadre of health professionals support these models theoretically
  - Successful implementation often impeded due to:
    - Lack of understanding of scopes of practice
    - Payment models that support team-based care and value-based care
- Opportunities exist for focused efforts to create a pipeline and workforce development strategy in the District encompassing allied health, nursing, dentistry, and medicine
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.

**TECHNOLOGY**

- Technological advances in healthcare delivery reduces the reliance on inpatient care
  - Robotics
  - Pharmacogenetics/Pharmacogenomics/Personalized medicine

- 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.

**FUTURE OF HEALTHCARE**

- Transition away from freestanding hospitals and health centers to Strategic Partnerships, Clinically Integrated Networks, and Accountable Care Organizations
- Use of population management tools to improve patient outcomes and reduce cost
- Increased Public Health and Clinical Care collaboration to improve individual and community health
- Continued shift away from physician-nurse dichotomy to a diversified cadre of health professionals in a number of care settings
- Advances in health technology beyond EHR/HIT with potential to improve access to care and reduce reliance on inpatient services
FUTURE OF HEALTHCARE

- Government is them, Governance is all of us
  - What recommendations will be most effective in changing the landscape in the District short-term and long-term?
  - What are the facilitators/barriers to the creation of integrated healthcare delivery systems in the District of Columbia relative to the work of your subcommittee?
  - How can the issues addressed by your subcommittee facilitate access to an integrated healthcare delivery system for every resident of the District of Columbia?
  - What factors internal to the healthcare delivery system pose the greatest risk of success to the recommendations from your subcommittee?
  - What factors external to the healthcare delivery system pose the greatest risk of success to the recommendations from your subcommittee?

- 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

- 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.

HISTORY OF NFPHC

At A Glance...
- Began as 380-bed Morris Cafritz Memorial Hospital in 1966.
- Renamed as Greater Southeast Community Hospital in 1974.
- Opened a 1800-bed nursing home in 1980.
- Became United Medical Center in 2008.
- Had multiple owners from 1999-2010.
• UMC’s governance structure is unique, including how it is an instrumentality of the District of Columbia.

**DISTRICT GOVERNMENT ROLE AT UMC**

**Hospital Structure**
- UMC is an instrumentality of the District of Columbia.
- The District purchased the assets of the Hospital in 2010.
- DC Government provides capital and operating funds to the facility annually.
- UMC works closely with key agencies such as:
  - Department of Healthcare Finance
  - Department of Health
  - Board of Ethics and Government Accountability

**Board of Directors**
- Appointed by the Mayor’s Office of Talent and Appointments
  - The Mayor appoints 6 seats of the Board
  - The Council appoints 3 seats of the Board
  - The CFO of the District or designee serves as voting ex-officio member.

• Dr. Fair presented the organization chart for UMC.

**ORGANIZATIONAL CHART: BOARD OF DIRECTORS**
• 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.

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

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

• 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

Acute Care Admissions*

*Includes observation admissions

SURGERIES BY STATUS

Surgeries by Status

John A. Wilson Building | 1350 Pennsylvania Ave., NW, Suite 513 | Washington, DC 20004
**Clinic Visits**

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<thead>
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<th>Year</th>
<th>Visits</th>
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<tr>
<td>FY 2015</td>
<td>12,651</td>
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<tr>
<td>FY 2016</td>
<td>18,634</td>
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<td>FY 2017</td>
<td>17,493</td>
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<tr>
<td>FY 2018</td>
<td>13,840</td>
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**Hospital Based Specialty Clinics:**
- Cardiology
- Urology
- Gastroenterology
- Obstetrics and Gynecology
- Orthopedic
- Infectious Disease
- Primary Care
- General Surgery

**Ob/Gyn Background**

**Figure III: OB/GYN Beds in District of Columbia**
Source: DC DOH Health Regulation Licensing Administration

<table>
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<th>Hospital</th>
<th>Beds</th>
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<td>Georgetown University Hospital</td>
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<tr>
<td>Armed Forces Hospital</td>
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<td>Walter Washington University Hospital</td>
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<td>Howard University Hospital</td>
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<td>St. Anne's Hospital</td>
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<td>United Medical Center</td>
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2007-2017, births at UMC decreased 19% 
- 2010 and 2011, UMC had 10% of total births to Ward 7 and Ward 8 residents 
- In 2017, residents 7 and 8 residents, only 4% delivered at UMC

Source: DC DOH Center for Policy, Planning and Evaluation
WHY THE DECLINE IN VOLUMES?

- Detrimental headlines in major newspapers and media outlets
- Public belief that UMC is closed or closing immediately
- Closure of Obstetrics Service Line
- Public notice of layoffs due to subsidy reduction resulting in increased employee turnover
- Loss of MRI capability since December 2018
- Emergency department wait times

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

QUALITY OF CARE 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

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<tr>
<th>PATIENT SATISFACTION</th>
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<td>CAHPS</td>
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<td>2016</td>
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<td>Top Box</td>
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<tr>
<td>Rate hospital 0-10</td>
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<td>Recommend the hospital</td>
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<td>Cleanliness of hospital environment</td>
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<td>Quietness of hospital environment</td>
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<td>Comm w/ Nurses</td>
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<td>Response of Hosp Staff</td>
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<td>Comm w/ Doctors</td>
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<tr>
<td>Hospital Environment</td>
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<tr>
<td>Communication About Pain</td>
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<tr>
<td>Pain Management</td>
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<tr>
<td>Comm About Medicines</td>
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<tr>
<td>Discharge Information</td>
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</tbody>
</table>
• 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.

### CONTRIBUTING FACTORS TO FINANCIAL DECLINE

**Contributing Factors to Revenue Decline:**

- Declining volumes due to public perception and lack of trust in patient care
- UMC’s only MRI became inoperable in December 2018 resulting in loss of volume and transfers for all inpatients and outpatients needing MRI services
- IT Interface not built for streamlined billing of outpatient services until FY 2019

• 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.

### OBSTACLES AFFECTING EXPENSE MANAGEMENT

- UMC has 4 Collective Bargaining Agreements. Over 65% of all positions are unionized
- ICU flooded in January 2019 resulting in transferring some patients and establishing temporary ICU with less beds and less efficiency
- Lack of digital processes in critical areas such as Human resources and supply chain purchasing and ordering
- Historical reputation of UMC’s failure to pay vendor’s timely has limited vendor choices for services
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
• Balancing the budget has resulted in a realignment and reductions in force at UMC.

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**SUBSEQUENT UMC ACTIONS**

- Organizational realignment:
  - Impact analysis of all reduced positions presented and approved by board
  - Reduce vendor agreements spend
  - Eliminate merit increases for FY19 and FY20
  - Reduce agency spend
  - Obtained DSH appeal payments

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**REALIGNMENT AT UMC**

- RIF was accomplished without terminating bedside personnel or eliminating any service lines
- The RIF for non-union employees was implemented July and union RIF was facilitated on August 12th
- UMC management offered affected employees all open critical vacant positions to include bedside nursing, technicians, and sitter positions
- The RIF has caused internal morale problem and led many employees to actively search for employment outside of UMC
- The increased turnover has caused staffing challenges and the current narrative of UMC has made it difficult to fill critical vacancies
• There are several current efforts to ensure the quality of care at UMC, particularly while facing a reduction in force.

**CURRENT EFFORTS**

- Ensure the quality of care
- Supporting local businesses
- Local workforce recruitment

• 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.

**FUTURE PLANS**

- Community partnerships
- Internal workforce development
- Contribute to developing a health system
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.
Hospitals play an important role in the economy of the District of Columbia. Hospitals represent the second largest employer in the District.
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.

### Hospital Bed Considerations

1. **Looking at operational beds and capacity only tells one story.**
   a. Because a bed is available doesn't mean it can be used.
   b. Beds are designated for certain conditions. Hospitals can't admit a patient to an OB/GYN bed if they are not in labor and in need of psychiatric services.

2. **Boarding happens when beds are not available for immediate use of the admitted patients.**
   a. Hospitals could be waiting for discharges to be completed and environmental services to clean the room.
   b. Boarding can take place for 24-72 hours, but during that time the patient receives the care needed.
   c. Overuse of ED can slow the process of admitting.

3. **Operationalizing beds is a complex formula of available space, staffing and appropriate settings.**

4. **Hospitals also must account for seasonal spikes and emergency situations.**

### Hospital Bed Considerations (cont.)

5. **Health care has changed since many District hospitals received their licenses.** We've moved from hospital wards to semi-private rooms and are now transitioning to private rooms only.
   a. The move to private rooms are for patient satisfaction and infection control.

6. **In many hospitals, converting beds from licensed to operational require construction of additional space to operationalize the beds.**
   a. Hospitals must deal with the issue of shared facilities that impact the admittance of different genders.

7. **Hospitals and health care providers around the District face a nursing shortage, especially in specialty fields.**
   a. Hospitals have been implementing nurse training programs to ensure that new nurses with less experience can be hired and receive the necessary training to increase the pool.
• 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.

Ideas to Address the Problem

1. Improved discharge planning
   a. Patient navigation and coordination
   b. Continue to lower barriers for nursing home placement
   c. Expanded collaboration with post acute providers
      i. Medical respite
      ii. Home health
2. Accessible services
   a. Address skilled nursing needs for Alliance and homeless residents
   b. Streamlined process for waiver applications
3. Improved care management
   a. Increase primary care utilization
   b. Increase access to specialists (in-person/telehealth)
   c. Better manage chronic conditions
   d. Reduce over utilization of Emergency Department
4. Behavioral health
   a. Improved outpatient treatment for mental and substance use patients
   b. Sobering Centers

• 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 Selected Visit Data

- 617,100 Medical Visits
- 102,359 Dental Visits
- 108,664 Mental Health Visits (MH provider)
- 27,909 SUD Visits (SUD provider)
- 82,412 Enabling and other Services Visits
- 5,949 Vision Services

Almost 1 Million Visits!
## 2018 Prenatal Patients

Increased Prenatal Patients by 30% since 2016

| Prenatal | | |
|----------|---|---|---|
| Number of Prenatal Patients | 3,858 | 7,611 | 7,817 |
| Number of Prenatal Patients who delivered | 3,081 | 3,684 | 3,417 |

### Quality of Care Measures

#### Prenatal Health

| Percentage of Prenatal Patients with Access to Prenatal Care (First Prenatal Visit in 1st Trimester) | 64.0% | 63.4% | 63.1% |
| Number of Access to Prenatal Care (First Prenatal Visit in 1st Trimester) | 3,050 | 4,687 | 4,785 |
| Percentage of Newborns with Low and Very Low Birth Weight | 10.70% | 8.49% | 8.64% |
| Number of Newborns with Low and Very Low Birth Weight | 301 | 217 | 287 |

---

### FQHC Payers

- Medicaid: 54%
- Medicare: 13%
- Other Public: 13%
- Uninsured: 15%
- Private: 6%
Patient Income

- 52% At/Below 100% of Poverty
- 100% and below 52%
- 101-150% 14%
- 151-200% 6%
- Over 200% 9%
- Unknown 20%

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

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John A. Wilson Building  | 1350 Pennsylvania Ave., NW, Suite 513 | Washington, DC 20004
2019 Quality Awards

- 7 of 8 are PCMH Recognized
- All recognized for HIT Quality
- 2 achieved the best overall clinical performance nationally
- 4 demonstrated at least 15% improvement on a clinical quality measure
- 5 increased the total number of patients served and the number of patients receiving comprehensive services
- 4 met or exceeded the Healthy People 2020 goals, or made at least a 10% improvement across different racial/ethnic groups

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

2018 FQHC Health-Related Social Supports

- Food Security Programs
- Housing Stability Interventions
- Interpersonal Violence Programs
- Home Visitation
- Legal Assistance
- Workforce Development
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.
• 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.

**Connected Care Network**

Seven DC-based community health centers and the DC Primary Care Association (DCPCA) have come together to establish a clinically integrated network named the DC Connected Care Network (DCCCN).

**Key Stakeholders:**

![DCPCA](image1)

![We See You](image2)

![Community of Hope](image3)

![Bread For the City](image4)

![EMCS](image5)

![Mary's Center](image6)

![La Clinica Del Pueblo](image7)

![Unity Health Care](image8)

• 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.

**Components of CCN FQHC Partnership Model**

- 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

• 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 positive 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

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

9. Adjournment

• 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.