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# **MAYOR'S COMMISSION ON HEALTHCARE SYSTEMS TRANSFORMATION**

## **Report and Recommendations of the Mayor's Commission on Healthcare Systems Transformation**

The Honorable Muriel Bowser, Mayor  
District of Columbia

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## I. EXECUTIVE SUMMARY

The District of Columbia's health care system has faced a number of challenges over the last several years, resulting in inequitable access to the many health care resources available to residents. With the closure of Providence Hospital and a new hospital at St. Elizabeths East on the horizon, the District is approaching a critical juncture. In anticipation, Mayor Muriel Bowser established the Mayor's Commission on Healthcare Systems Transformation, composed of 27 key leaders across the District's health care system.<sup>1</sup> In particular, Mayor Bowser requested that the Commission develop recommendations, addressing the current stresses in the District's health care system.

Pursuant to Mayor Bowser's request, the Commission sought to develop a set of recommendations, outlining the strategies and investments necessary to transform health care delivery in the District of Columbia, with the overall goal of creating a more equitable, robust, and integrated system of care for all District residents. These recommendations were developed by six Committees, each focused on a key challenge facing the health care system:

- Equitable geographic distribution of acute, urgent, and specialty care;
- Overcrowding in emergency rooms and the general reliance on inpatient hospital care;
- Discharge planning and transitions of care;
- Access to critical and urgent care services, specifically maternal, behavioral, and emergency services;
- Allied health care professionals and workforce development; and
- Value-based purchasing of health care services.

Each Committee was tasked with conducting an in-depth examination of its focus area and developing a robust set of recommendations tailored to the unique needs of the District and its residents. Once these recommendations were finalized, they were brought before the full Commission for consideration and approval. The result of this work is 42 recommendations, with a number of sub-recommendations, grouped by the six key issues examined at the committee level. These recommendations, which have garnered support across the health care stakeholders serving on the Commission, are all aimed at creating equity and ensuring the long-term strength of the health care system.

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<sup>1</sup> Commission Co-Chairs later added three additional members to the Commission.

## **II. INTRODUCTION**

### **A. Commission Background**

Recognizing the ongoing changes in the health care ecosystem within the District, especially after the closure of Providence Hospital, Mayor Muriel Bowser established the Mayor's Commission on Healthcare Systems Transformation on June 3, 2019 in order to recommend the strategies and investments necessary to improve health care delivery in the District of Columbia.

Over the last 7 months, the Commission worked collaboratively to produce the recommendations included in this report. Given a specific set of requests, and mindful that the Commission is scheduled to sunset on December 31, 2019, the Commission adopted an aggressive timeline and work schedule for the production of this report.

Collectively, the Commission's work focused on developing recommendations that address the current challenges in the District's health care system, while specifically targeting the following issues: improving access to primary, acute, and specialty care services, including behavioral health care; addressing health system capacity issues for inpatient, outpatient, pre-hospital, and emergency room services; and promoting an equitable geographic distribution of acute care and specialty services in communities east of the Anacostia river.

Accepting its charge, the Commission divided itself into six Committees to examine and provide recommendations regarding:

- Equitable geographic distribution of acute, urgent, and specialty care;
- Overcrowding in emergency rooms and the general reliance on inpatient hospital care;
- Discharge planning and transitions of care;
- Access to critical and urgent care services, specifically maternal, behavioral, and emergency services;
- Allied health care professionals and workforce development; and
- Value-based purchasing of health care services.

The Commission was led by former Councilmember and Chairman of the Committee on Health, David A. Catania, and Sister Carol Keehan, the long-time CEO of the Catholic Health Association of the United States and a former CEO of Providence Hospital. Both Co-Chairs, along with the Commission members below are respected and recognized leaders in the District's health care community.

## B. Commission Membership

On June 3, 2019, Mayor Bowser issued an Executive Order to create the Mayor's Commission on Healthcare Systems Transformation and appointed the members below to the Commission.<sup>2</sup>

|                                      |  |
|--------------------------------------|--|
| <b>Co-Chairs (2)</b>                 |  |
| David Catania                        | Managing Director, Georgetown Public Affairs   |
| Sister Carol Keehan                  | CEO, Catholic Health Association of the United States (Retired)  |
| <b>Acute Care Hospitals (5)</b>      |  |
| Kimberly Russo                       | CEO, The George Washington University Hospital   |
| Kevin Sowers                         | President, Johns Hopkins Health System; Executive Vice President, Johns Hopkins Medicine   |
| Oliver Johnson                       | Executive Vice President and General Counsel, MedStar Health   |
| Dr. Malika Fair                      | Vice Chair, Board of Directors, United Medical Center  |
| Dr. Hugh Mighty                      | Dean and Vice President of Clinical Affairs, College of Medicine, Howard University  |
| <b>Specialty Hospitals (3)</b>       |  |
| Corey Odol                           | Director of Business Development and Government Affairs, Psychiatric Institute of Washington                                       |
| Dr. Denice Cora-Bramble              | Executive Vice President and Chief Medical Officer for Ambulatory and Community Health Services, Children's National Health System |
| Marc Ferrell                         | President and CEO, BridgePoint Healthcare  |
| <b>Community Representatives (6)</b> |  |
| Don Blanchon                         | CEO, Whitman-Walker Health System  |
| Kim Horn                             | President, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.  |
| Maria Harris Tildon                  | Executive Vice President for Marketing, Communications and External Affairs, CareFirst BlueCross BlueShield                        |
| Dr. David Stewart                    | Chair, Department of Family & Community Medicine, University of Maryland School of Medicine  |
| Kelly Sweeney McShane                | President and CEO, Community of Hope   |
| Maria Gomez                          | President and CEO, Mary's Center   |

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<sup>2</sup> Vincent Keane, Dr. Raymond Tu, and Karen Dale were added as members of the Commission by the Commission Co-Chairs.

| <b>Ex Officio Members (13)</b> |   |
|--------------------------------|---|
| Rashad Young                   | City Administrator  |
| Wayne Turnage                  | Deputy Mayor for Health and Human Services                                      |
| Dr. LaQuandra Nesbitt          | Director, Department of Health  |
| Dr. Barbara Bazron             | Director, Department of Behavioral Health                                       |
| Melisa Byrd                    | Senior Deputy Director and Medicaid Director, Department of Health Care Finance |
| Dr. Faith Gibson Hubbard       | Executive Director, Thrive by Five DC   |
| Gregory Dean                   | Fire and EMS Chief, Fire and Emergency Medical Services Department              |
| Vince Gray                     | Chair, Committee on Health, Council of the District of Columbia                 |
| Tamara Smith                   | President and CEO, D.C. Primary Care Association                                |
| Jacqueline Bowens              | President and CEO, D.C. Hospital Association                                    |
| Dr. Gregory Argyros            | President, MedStar Washington Hospital Center                                   |
| Vincent Keane                  | President and CEO, Unity Health Care, Inc.                                      |
| Dr. Raymond Tu                 | President, Medical Society of the District of Columbia                          |
| Karen Dale                     | Market President, AmeriHealth Caritas District of Columbia                      |

## C. Commission Committees

The Commission's work was divided into 6 Committee's with the following jurisdictions and memberships:

| <b>Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care</b>   |
|--|
| <p><i>Committee Jurisdiction</i></p> <p>The District's health care system capacity, with emphasis on the equitable geographic distribution of acute, urgent, and specialty care throughout the city.</p>   |
| <p><i>Requested Recommendations</i></p> <p>The Committee's recommendations should include long term solutions to the capacity issues faced, including access to services by residents who live in Wards 7 and 8.</p>   |
| <p><i>Committee Chairperson &amp; Members</i></p> <p>Chairperson:<br/>Malika Fair, M.D. (Vice Chair, Board of Directors, United Medical Center)</p> <p>Vice- Chairperson:<br/>Vince Gray (Chair, Committee on Health, Council of the District of Columbia)</p> <p>Committee Members:<br/>Kelly Sweeney McShane (President and CEO, Community of Hope)<br/>Dr. LaQuandra Nesbitt (Director, Department of Health)<br/>Kevin Sowers (President, Johns Hopkins Health System; Executive Vice President, Johns Hopkins Medicine)<br/>Dr. Gloria Wilder (President and CEO, Core Health and Wellness Centers)</p> <p>Ex-Officio:<br/>David Catania (Co-Chair)</p> <p>Committee Government Liaison:<br/>Cavella Bishop (Program Manager, Clinicians, Pharmacy, and Acute Provider Services, Department of Health Care Finance)</p> |

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

### *Committee Jurisdiction*

Overcrowding in emergency rooms and the general heavy reliance on inpatient hospital care.

### *Requested Recommendations*

The Committee's recommendations should address the existing barriers to decreasing non-emergency 911 emergency medical service call volume, emergency department wait times, and unnecessary demands on the system.

### *Committee Chairperson & Members*

#### Chairperson:

Kimberly Russo (CEO, The George Washington University Hospital)

#### Vice- Chairperson:

Gregory Dean (Fire and EMS Chief, Fire and Emergency Services Department)

#### Committee Members:

Oliver Johnson (Executive Vice President and General Counsel, MedStar Health)

Vince Keane (President and CEO, Unity Health Care, Inc.)

Rashad Young (City Administrator)

Karen Dale (Market President, AmeriHealth Caritas District of Columbia)

#### Ex-Officio:

David Catania (Co-Chair)

#### Committee Government Liaison:

Dr. Robert Holman (Medical Director, Fire and Emergency Medical Services Department)

John Coombs (Deputy Chief of Staff, Fire and Emergency Medical Services Department)



## Committee on Discharge Planning and Transitions of Care

### *Committee Jurisdiction*

Discharge planning and transitions of care.

### *Requested Recommendations*

The Committee should provide recommendations on how to improve inpatient discharge processes and respite care capacity, particularly for those in need of intermediate care and nursing home care. This includes identifying strategies to address transitions of care for the homeless population. The Committee should also recommend innovative programs that the city could employ through private partnerships to address the issues.

### *Committee Chairperson & Members*

#### Chairperson:

Marc Ferrell (President and CEO, BridgePoint Healthcare)

#### Vice- Chairperson:

Dr. Gregory Argyros (President, MedStar Washington Hospital Center)

#### Committee Members:

Corey Odol (Director of Business Development and Government Affairs, Psychiatric Institute of Washington)

Dr. David Stewart (Chair, Department of Family & Community Medicine, University of Maryland School of Medicine)

Dr. Feseha Woldu (Vice President, Population Programs and Community Affairs, MedStar Health)

Veronica Damesyn (Executive Director, DC Health Care Association)

#### Ex-Officio:

David Catania (Co-Chair)

#### Committee Government Liaison:

Dr. Sharon Lewis (Senior Deputy Director, Health Regulation and Licensing Administration, Department of Health)

Raessa Singh (Programs and Policy Coordinator, Systems Transformation Administration, Department of Behavioral Health)

## Committee on Access to Critical and Urgent Care Services

### *Committee Jurisdiction*

Access to critical and urgent care services, specifically maternal, behavioral, and emergency services. The Committee should examine and report on factors that contribute to problems related to behavioral health care delivery and what policy changes are required to relieve the current strain on the system.

### *Requested Recommendations*

The Committee should offer an array of recommendations and should consider all options, including technology-based solutions.

### *Committee Chairperson & Members*

#### Chairperson:

Dr. Hugh Mighty (Dean and Vice President of Clinical Affairs, College of Medicine, Howard University)

#### Vice- Chairperson:

Wayne Turnage (Deputy Mayor for Health and Human Services)

#### Committee Members:

Dr. Barbara Bazron (Director, Department of Behavioral Health)

Dr. Faith Gibson Hubbard (Executive Director, Thrive by Five DC)

Maria Harris Tildon (Executive Vice President for Marketing, Communications and External Affairs, CareFirst BlueCross BlueShield)

Dr. Patrick Canavan (Vice President for Consulting Services, IdeaCrew)

Dr. Jeffrey Dubin (Senior Vice President, Medical Affairs, and Chief Medical Officer, MedStar Washington Hospital Center)

Dr. Robert Holman (Medical Director, Fire and Emergency Medical Services Department)

Michael Crawford (Associate Dean for Strategy, Outreach, and Innovation, College of Medicine, Howard University)

#### Ex-Officio:

Sister Carol Keehan (Co-Chair)

#### Committee Government Liaison:

Fern Johnson-Clarke (Senior Deputy Director, Center for Policy, Planning and Evaluation, Department of Health)

Noah Smith (Associate Director, Division of Health Information Technology & Exchange, Health Care Reform and Innovation Administration, Department of Health Care Finance)

## **Committee on Allied Health Care Professionals and Workforce Development**

### *Committee Jurisdiction*

Obstacles to allied health care professions serving communities throughout the District.

### *Requested Recommendations*

The Committee should identify barriers to meeting the demands of communities throughout the District for locally-based allied health care professionals and recommendations to reduce the obstacles certain provider types face in trying to serve a community.

### *Committee Chairperson & Members*

#### Chairperson:

Maria Gomez (President and CEO, Mary's Center)

#### Vice- Chairperson:

Tamara Smith (President and Chief Executive Officer, D.C. Primary Care Association)

#### Committee Members:

Melisa Byrd (Senior Deputy Director and Medicaid Director, Department of Health Care Finance)

Corey Odol (Director of Business Development and Government Affairs, Psychiatric Institute of Washington)

Dr. Raymond Tu (President, Medical Society of the District of Columbia)

Ronald Mason, Jr. (President, University of the District of Columbia)

#### Ex-Officio:

Sister Carol Keehan (Co-Chair)

#### Committee Government Liaison:

Lauren Ratner (Special Advisor, Health Care Transformation, Office of the Director, Department of Health)

| <b>Committee on Value-Based Purchasing of Health Care Services</b>  |
|---|
| <p style="text-align: center;"><i>Committee Jurisdiction</i></p> <p>Value-based purchasing and how the current financing system (public and private) serves as a barrier or facilitator to transformation.</p>  |
| <p style="text-align: center;"><i>Requested Recommendations</i></p> <p>The Committee should offer recommendations that outline how innovative models in health care financing would contribute to better patient outcomes or system efficiencies and explore investments and realignments that can further transformation.</p>  |
| <p style="text-align: center;"><i>Committee Chairperson &amp; Members</i></p> <p>Chairperson:<br/>Don Blanchon (CEO, Whitman-Walker Health System)</p> <p>Vice- Chairperson:<br/>Jacqueline Bowens (President and CEO, D.C. Hospital Association)</p> <p>Committee Members:<br/>Melisa Byrd (Senior Deputy Director and Medicaid Director, Department of Health Care Finance)<br/>Dr. Denice Cora-Bramble (Executive Vice President and Chief Medical Officer for Ambulatory and Community Health Services, Children’s National Health System)<br/>Kim Horn (President, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.)<br/>Oliver Johnson (Executive Vice President and General Counsel, MedStar Health)<br/>Dr. Feseha Woldu (Vice President, Population Programs and Community Affairs, MedStar Health)<br/>Michael Crawford (Associate Dean for Strategy, Outreach, and Innovation, College of Medicine, Howard University)<br/>Tamara Smith (President and Chief Executive Officer, D.C. Primary Care Association)</p> <p>Ex-Officio:<br/>Sister Carol Keehan (Co-Chair)</p> <p>Committee Government Liaison:<br/>Amelia Whitman (Policy Director, Office of the Deputy Mayor for Health and Human Services)</p> |

### III. COMMISSION RECOMMENDATIONS

Pursuant to the Commission’s unanimously adopted schedule, each Committee submitted “Committee Recommendations” to the Commission on September 27, 2019. These “Committee Recommendations” were, in turn, assembled and evaluated by the Commission Co-Chairs, and presented to the entire Commission for consideration.

#### A. Summary of Commission Recommendations

The following Committee Recommendations were adopted by the full Commission:

##### **Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care**

1. Provide increased loan repayment/incentives to recruit and retain primary care and designated specialty providers, as well as non-clinical staff, in Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs).
2. Facilitate health system integration by providing legal and regulatory technical assistance to providers who wish to develop clinically integrated networks (CINs), Accountable Care Organizations (ACOs), and Independent Physician Associations.
3. Adjust the closure date of United Medical Center (UMC) to align UMC’s operations with the opening date for a new hospital to allow for sufficient overlap with the new hospital. This includes ensuring smooth transition for the residents of the skilled nursing facility at UMC.
4. Develop a work plan for the success of a new hospital at St. Elizabeths, which should include the establishment of an integrated health system for all Washingtonians, with an emphasis on the East End.
5. Pilot a city-wide model, with a focus on Wards 7 and 8, to better connect prenatal care to the labor and delivery options in other parts of the city – through peer support networks, co-management, access to maternal and fetal medicine specialty, improvement in health information exchange, and assistance with transportation.
6. Maintain the obligation that requires financial resources received from the redevelopment of Reservation 13 be used for initiatives focused on the uninsured and addressing health care inequities.

7. Develop a shared, central repository of emergency department (ED) and urgent care access data to promote understanding of changes in patient use of ED, urgent, and primary care services over time.
8. Provide appropriate training and skill development to students in the Summer Youth Employment Program (SYEP) to facilitate their employment in peer-to-peer health education and support.
9. Use recurring local funds to support State Health Planning and Development Agency's (SHPDA) Certificate of Need (CON) responsibilities, and utilize existing CON fees for modernization, innovation, and special projects to meet the needs of medically underserved areas, as well as to develop the Health Systems Plan.

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

1. Develop a citywide, broad-based community public relations campaign regarding available health resources in the District, including how to access these medical services, along with the proper use of 911.
2. Convene governmental and non-governmental partners to build on the initial successes of the Fire and Emergency Medical Services (FEMS) "Right Care, Right Now" Nurse Triage Line program, with the goal of diverting an additional 15% of calls that are non-emergent.
3. Evaluate other models of care to meet the demand of medical services requested in the field – such as the federal Emergency Triage, Treat, and Transport (ET3) Medicare model; community paramedicine responders; and community health workers – with the goal of directing individuals to the right level of care, and reducing the overutilization of the resources of emergency departments and FEMS.
4. Implement the National Emergency Department Overcrowding Score (NEDOCS) in all acute care hospitals, as a validated tool to assist FEMS in adequate level loading of emergent transfers and surge management within the facilities. Implementing surge management protocols, during periods of overcrowding, should not result in penalties or further scrutiny to the healthcare facility.
5. Use telehealth to provide initial consultations, pre-arrival assessments, and follow-up care to promote appropriate care intervention in a timely fashion. Incentives and regulatory constraints should be assessed to entice participation by providers and patients. A successful model should include telehealth reimbursement rates that meet the market rate/cost of the service.

6. Engage in a comprehensive process to address the specialized needs and challenges presented by justice-involved individuals, with the goal of treating these patients safely in appropriate care settings, e.g., the Central Cell Block or other Department of Corrections facilities.
7. Develop incentives for use of the appropriate level of care, and disincentives for use of emergency departments, for non-emergency issues.
8. Encourage and promote enrollment in comprehensive case management for all participants in publicly-funded healthcare.

### **Committee on Discharge Planning and Transitions to Care**

1. Place a DC Medicaid eligibility staff member onsite at certain qualified providers, such as hospitals or skilled nursing facilities (SNFs). This practice will allow care management departments to obtain eligibility decisions more quickly, thereby reducing delays in discharges, turning over patient beds for new admissions, and moving patients efficiently.
2. Approve a retrospective review process (as opposed to prospective) to improve the efficiency of approvals and transfers of patients. Develop acceptable pre-admission criteria, in cooperation with medical providers, which will expedite the process of transitioning some of the Districts most medically complex patients to the correct level of care.
3. Expand the availability and support for medical respite facilities by reviewing and updating the regulatory requirements, which may create barriers to additional medical respite options.
4. Reduce barriers to operating Advanced Life Support (ALS) and Basic Life Support (BLS) transports in the District through examining licensure and regulatory obstacles.
5. Fund a pilot program with District skilled nursing and long-term acute care facilities in order to determine how telemedicine consultations might reduce unnecessary ED visits and 911 calls.
6. Establish a telecourt for involuntary commitment and probable cause hearings, and consider providing District funding for all District providers, which care for FD-12 (involuntary) individuals, to have a secure platform to interface with the courts in all commitment and probable cause hearings.

## **Committee on Access to Critical and Urgent Care Services**

1. Ensure there is a single, easily accessible citywide health care advice line, staffed by clinicians, to provide medical advice, health care system navigation, and appointment scheduling to all residents.
2. Implement a health literacy campaign focused on *when* and *how* to access care.
3. Conduct surveys and focus groups to understand residents' healthcare decision-making priorities.
4. Consider the final recommendations from the HIE Policy Board, which proposes to make available necessary patient information from the electronic medical record and the minimum data set that should be transmitted upon discharge, to improve transitions of care.
5. Exchange electronic advance directive forms among providers.
6. Incentivize the assessment and sharing of social determinants of health during a first prenatal visit.
7. Increase the capacity of primary care providers to treat substance use disorders.
8. Incentivize the establishment of new Comprehensive Psychiatric Emergency Programs (CPEP) sites and endorse the Department of Behavioral Health proposal for a comprehensive waiver to redesign the CPEP.
9. Open Sobering Centers as an alternative care site for intoxicated individuals who do not require acute medical attention.
10. Increase the capacity of health clinics to provide urgent care services.
11. Implement cultural competence and implicit bias training for clinicians.



### **Committee on Allied Health Care Professionals and Workforce Development**

1. Establish a health careers training consortium to strategize around and guide health workforce training investments to accelerate the expansion of training programs for position shortages and emerging (e.g., telehealth, data analytics) roles; expand early career education; recruit English as a Second Language (ESL) residents; and otherwise ensure training programs are responsive to resident and health system needs.
2. Conduct a quality improvement review of the licensure process to address delays in all aspects of clinical licensing, and develop and implement process improvement plans to reduce turnaround time.
3. Ensure value-based purchasing initiatives calculate the actual costs of and include sufficient reimbursement to support non-clinical patient care positions, such as care coordinators, discharge planners, community health workers, etc.
4. Establish a center for health care workforce analysis to systematically gather, link, and analyze national and local data on current and projected workforce supply and demand and training needs; and develop policy documents and recommendations for District agencies, Council, and funders (e.g., shortages to be addressed, emerging industries, data to be collected through the licensure process, common core skill sets, training resources needed, career pathways, etc).

### **Committee on Value -Based Purchasing of Health Care Services**

1. Engage the community for the road ahead.
  - a. Survey patients and caregivers about current behaviors and perspectives informing access to care choices.
  - b. Share total cost of care information for specific populations by payer with all stakeholders.
  - c. Engage patients and other key stakeholders (i.e., health care groups, payers, and government) in ongoing community dialogue about current value-based purchasing (VBP) and accountable care models, and potential options for the District of Columbia.

- d. Conduct operational readiness assessments of all major health care groups for VBP.
- 2. Expand quality measurement to capture more data on health system effectiveness and to inform care delivery, payment incentives, and population health. Measures should align with existing measures required by federal and other partners.
  - a. Refine the core measure set of health priorities.
  - b. Engage health care groups to achieve multi-payer alignment.
  - c. Adopt public reporting to disseminate performance on the core set.
- 3. Make key investments and policy changes to promote system integration for accountable care transformation.
  - a. Invest in practice transformation capacities.
  - b. Ensure alignment and integration to enable accountability.
- 4. Align payments with value-based care goals to move towards a risk-based model encouraging care coordination and health promotion.
  - a. Expand current VBP measures into other appropriate provider settings.
  - b. Establish a Medicaid accountable care organization (ACO) certification.
  - c. Adopt VBP models.

## B. Explanation of Commission Recommendations

Mayor Bowser's Executive Order establishing the Commission directed its members to examine and provide recommendations regarding six key areas of interest. In order to accomplish this goal, the Commission divided itself into six Committees, aligning with each of the key areas of interest. The full Commission considered the individual recommendations of the Committees and selected the following for inclusion in this report.

### 1. Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care

#### Recommendation #1:

Provide increased loan repayment/incentives to recruit and retain primary care and designated specialty providers, as well as non-clinical staff, in Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs).

#### Background:

In addition to federal loan repayment programs, the District provides the Health Professional Loan Repayment Program (HPLRP) to recruit primary care providers to serve in Health Professional Shortage and Medically Underserved Areas of the District. Current District-run incentive programs are limited to loan repayment and do not target long-term retention. In addition, these incentive programs are restricted to certain provider groups (e.g., no specialists, no entry-level positions). Members of the Committee expressed concern with the inability to *retain* primary care providers and recommend an additional investment in loan repayment, bonuses, and other incentives with a specific emphasis on *retaining* providers. The Committee also recommends funding to recruit and retain additional specialty providers, as well as non-clinical staff, to underserved areas within the District.

#### Expected Impact:

The expected impact is fewer vacancies and lower turnover of providers and staff in the most vulnerable areas of the District. Additionally, usage of the program to attract and retain specialty providers will expand access to services in additional parts of the District.

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| <b>Budget Implications:</b>                    | This recommendation will require a financial investment from the District, as well as a strategic implementation to ensure more longevity of providers in MUAs and HPSAs. Currently, eligible physicians (family practice medicine, general internal medicine, general pediatrics, obstetrics/gynecology, psychiatry, or osteopathic general practice) and dentists can receive a maximum loan repayment of \$151,841.29 over four years. Other eligible providers (dental hygienists, registered nurses, advanced practice nurses, physician assistants, clinical social workers, clinical psychologists, and professional counselors) can receive a maximum of \$83,510.61 over four years. |
| <b>Risk Factors:</b>                           | Consistent and predictable funding will be critical to the success of this effort.  |
| <b>Equality Implications:</b>                  | Further investment in this area would help to enhance healthcare equity by expanding access to primary and specialty healthcare providers.  |
| <b>Social Impact<br/>&amp; Sustainability:</b> | A fully staffed, committed, and long-term primary and specialty care workforce, as well as non-clinical staff, can lead to better health outcomes and improved health equity in the District of Columbia.   |
| <b>Legislative Action:</b>                     | Legislation may be required to expand the program to specialty providers beyond those currently listed. The annual Budget Support Act may be an appropriate vehicle to implement this recommendation, assuming funding is identified.   |

## **Recommendation #2:**

Facilitate health system integration by providing legal and regulatory technical assistance to providers who wish to develop clinically integrated networks (CINs), Accountable Care Organizations (ACOs), and Independent Physician Associations.

### **Background:**

The District's health care infrastructure remains frustratingly fragmented. Smaller providers often lack the basic legal and regulatory understanding and/or resources to approach other providers for purposes of integration. Issues like HIPAA, liability, professional credentialing, cost and revenue sharing, etc. often present daunting challenges to undercapitalized entities that lack the staff and expertise to forge these often complicated relationships.

The establishment of a regulatory/compliance clearinghouse of documents and resources could assist in removing an important barrier to greater cooperation and integration. The Committee also recommends developing a workshop, led by the Departments of Health and Health Care Finance, for entities and individuals who are interested in learning more about developing these networks, as well as how to initiate service in the District.

### **Expected Impact:**

Increased understanding of legal and regulatory obligations will facilitate a stronger infrastructure for organizations seeking to integrate with other providers.

### **Budget Implications:**

This effort would require the creation of handbooks or resource guides and templates to guide these activities. These documents already exist among the larger, better resourced health care entities in the District. The cost of this effort could be greatly reduced if the larger entities were willing to share their existing templates with the clearinghouse.

### **Risk Factors:**

The Committee did not identify any risk factors associated with this recommendation. However, there may be other issues beyond legal and regulatory infrastructure that impact a provider's ability to integrate with other providers or network.

|  |   |
|--|---|
| <b>Equality Implications:</b>                  | A legal and regulatory clearinghouse would allow lesser resourced health care entities to explore CINs, etc.                    |
| <b>Social Impact<br/>&amp; Sustainability:</b> | A better integrated health care system should lead to greater efficiencies and improved health outcomes for District residents. |
| <b>Legislative Action:</b>                     | No legislation is needed.   |

**Recommendation #3:**

Adjust the closure date of United Medical Center (UMC) to align UMC's operations with the opening date for a new hospital to allow for sufficient overlap with the new hospital. This includes ensuring smooth transition for the residents of the skilled nursing facility at UMC

**Background:**

The current law calls for UMC to cease admitting patients by December 31, 2022 and the UMC Corporation to dissolve by January 31, 2023. Although every effort must be made to accelerate the planning, design, construction, and opening of the new hospital, the recent experience of the closure of Providence Hospital highlights the importance of providing sufficient overlap. To assure a commitment to quality and safety of our citizens, UMC should remain open for a minimum of two additional weeks post go-live of the new facility. During this two-week period only "essential" services (i.e., emergency department, labs, radiology) would remain open in order to facilitate transfer to the new facility or other existing facilities in the District, based upon clinical presentation and services required. A plan, in collaboration with the Fire and Emergency Medical Services Department, should be developed to support hospital-to-hospital transfers during this two-week period.

As the closure date approaches, staff will likely leave the hospital for new jobs, similar to the experience involving the recent closure of Providence Hospital. This can create safety concerns if the proper contracts are not in place for agency personnel. Incentive payments to existing employees at UMC will be required to keep the services functional and staff at the hospital through closure. This may necessitate the extension of budget subsidies from the District beyond the current anticipated date of December 31, 2022 in order to maintain access to needed services, including acute inpatient services, until the new system of care is operational.

**Expected Impact:**

This recommendation will demonstrate to the community that there is a thoughtful transition plan from UMC to the new facility with a commitment to quality and safety.

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| <b>Budget Implications:</b>                    | Incremental dollars will be needed to support keeping “essential” services open for additional time, including the funding of agency contracts, and incentive payments to keep services staffed at UMC.  |
| <b>Risk Factors:</b>                           | The flight of staff and premature closure is a risk if the appropriate contracts and incentives are not in place once a closure date is set. Additionally, patients may still show up at UMC during the initial phase of opening the new hospital so communication to the community will be essential.   |
| <b>Equality Implications:</b>                  | A successful clinical transition plan for the closure of UMC and start-up of the new facility will demonstrate the District’s commitment to the health of the citizens in Ward 7 and 8.  |
| <b>Social Impact<br/>&amp; Sustainability:</b> | The implementation of a thoughtful closure plan that allows for a successful transition will provide community members with a sense of security that quality hospital services will be maintained through the opening of the new hospital. In order to overcome the legacy of failure that has characterized acute health care in the East End of Washington for more than a generation, special focus is needed to ensure that everything associated with the launch of the new hospital will inspire confidence in it by the residents of the community. |
| <b>Legislative Action:</b>                     | Potential legislation may be needed to support the change in the definition of essential services and the extension of the closure date at UMC. In addition, an appropriation may be required for incremental dollars required to support this change.   |



#### **Recommendation #4:**

Develop a work plan for the success of a new hospital at St. Elizabeths, which should include the establishment of an integrated health system for all Washingtonians, with an emphasis on the East End.

The Committee recommended the following components of the above-recommended work plan:

- Strong encouragement for the health system and the hospital to accept all public insurances.
- Ways that a new health system will address prenatal and delivery needs for women on the East End.
- Shared planning and community input as plans for the new hospital are made, so that a network and trust is created upon its opening.
- A communications plan to explain to the community the type and level of services to be provided at the new hospital, as well as the corresponding ambulatory and urgent care facilities, which are established as part of the District's partnership.
- A strategy to engage with the current providers in the medical office building of UMC, as well as other relevant providers, regarding information about opportunities at the new location.

#### **Background:**

The systems of care in Wards 7 and 8 demand considerable improvement. Opening a new hospital in Ward 8 creates significant opportunities to improve the inequitable distribution of acute, urgent, and specialty care in Wards 7 and 8. It is essential to use this opportunity to build for the future and not replicate the failures of the past. This will require speed, outreach, and coordination of an unprecedented degree. The opportunity to reduce inequities in health outcomes is partially dependent on building trust with residents to encourage usage and with providers to ensure referrals. Early and regular communication will build trust and allow for input to ensure the best implementation possible.

Successful implementation of all the proposed components of the work plan outlined in the recommendation will likely take longer than the current timeframe envisioned. At a minimum, this will necessitate the development of an appropriately sized and configured program plan for the new hospital and the immediate adoption of a transition document, which includes a prioritization

of key strategies and objectives integral to opening the new hospital.

Other priorities included in the recommendation can proceed in parallel following that initial work. The Committee recommends that the Mayor develop a comprehensive plan to ensure that there is coordination between multiple parts of government, community providers, community members, and the hospital operator, which will facilitate a successful transition to a new hospital.

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| <b>Expected Impact:</b>                    | The expected impact is more transparency, communication, and trust with residents of Wards 7 and 8, as well as with community providers.   |
| <b>Budget Implications:</b>                | This plan may require funds for an education and marketing campaign related to accessing care in the right place, at the right time.   |
| <b>Risk Factors:</b>                       | The Committee did not identify any risk factors associated with this recommendation.   |
| <b>Equality Implications:</b>              | The recommendation ensures that residents of Wards 7 and 8 are part of the process in the transition from UMC to the new health system. Further, it ensures that the execution of the transition incorporates issues important for the community and improves health outcomes. |
| <b>Social Impact &amp; Sustainability:</b> | There will be long-term positive influences that will help make the community hospital more successful.  |
| <b>Legislative Action:</b>                 | No legislation is needed.  |

**Recommendation #5:**

Pilot a city-wide model, with a focus on Wards 7 and 8, to better connect prenatal care to labor and delivery options in other parts of the city – through peer support networks, co-management, access to maternal and fetal medicine specialty, improvement in health information exchange, and assistance with transportation.

**Background:**

The District has many providers across the city that provide services and medical care to families who are expecting a child, including follow up care. However, families are often not aware of all of their options for accessing those services before, during, and after a pregnancy. Further, the District continues to have great inequities for maternal and infant health for women of color. While data shows that there are not any “cold spots” for prenatal care, there continues to be many women who do not enter prenatal care in the first trimester, and there are no options for delivery in Wards 7 and 8.

There are also additional challenges that women face in accessing prenatal care and labor and delivery options. These include: the regular diversion of several hospitals due to the demand for labor and delivery beds; difficulty in accessing maternal fetal medicine (MFM) services based on insurances and the distance to travel for appointments; little publicly available information on the quality of providers or the experiences that other families have had with them; and very few opportunities to engage with other community members who can help a family or expectant mother navigate their pregnancy.

Piloting models to address the disconnection between prenatal care and labor and delivery is important, even after the development of a new community hospital. The District should find innovative ways to establish new peer support programs and scale up programs that are already working for families. Several providers, such as those that provide midwifery services, already have peer support programs and families report having positive experiences from utilizing those experiences. Families will often return to those providers for ongoing care.

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| <b>Expected Impact:</b>                    | The expected impact is a reduction in maternal mortality and morbidity and infant mortality. In addition, District residents who are pregnant or planning to become pregnant will have trusted resources for information on where and how to receive services and allow families to engage with other community members who have been through similar experiences.  |
| <b>Budget Implications:</b>                | <p>The Committee recommends further research into existing funding to health clinics that are providing similar services. Funding from philanthropic sources could help to pilot new programs or expand existing services. There may be several other potential financial implications, based on the barriers to be overcome. Some include:</p> <ul style="list-style-type: none"> <li>• Financial incentives that cover the cost for MFM specialists, setting up telehealth, and setting up co-location opportunities in Wards 7 and 8.</li> <li>• Funding to address any barriers to fully implementing the Maternal Health Snapshot such that hospitals can see prenatal records for participating prenatal providers.</li> <li>• Assistance with transportation such as taxis, Uber, or Lyft to ensure that women arrive at the hospitals where they plan for birth. Note that there may be some implications for FEMS to reduce the incidence of diversion to hospitals where a patient's providers are not privileged.</li> <li>• Funding for evaluation of pilot initiatives to measure effectiveness.</li> <li>• Funding for technical assistance to address barriers around malpractice insurance, negotiating agreements, etc.</li> </ul> <p>These expenses should be offset by savings in areas such as reduction of NICU costs.</p> |
| <b>Risk Factors:</b>                       | The Committee did not identify any risk factors associated with this recommendation.  |
| <b>Equality Implications:</b>              | This addresses issues of inequality and inequity regarding prenatal maternal care and will ensure more equity of services among District residents, especially expectant mothers.   |
| <b>Social Impact &amp; Sustainability:</b> | Healthy pregnancies and births have positive long-term impacts on all health areas.   |

**Legislative Action:**

Funding will need to be included in the FY2021 Budget.

## **Recommendation #6:**

Maintain the obligation that requires financial resources received from the redevelopment of Reservation 13 be used for initiatives focused on the uninsured and addressing health care inequities.

### **Background:**

Reservation 13 is comprised of 67 acres located between the eastern edge of the Capitol Hill neighborhood and the western shore of the Anacostia River. It hosts the former DC General Hospital, now closed, the Central Detention Facility/DC Jail, and other buildings and parking lots. The District of Columbia is redeveloping 50 acres of Hill East into a vibrant, mixed-use urban waterfront community in accordance with the Hill East Master Plan, approved by the Council of the District of Columbia in October 2002. In April 2009, the DC Zoning Commission approved the new zoning code specific to the future Hill East development. Once fully built, this new waterfront community will connect the surrounding Hill East neighborhood to the Anacostia waterfront via tree-lined public streets, recreational trails, and accessible waterfront parklands.<sup>3</sup>

By law, any funds received by the District from the redevelopment of these parcels must be used to fund initiatives that support the improvement of health outcomes and reduction of health disparities in the District. The Committee recommends that this obligation be maintained and that there is proper oversight to ensure that the funds are used to support the final recommendations from this Commission.

### **Expected Impact:**

Funds from this development will be used to support modifications, enhancements, and innovation to improve health in the District of Columbia.

### **Budget Implications:**

The Committee did not identify any budget implications for this recommendation.

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<sup>3</sup> <https://dmped.dc.gov/page/hill-east-district-redevelopment>, accessed 9/26/2019

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| <b>Risk Factors:</b>                           | The Committee did not identify any risk factors associated with this recommendation.   |
| <b>Equality Implications:</b>                  | These funds would be used to improve health equity in the District.  |
| <b>Social Impact<br/>&amp; Sustainability:</b> | Given the history of DC General, the transformation of this property into a revenue source for health care is a fitting honor to the legacy of the hospital. |
| <b>Legislative Action:</b>                     | No legislation is needed.  |

**Recommendation #7:**

Develop a shared, central repository of emergency department (ED) and urgent care access data to promote understanding of changes in patient use of ED, urgent, and primary care services over time.

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| <b>Background:</b>                         | The District's Department of Health receives ED utilization data from all District hospitals except for UMC, as well as data from the 13 District EMS organizations. Additionally, the Department of Health has access to real time surveillance data through ESSENCE to monitor general trends and provide insight into the reasons that patients seek care. One limitation is the lack of access to identifiable data that can help to better understand the extent to which individual behaviors are changing based on policy changes, investments, and interventions versus a global decrease in utilization. This proposed change in data collection would allow the global view to be seen including transports by private vehicle, ambulances, and visits to urgent cares. |
| <b>Expected Impact:</b>                    | A new or enhanced database would allow for better understanding of healthcare utilization patterns in the District for planning purposes.   |
| <b>Budget Implications:</b>                | This policy proposal has budgetary implications, especially for urgent and primary care practices that are not currently required to report their data. Currently the District's hospitals pay a considerable amount of money to ensure their data is validated by a private company prior to submission to DC Health.  |
| <b>Risk Factors:</b>                       | Data breaches are a risk if the proper privacy protections are not in place.  |
| <b>Equality Implications:</b>              | Better access to utilization data will help the District to respond to health inequities.   |
| <b>Social Impact &amp; Sustainability:</b> | A more comprehensive database can help determine how effective policy changes, investments, and interventions are to improve health outcomes in DC.   |
| <b>Legislative Action:</b>                 | No legislation is needed.   |



## **Recommendations #8:**

Provide appropriate training and skill development to students in the Summer Youth Employment Program (SYEP) to facilitate their employment in peer-to-peer health education and support.

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| <b>Background:</b>            | Many District residents lack basic public health knowledge, including in the areas of proper usage of emergency rooms, the importance of primary care, diet and nutrition, etc. In an effort to address these issues, the Committee recommends the use of the Marion S. Barry Summer Youth Employment Program (SYEP) to train SYEP participants to be peer educators in their communities on health issues.   |
| <b>Expected Impact:</b>       | In addition to providing public health information to their families and communities, the creation of this Health Corp would serve to expose young people to health care professions, which might influence their career choices.   |
| <b>Budget Implications:</b>   | In recent years, the District government has expended approximately \$10 million annually to support the SYEP program. Additional funding to support the development of the training program and identify organizations to create the corps would be needed.  |
| <b>Risk Factors:</b>          | Balancing the time in training with the time needed in the community will be critical. This concern could be mitigated by beginning instructions during the second semester of school, as part of a comprehensive public health course.   |
| <b>Equality Implications:</b> | The SYEP hires approximately 10,000 participants each year who are between 14-24 years old. Nearly 60% of the participants are residents of Wards 7 and 8. Arguably, the communities that are most in need of enhanced public health knowledge are in these wards. Giving young people who reside in these communities an opportunity to serve their families and neighbors is a powerful tool in narrowing health disparities that continue to afflict our city. |

**Social Impact  
& Sustainability:**

In addition to the impact listed above, this effort will serve to supplement the public health knowledge of the program's participants, hopefully leading to better life-long outcomes for the participants and their families.

**Legislative Action:**

Legislative action is not necessary to effectuate this program. The Mayor could implement the program administratively.

**Recommendation #9:**

Use recurring local funds to support State Health Planning and Development Agency's (SHPDA) Certificate of Need (CON) responsibilities, and utilize existing CON fees for modernization, innovation, and special projects to meet the needs of medically underserved areas, as well as to develop the Health Systems Plan.

**Background:**

The Committee recommends the continuation of a non-lapsing fund into which CON fees are deposited. Further, the Committee recommends against sweeps by the Executive and Council of non-lapsing special funds in health programs (i.e., SHPDA, HRLA) because it discourages long-term investment and technological innovation.

In the past, to accommodate the needs of facilities that provide care to underserved populations, the Council of the District of Columbia, on a case-by-case basis, has legislatively reduced or waived the CON fee requirements. In order to streamline the review process, the Committee recommends the SHPDA develop regulations for expedited review processes of applications, waive certain fees (in-part or in-whole) for projects in underserved areas, as well as receive additional recurring local funds that will allow it to reduce the fees based on an organization's need. However, the CON process should not be waived in these instances because the CON process can provide valuable information about an organization's financial viability, institutional capacity, and quality of services.

Finally, the Committee recommends that the Administration consider shifting behavioral health service approvals to SHPDA to ensure that behavioral health services are better integrated with all other health services, and to ensure consistency with the Health Systems Plan.

**Expected Impact:**

The availability of recurring local funds would allow SHPDA to replace waived or reduced CON fees under hardship circumstances, incentivizing health care facilities to locate in underserved areas. The existing O-type fund should be used to modernize SHPDA and foster technological innovation of the CON process.

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| <b>Budget Implications:</b>                    | This would require the appropriation of \$1,565,551 in recurring local funds in the FY 2021 budget to ensure that DC Health's SHPDA program is held harmless.  |
| <b>Risk Factors:</b>                           | This potentially leaves SHPDA vulnerable to local budget cuts. However, this vulnerability could be mitigated by ensuring funding would be built into the baseline Current Services Funding Level budget.  |
| <b>Equality Implications:</b>                  | This recommendation should improve the equitable distribution of health care services and facilities, while still ensuring appropriate oversight.  |
| <b>Social Impact<br/>&amp; Sustainability:</b> | This proposal will likely incentivize health systems development in underserved areas and make it possible for existing providers to remain in those areas.  |
| <b>Legislative Action:</b>                     | This will require a legislative amendment through the Fiscal Year 2021 Budget Support Act of 2020 to (1) appropriate recurring local funds; (2) permit SHPDA to develop regulations to expedite certain CON review processes and to address requests to reduce or waive CON fees to incentivize health care facilities to locate in underserved areas; and (3) shift behavioral health service approvals to SHPDA. |

## 2. Committee on Emergency Room Overcrowding & General Reliance on Inpatient Hospital Care

### Recommendation #1:

Develop a citywide, broad-based community public relations campaign regarding available health resources in the District, including how to access these medical services, along with the proper use of 911.

#### Background:

According to research conducted by Committee members, patients believe that hospitals are the best place to seek “one-stop” care on an on-demand basis.

AmeriHealth Caritas DC (AHCDC), a member of the Committee, conducted a Member Engagement Project during the period May 1, 2019 – July 31, 2019.<sup>4</sup> The goal of this project was to better understand: (1) barriers to engagement in routine health care; and (2) member receptivity to and willingness to use digital health solutions.<sup>5</sup> The insights highlight the challenges ahead:

- **Patients are appreciative of, but don’t understand, available resources.**
- **Primary care is not valued or trusted.** In general [patient] satisfaction with the healthcare experiences was low and primary care is not a valued service. Many were unsure why it should matter to them. The feelings about primary care were nearly universal. [Patients] grow frustrated with inability to obtain appointments and when they do, the experiences are often negative and they leave feeling as if their concerns were not addressed and no one listened to them or took them seriously.

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<sup>4</sup> Grapevine Health, “A community-based exploration of member engagement,” August 12, 2019 (study conducted for AmeriHealth Caritas DC). Referenced with permission.

<sup>5</sup> The project prioritized pregnant women and members with recurrent low-acuity non-ED visits but no primary care visits in the preceding year. Members were contacted and invited to participate in group discussions or face-to-face conversations. This initial engagement led to additional engagement offerings.

- **Communication approaches should be refined and tailored by group and personality.** Communication with [patients] requires a multi-faceted and tailored approach. [Patients] are least likely to explore the website or read written materials, but enjoy graphics such as photos and videos.
- **Health literacy is critically low.** [Patients] need support navigating the language of health care and communication with providers.
- **Social determinants support may not be linked to outcomes.** Recurring areas of discussion included food and transportation. Pregnant women were generally aware of and some were receiving support for both. ED users were not always aware of transportation support.
- **Patients use technology and are open to digital health support.**
- **Subtle trauma is likely influencing health behavior, including ED use.** Despite the physical and mental stress of living in communities engulfed in trauma, [patients] have become immune to the sights and sounds of violence, neglect and scarcity. These are subtle traumas, often invisible to the health system and even members don't appreciate how their environment might influence their health.<sup>6</sup>

The Fire and Emergency Medical Services Department (FEMS) also created a case study on their experience with the “Right Care, Right Now” Nurse Triage Line (NTL) program. Prior to the launch of the NLT program, described further below, FEMS conducted extensive public education on the program, including through attendance at community and ANC meetings in all eight wards; earned media with local TV, radio and print reporters; and a contract with an outside vendor to conduct digital engagement with government and non-government partners, as well as FEMS patients. Since the launch of the program, the vendor has

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<sup>6</sup> *Id.*

continued its digital outreach to a growing list of text and email subscribers that includes FEMS high volume utilizers, every patient referred to the NTL since launch, and individuals who sign up for the list. This digital engagement program may be a model for other public education campaigns.

Figure 1.

| ← SEEKING CARE AT THE RIGHT PLACE AND RIGHT TIME → |                         |                            |                                   |                    |                    |         |
|--|-------------------------|----------------------------|-----------------------------------|--------------------|--------------------|---------|
| BEFORE 911   |                         | WHEN THE PATIENT DIALS 911 |                                   | WHAT HAPPENS NEXT  |                    | UNKNOWN |
| Understand Interests/<br>Define Incentives         | Robust Public Education | Minimizing ED Visits       | Alternative Transport Destination | Discharge Planning | After the ED Visit | Unknown |

**Expected Impact:** This effort will result in an increase in individuals receiving care in the right setting at the right time through the development of a highly engaged citizenry armed with the information of the services available to them in their community.

**Budget Implications:** Funding will need to be allocated for this effort from a combination of governmental, private, and institutional sources directed towards the Department of Health.

**Risk Factors:** The inability of residents to trust new providers or change usage behaviors may continue even after the campaign.

**Equality Implications:** Increased utilization of primary and specialty care would have a positive impact on health outcomes.

**Social Impact & Sustainability:** Receiving the proper level of care at the right time will free up resources to improve the services received by all residents and lower the cost of delivering care, as well as free up resources to invest in other health initiatives.

**Legislative Action:** Legislation will be required to provide the budget authority needed to implement the communications initiative.

## **Recommendation #2:**

Convene governmental and non-governmental partners to build on the initial successes of the Fire and Emergency Medical Services (FEMS) “Right Care, Right Now” Nurse Triage Line program, with the goal of diverting an additional 15% of calls that are non-emergent.

### **Background:**

The “Right Care, Right Now” Nurse Triage Line program connects callers to 911 with non-emergency medical needs to non-emergency transportation, self-care, and walk-in appointments at community clinics. The nurse asks the caller questions and assesses his or her symptoms so that the nurse can refer the caller to the most appropriate non-emergency medical care available: either self-care, care at a community clinic, or urgent care clinic in the caller’s neighborhood. Over 2,000 patients have been diverted to date. While FEMS is still analyzing data from the first year of operations, patients who have gone through this process generally have a more positive health care and transportation experience than they would have taking an expensive ambulance ride to an emergency department.

### **Expected Impact:**

This recommendation will reduce congestion in the city’s emergency departments and increase the availability of EMS transports for those with emergent conditions.

### **Budget Implications:**

The Committee did not identify any budget implications for this recommendation as this initiative is currently funded.

### **Risk Factors:**

Individuals being referred to the nurse triage line may have a negative initial reaction because they feel they are being denied a service they are accustomed to receiving.

### **Equality Implications:**

Reduction in the call volumes to 911 would increase the availability of this resource to the entire city.

### **Social Impact & Sustainability:**

Moving individuals to the proper level of care will ultimately improve the health outcomes in the District. Reduced call volume will allow for the allocation of resources to other services and make the EMS and health care delivery system more sustainable.



**Legislative Action:**

No legislation is needed.

### **Recommendation #3:**

Evaluate other models of care to meet the demand of medical services requested in the field – such as the federal Emergency Triage, Treat, and Transport (ET3) Medicare model; community paramedicine responders; and community health workers – with the goal of directing individuals to the right level of care, and reducing the overutilization of the resources of emergency departments and FEMS.

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| <b>Background:</b>                         | The Centers for Medicare and Medicaid Services (CMS) has announced the Emergency Triage, Treat, and Transport (ET3) Payment Model. The Fire and Emergency Medical Services Department (FEMS) is applying to participate in this voluntary, five-year payment model, which is intended to provide greater flexibility to emergency medical services providers to address emergency health care needs of Medicare beneficiaries following a 911 call. The program will allow ambulances to transport patients to non-acute care facilities and receive reimbursement for those trips. The planning and application process requires the development of a plan for the transport of patients to a pre-approved clinic or medical facility other than a hospital emergency department. FEMS is currently in the process of finalizing its submission to CMS. |
| <b>Expected Impact:</b>                    | This will result in the diversion of patients from emergency departments and acceleration of innovation in the types of permissible modes of care eligible for payment under federal programs.   |
| <b>Budget Implications:</b>                | Federal, local, or private grant dollars will need to be identified to fund this program.  |
| <b>Risk Factors:</b>                       | Failure to qualify for the five-year payment model.  |
| <b>Equality Implications:</b>              | Implementation of this recommendation would result in the referral of patients to care in or near their community.   |
| <b>Social Impact &amp; Sustainability:</b> | Implementation would ideally result in a healthier community with improved outcomes. Sustainability will have to be examined throughout the 5-year payment model experiment.   |

**Legislative Action:**

Programmatic and budgetary authorization will likely be needed from the Council.

#### **Recommendation #4:**

Implement the National Emergency Department Overcrowding Score (NEDOCS) in all acute care hospitals, as a validated tool to assist FEMS in adequate level loading of emergent transfers and surge management within the facilities. Implementing surge management protocols, during periods of overcrowding, should not result in penalties or further scrutiny to the healthcare facility.

#### **Background:**

NEDOCS is a regular measure of patient volume and throughput in hospitals.<sup>7</sup> It is intended to improve patient flow and operating efficiency.<sup>8</sup> NEDOCS is a linear regression model that associates five operational variables with the degree of crowding assessed by physicians and nurses, and is used by EDs to quantitatively determine crowding.<sup>9</sup> The NEDOCS measure tracks: (1) ED Patients; (2) ED Beds; (3) ED Admits; (4) all inpatient beds regularly staffed; (5) door to bed time for the last patient to receive a bed; (6) the longest holdover, admit waiting for an inpatient bed in the ED; and (7) the number of patients in 1:1 care.<sup>10</sup>

#### **Expected Impact:**

Having this data set in real time will enhance FEMS' efforts to effectively distribute patients to EDs.

#### **Budget Implications:**

Implementation may require funding allocations from both the government and private sector, specifically the hospitals implementing the tool.

#### **Risk Factors:**

The Committee did not identify any risk factors associated with this recommendation.

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<sup>7</sup> NEDOCS Variables and Definitions, <https://www.nedocs.org/News/Article/NEDOCS-Variables-and-Definitions> (last accessed Sept. 26, 2019).

<sup>8</sup> *Id.*

<sup>9</sup> U.S. Department of Health and Human Services, Assistant Secretary for Preparedness and Response, Technical Resources, Assistance Center, and Information Exchange (TRACIE), "Hospital Emergency Department (ED) Overcrowding Scales," <https://files.asprtracie.hhs.gov/documents/aspr-tracie-ta-ed-overcrowding-scales-072715-508.pdf> (last accessed Sept. 26, 2019).

<sup>10</sup> NEDOCS Variables.

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| <b>Equality Implications:</b>                  | This recommendation may divert patients to a hospital other than the one closest to them based on the status of the system.   |
| <b>Social Impact<br/>&amp; Sustainability:</b> | The Committee members determined that its recommendations would better target resources to communities where the need is greatest. The strategies agreed to by the Committee are intended to systemically reduce EMS call volume, and divert patients from emergency departments when clinically appropriate, saving those resources for high acuity patients. This, in turn, will have the greatest social impact and will make the system in the District more sustainable. |
| <b>Legislative Action:</b>                     | There will likely be a need to amend DC Health regulations to implement the program along with programmatic authorization if contained within FEMS.   |

### **Recommendation #5:**

Use telehealth to provide initial consultations, pre-arrival assessments, and follow-up care to promote appropriate care intervention in a timely fashion. Incentives and regulatory constraints should be assessed to entice participation by providers and patients. A successful model should include telehealth reimbursement rates that meet the market rate/cost of the service.<sup>11</sup>

#### **Background:**

Healthcare increasingly uses telehealth in a variety of settings and should be optimized in the District. Emerging technologies and novel types of health care delivery, including telemedicine, have proven problematic in the District. Frequently cited reasons for this situation include: the start-up costs associated with the acquisition of the technology and the initial salaries of the providers. Specific consideration should be given to ensure suitable reimbursement of telehealth services by all payers.

#### **Expected Impact:**

Expansion of telehealth services will improve access to care and patient health outcomes. Both primary and specialty care providers can utilize remote access to improve the timeliness of care and to deliver appropriate services to patients who may not be able to utilize place-based services; effectively closing care gaps and facilitating integration between patients, community-based organizations, and providers.

#### **Budget Implications:**

This recommendation may require subsidies for purchase of new technology. There may be additional budgetary considerations for both the public and private sector to allow for new reimbursement models for telehealth.

#### **Risk Factors:**

The Committee did not identify any risk factors associated with this recommendation.

#### **Equality Implications:**

Enhancing telehealth in the District would assist in overall efforts to provide equitable access to care. Expansion of the use and

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<sup>11</sup> Aligns with recommendation 5 from the Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care

definition of telehealth can facilitate greater opportunity for patients to have greater choice and broader access to providers both within and outside of the District of Columbia.

**Social Impact  
& Sustainability:**

As this is part of a national trend, investments in telehealth would be sustainable as long as reimbursement is adequate. Investments in telehealth will allow the District to leverage regional and national care networks to expand access to specialty, research, and primary care outside of the physical boundaries of our jurisdiction.

**Legislative Action:**

Programmatic and budget authority will be needed to continue funding the Budget Support Act's telehealth pilot programs in different settings and applications, including skilled nursing facilities, behavioral health, remote patient monitoring, and specialty care. A review of the barriers to providers licensed outside of the District of Columbia to practice medicine utilizing telehealth modalities through interstate licensure recognition or a new designation of DC licensure that provides for a limited scope of service is also needed.

## **Recommendation #6:**

Engage in a comprehensive process to address the specialized needs and challenges presented by justice-involved individuals, with the goal of treating these patients safely in appropriate care settings, e.g., the Central Cell Block or other Department of Corrections facilities. This effort should include a focus on the safety of first responders and other health care workers, as well as reducing costs associated with such treatment.

### **Background:**

There is a need for regulatory and capacity review of health care delivery to justice-involved individuals, and the Committee recommends a thorough review of so-called FD-12 cases in the health care system.<sup>12</sup>

Recommendations included requiring detainees of the criminal justice division to receive non-emergent medical evaluations in alternative care sites versus hospital-based emergency departments, such as within the Central Cell Block, operated by the Department of Corrections. This would have the dual benefit of reducing costs associated with care and enhancing safety of all personnel involved.

There is also an emergent need for mobile courts to decompress the hospitals and enhance safety of personnel, the community, and the patients.

This recommendation should be implemented by engaging in a thoughtful process with health care providers and local and federal public safety partners – including, but not limited to, the Metropolitan Police Department, Department of Corrections, Court Services and Offender Supervision Agency, DC Superior Courts, Corrections Information Council, Criminal Justice Coordinating Council, and the Public Defenders Service – to address the specialized challenges presented by justice-involved patients.

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<sup>12</sup> FD-12 Form (Application for Emergency Hospitalization by a Physician, Officer or Agent of the D.C. Department of Human Services or an Officer Authorized to Make Arrests).



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| <b>Expected Impact:</b>                    | Safer delivery of care for both hospitals and justice-involved individuals.  |
| <b>Budget Implications:</b>                | This recommendation could require investment in expanded health resources in the jail to treat low-acuity conditions, while also saving resources by avoiding transports.  |
| <b>Risk Factors:</b>                       | Resource allocation.   |
| <b>Equality Implications:</b>              | The Committee recommendations are intended to improve access to emergent and primary health care by identifying the appropriate access points for all patients at their actual level of acuity. The Committee believes that by implementing new strategies and innovative health care delivery methods, access to care by all members of the community will be improved. Emergency departments, emergency medical services providers, and other health care professionals can deliver better care when it can be targeted to specific needs, rather than using a one-size-fits-all approach. Ultimately, if these efforts are successful, more resources will be preserved for patients with life threatening injuries and illnesses, who are disproportionately low income patients of color who live in communities with high EMS call volume and other needs. |
| <b>Social Impact &amp; Sustainability:</b> | The Committee members determined that its recommendations would better target resources to communities where the need is greatest. The strategies agreed to by the Committee are intended to systemically reduce EMS call volume, and divert patients from emergency departments when clinically appropriate, saving those resources for high acuity patients. This, in turn, will have the greatest social impact and will make the system in the District more sustainable.  |
| <b>Legislative Action:</b>                 | Legislative changes to the Ervin Act would be required to address the mobile court portion of the recommendation.  |

### **Recommendation #7:**

Develop incentives for use of the appropriate level of care, and disincentives for use of emergency departments, for non-emergency issues.

#### **Background:**

Currently, the District spends considerable resources on hospital care for individuals with low-acuity, non-emergent conditions, and on preventable admissions.

While there are options for Medicaid programs to implement some sort of incentive regime, the authorization process can be arduous, and at the same time, there is little research to document their success in lowering emergency department (ED) utilization.<sup>13</sup> State incentives and penalties to reduce improper ED use are legally permissible, but the implementation of those provisions is complex. To address ED use, policy solutions such as care coordination and community clinics have some evidence to support their effectiveness to reduce ED use, but their cost effectiveness is questionable. Some programs that have tried to create penalties and incentives for beneficiaries have prompted access and implementation issues that have been challenged in court.

Current efforts to limit Medicaid beneficiaries' use of the ED have focused on applying co-pays of the patients or the development of a health savings account. The ED co-pay approach has so far been unsuccessful, due to the difficulties of both collections and of ED staff being forced to determine whether each case is an emergency conflicting with federal law. There is debate about what percentage of ED visits are unnecessary. The Committee recommends that the District explore creative strategies that would provide incentives to reduce the use of emergency rooms.

#### **Expected Impact:**

This initiative would result in reduced expenditures for LANE visits and preventable admissions.

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<sup>13</sup> Email from Melanie Williamson, Chief of Staff, Department of Health Care Finance to Committee staff (August 26, 2019 4:46 p.m.).

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| <b>Budget Implications:</b>                | Budgetary authority would be needed for any such program whether from a governmental or non-governmental source.   |
| <b>Risk Factors:</b>                       | Compliance with Medicaid and Medicare rules limiting permissible uses of incentives.   |
| <b>Equality Implications:</b>              | The Committee recommendations are intended to improve access to emergent and primary health care by identifying the appropriate access points for all patients at their actual level of acuity. The Committee believes that by implementing new strategies and innovative health care delivery methods, access to care by all members of the community will be improved. Emergency departments, emergency medical services providers, and other health care professionals can deliver better care when it can be targeted to specific needs, rather than using a one-size-fits-all approach. Ultimately, if these efforts are successful, more resources will be preserved for patients with life threatening injuries and illnesses, who are disproportionately low income patients of color who live in communities with high EMS call volume and other needs. |
| <b>Social Impact &amp; Sustainability:</b> | The program would hopefully result in a healthier population, with the savings offsetting any recurring costs.   |
| <b>Legislative Action:</b>                 | This recommendation would likely require legislative and regulatory approval from both the District and CMS to implement.  |

**Recommendation #8:**

Encourage and promote enrollment in comprehensive case management for all participants in publicly-funded healthcare

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| <b>Background:</b>                         | Currently, Medicaid beneficiaries who are considered high utilizers frequently decline case management services. The inability to assist these beneficiaries with their medical conditions results in higher expenditures.   |
| <b>Expected Impact:</b>                    | Improved health outcomes for beneficiaries, as well as reduced Medicaid expenditures.  |
| <b>Budget Implications:</b>                | The Committee did not identify any budget implications for this recommendation.  |
| <b>Risk Factors:</b>                       | The Committee did not identify any risk factors associated with this recommendation.   |
| <b>Equality Implications:</b>              | The Committee recommendations are intended to improve access to emergent and primary health care by identifying the appropriate access points for all patients at their actual level of acuity. The Committee believes that by implementing new strategies and innovative health care delivery methods, access to care by all members of the community will be improved. Emergency departments, emergency medical services providers, and other health care professionals can deliver better care when it can be targeted to specific needs, rather than using a one-size-fits-all approach. Ultimately, if these efforts are successful, more resources will be preserved for patients with life threatening injuries and illnesses, who are disproportionately low income patients of color who live in communities with high EMS call volume and other needs. |
| <b>Social Impact &amp; Sustainability:</b> | The Committee members determined that its recommendations would better target resources to communities where the need is greatest. The strategies agreed to by the Committee are intended  |

to systemically reduce EMS call volume, and divert patients from emergency departments when clinically appropriate, saving those resources for high acuity patients. This, in turn, will have the greatest social impact and will make the system in the District more sustainable.

**Legislative Action:**

Legislative and regulatory action would be needed to effectuate this change.

### 3. Committee on Discharge Planning and Transitions of Care

#### **Recommendation #1:**

Place a DC Medicaid eligibility staff member onsite at certain qualified providers, such as hospitals or skilled nursing facilities (SNFs). This practice will allow care management departments to obtain eligibility decisions more quickly, thereby reducing delays in discharges, turning over patient beds for new admissions, and moving patients efficiently. The Medicaid specialist will serve as a liaison between the DC Medicaid office and member hospitals. Qualified providers will be required to share in the cost of an onsite specialist.

#### **Background:**

Hospitals do not have real-time insight into the status of Medicaid eligibility applications for first-time patients, or those applying for reinstatement of benefits. This opaque process requires hospital staff to spend a significant amount of time making phone calls and checking systems to inquire about the patient's eligibility status before they can discharge a patient. This process causes significant delays which force patients to remain in an acute care facility although they no longer require those services. A specialist placed in hospitals could improve the efficiency of these applications, decreasing the turn-around time of Medicaid applications, a process that currently takes up to 45 days. A specialist could also serve as a valuable liaison between the DC Medicaid office and member hospitals, educating the hospitals on governmental processes and bringing challenges from the bedside to the Medicaid office. As an example, MedStar Washington Hospital Center has a Medicaid representative from Maryland placed in the hospital 5 days/week to serve this same purpose for Maryland residents.

#### **Expected Impact:**

As this would have a significant impact on patients' throughput and provide for safe discharges, placement of a Medicaid Specialist in hospitals would directly improve emergency department boarding.

#### **Budget Implications:**

The execution of this recommendation would require the hiring of additional personnel by the DC Medicaid office; however, the cost would be shared between DHCF and the hospitals in which the

specialists are located. Placement of a Medicaid Specialist in hospitals would be a low-cost, high-return action that would have a direct impact on the patients of the District.

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| <b>Risk Factors:</b>                       | The Committee did not identify any notable risk factors associated with this recommendation.                       |
| <b>Equality Implications:</b>              | The Committee did not identify any equality implications for this recommendation.                                  |
| <b>Social Impact &amp; Sustainability:</b> | The Committee did not identify any social impact or sustainability concerns for this recommendation.               |
| <b>Legislative Action:</b>                 | The District’s Emergency and Safety Alliance (ESA) would need to establish qualified facilities for such services. |

**Recommendation #2:**

Approve a retrospective review process (as opposed to prospective) to improve the efficiency of approvals and transfers of patients. Develop acceptable pre-admission criteria, in cooperation with medical providers, which will expedite the process of transitioning some of the Districts most medically complex patients to the correct level of care.

**Background:**

The District of Columbia currently contracts with Comagine Health to manage the authorization and review process for Inpatient Rehabilitation Hospitals, Psychiatric Hospitals, and Long-Term Care Hospitals. The process requires prior authorization before a patient can be moved to the next and more appropriate level of care. This includes the exchange of medical information between the referring hospital, accepting specialty facility, and Comagine. The information is then reviewed and can result in an approval, denial, or request for more information. This wait time, which has been documented to take up to two weeks, prohibits a patient from obtaining the care they need from a specialty provider in a timely manner. Keeping a patient unnecessarily in the acute care setting puts them at risk for a relapse of their condition, thus prolonging the stay even further. Additionally, delays also reduce the number of available beds in hospitals, slowing turn-over and clogging the system from the hospital bed to the emergency department.

It is estimated that delays in this process could be costing DC Hospitals as much as \$3-\$5 million dollars annually.

**Expected Impact:**

A retrospective review process would decrease the unnecessary wait time for patients moving from one level of care to another. It will eliminate the waste in costs a hospital absorbs by having a valuable acute care bed occupied when not clinically indicated. Using an agreed-upon industry acceptable pre-admission criteria should reduce the risk incurred by providers.

**Budget Implications:**

By changing to retrospective reviews, with transparent admission criteria, it is estimated the acute care hospitals will save an estimated \$3-\$5 million dollars in wasted healthcare costs currently being absorbed by the hospitals.



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| <b>Risk Factors:</b>                       | The Committee did not identify any notable risk factors associated with this recommendation.  |
| <b>Equality Implications:</b>              | The Committee did not identify any equality implications for this recommendation.   |
| <b>Social Impact &amp; Sustainability:</b> | This would allow Medicaid recipients to receive the right level of care at the right time with the same efficiencies as other patients.                         |
| <b>Legislative Action:</b>                 | DHCF would need to direct Comagine to adjust their process of providing retrospective reviews. This process already exists with other services in the District. |

**Recommendation #3:**

Expand the availability and support for medical respite facilities by reviewing and updating the regulatory requirements, which may create barriers to additional medical respite options.

- a. Recommend a State Plan Amendment to provide for Medicaid coverage to finance medical respite care services generally, rather than relying disproportionately on local grants.
- b. Adopt standards for defining medical respite programs such as those from the National Health Care for the Homeless Council.
- c. Develop regulations to address qualifications and standards for medical respite providers. Services should be defined in accordance with the licensed professionals who provide them. Qualifications on admissions and discharges shall be clarified.
- d. Amend the D.C. Law 22-65 “Homeless Services Reform Amendment Act of 2017” to exempt Certificate of Need (CON) requirements for a medical respite provider of services. The exemption should include a clear definition of the services in question to distinguish them from covered services.
- e. Amend the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, D.C. Law 5-48 (“the Act”) to define a medical respite program as a health care facility under the Act and to outline the guidelines needed for the clients, staff and operation of the program. Amendment should address any exemptions that apply to providers.

**Background:**

According to D.C. Law 22-65, Homeless Services Reform Amendment Act of 2017, D.C. Official Code §4-751.01(26A), medical respite is a time-limited acute and post-acute medical care that is provided in a residential medical facility or shelter to individuals who are both (A) Homeless and (B) Determined by a qualified medical professional licensed in the District to require medical assistance.

Medical respite has shown to reduce Medicaid spending, by reducing hospital admissions and re-visits. Homeless individuals are nearly five times more likely to be hospitalized than housed patients. Also, the average hospital stay for a homeless patient is double the 4.6 days for a non-homeless patient. Homelessness, therefore, represents a major factor in hospital utilization and discharge planning. Studies confirm that the availability of medical respite care significantly reduces future hospitalizations for homeless individuals. In fact, by some estimates, they experience 50 percent fewer hospital readmissions within 90 days of being discharged compared to homeless patients discharged to their own care. Medical respite care dramatically improves recovery and adherence to a program of care, while providing an opportunity to treat other conditions, such as psycho-social conditions. In a Yale New Haven Health study, Kelly Doran, MD, RWJ Scholar, 2012 studied 113 homeless individuals over 30 days:

- 70.3% returned to the emergency department during that time;
- 50.8% were admitted to inpatient care; and
- 3.0% were readmitted for observation.

Seventy-five percent of these readmissions occurred within two weeks. The study estimated that on average, each medical respite patient who completes at least two weeks in the program saves Medicaid between \$12,000 and \$25,000 across all Medicaid claims in the year following respite. This savings is accomplished through the reduction of unnecessary emergency department visits and hospitalizations.

There are a few medical respite programs in the District, providing services in shelter settings:

- Christ House is a 33-bed facility, which opened in December 1985. It consists of a comprehensive continuous care program, offering medical services with a linkage to a Federally Qualified Health Center (FQHC), including case management and life skills recovery programs provided by certified counselors. Approximately 70 percent of its clients require behavioral health interventions. The average length of stay is 45 days.
- Joseph House opened in 1990 and provides comprehensive nursing and supportive care to homeless men and women with AIDS and cancer.

- Patricia Handy Place for Women maintains a 12-bed medical respite unit, offering services supported by an FQHC for 8-10 hours a day. Supportive staff are present during evening and night tours of duty.

**Expected Impact:** Medical respite care facilitates safe discharge planning from hospitals, and can reduce readmission of patients who are homeless.

**Budget Implications:** According to a March 2011 study that examined the medical respite program in Salt Lake City, inpatient hospital care is 10 times more expensive, on average, than medical respite care, costing \$1,359 per day versus \$135 per day, respectively. Over a year, the study confirmed that Salt Lake City hospitals saved \$5.5 million, by partnering with medical respite care centers. Similarly, a Los Angeles-focused study also concluded that inpatient hospital care is approximately 10 times more expensive than medical respite care, \$2,279 per day versus \$175 to \$200 per day. The utilization of respite care, according to the study, resulted in millions of dollars in reduced health care expenditures in Los Angeles and Orange County.

Presently, medical respite programs are supported predominately with grants, private fundraising and donations. Medical care coverage is limited by insurance type. District Medicaid recipients are not eligible for comprehensive medical respite services and neither are residents enrolled in the DC Healthcare Alliance Program (“the Alliance”). The District should re-examine its approach to publicly financing these critical services, if we are serious about improving the conditions of individuals experiencing homelessness.

A 2017 study conducted by Yale New Haven Health Hospital concluded its medical respite program resulted in significant savings. Specifically, “[w]e estimate that on average each Medical Respite patient that completes at least two weeks in the program saves Medicaid between \$12,000 and \$25,000 across all Medicaid claims in the year following respite.”<sup>14</sup>

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<sup>14</sup> Crombie, Paula, Director of Social Work, Yale New Haven Health & Cunningham, Alison, CEO of Columbus House, “Medical Respite Care: Reducing Readmissions, LOS, and ED Visits of People Experiencing Homelessness,”

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| <b>Risk Factors:</b>                       | The Committee did not identify any notable risk factors associated with this recommendation.  |
| <b>Equality Implications:</b>              | The District has roughly 7,500 individuals who are homeless on any given night. At present, two medical respite care facilities serve this population: Christ House, for men, and the Patricia Handy Place for Women. With a total of 45 beds (33 men and 12 women), which are always full, there is an acknowledged need for additional medical respite care beds in the District. To this end, the new 801 East Men's Shelter, which opens in January 2021, will include an additional 25 medical respite beds for men, bringing the District's total number of beds for men to 58. Aside from the obvious disparity in the actual total number of medical respite beds available to homeless men and women in the District, there are significant differences in the level of services afforded to these populations. Christ House, which is the recipient of a significant federal grant, can offer its male patients both substantially more hours of service and access to services provided by a more robust roster of medical staff. To achieve parity for women in the level of services offered in the District, additional resources are needed. |
| <b>Social Impact &amp; Sustainability:</b> | Providing medical respite services to homeless individuals is compassionate and cost-effective for both hospitals and publicly-financed health care systems. These services, though, remain elusive, <i>most especially for women</i> . Nationally, the evidence indicates that 57% of medical respite programs rely on funding from three or more sources, including hospitals and private donations, hence the challenge in launching and supporting these programs. Client placement in housing with supportive services for sustainability in a community setting is ideal. In truth, housing limitations exist. It can take six to nine months or more to find a suitable placement. However, there are opportunities for successful living arrangements in group home settings for individuals with mental health or aging challenges. Long-term care nursing home placement would be limited to those clients that meet the admission criteria. Likewise, other licensed facilities have mandated criteria for admission that accommodate the elderly and disabled but do not fit the medical respite for the  |

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Connecticut Coalition to End Homelessness. Retrieved from <http://cceh.org/wp-content/uploads/2017/02/Medical-Respite-Celebration-v19.pdf>

homeless model. It is also important that we clarify how the processes for housing and medical respite work together as the demand for housing steadily increases.

**Legislative Action:**

We urge the District to consider expanding Medicaid coverage to finance medical respite care services generally, rather than relying disproportionately on local grants. Specifically, the District could seek a Medicaid State Plan Amendment (SPA), under Section 1915(i) of the Social Security Act, proposing a package of “medical respite services” for homeless persons, beyond those offered under existing Home & Community Based Services. Alternatively, the District could request an 1115 waiver, pursuant to Section 1115 of the Social Security Act, to conduct a demonstration project involving medical respite services for homeless individuals. Given the high likelihood of savings associated with these services, the District should have little difficulty in demonstrating the budget neutrality of the 1115 waiver request.

In regard to regulatory oversight, the District does not have regulations as they pertain to the operation of medical respite for the homeless programs. As stated earlier, currently licensed facilities have mandated criteria for admission that accommodate long term care need, but do not fit the medical respite for the homeless model.

Although there is a requirement for a CON for new health services, medical respite operators are typically not providers of the medical services. An FQHC manages the medical services in most shelter-based medical respite providers. The National Health Care for the Homeless Council, a national organization dedicated to the care of homeless individuals, has Standards for Medical Respite Care,<sup>15</sup> which includes seven basic standards that cover the medical and behavioral health care and supportive care, and that the District could use as a reference.

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<sup>15</sup> Standards for Medical Respite Programs. <https://nhchc.org/clinical-practice/medical-respite-care/standards/>

**Recommendation #4:**

Reduce barriers to operating Advanced Life Support (ALS) and Basic Life Support (BLS) transports in the District through examining licensure and regulatory obstacles.

- a. Temporarily or permanently standardize licensing regulations to harmonize within the DMV region, providing reciprocity to ALS and BLS providers licensed in Virginia and Maryland allowing them to be able to drop off AND pick up from DC based facilities.
- b. For a two-year period, temporarily provide an expedited CON process to approve additional (ALS/BLS) transportation providers.
- c. Conduct a review of the EMS regulations, last changed in 2003, reviewing and updating current practices to meet the needs of the District. This should include the evaluation of the throughput of patients into emergency departments and hospitals, as well as the regulatory requirements that apply to patients and hospital related to the flow of patients.
- d. Expand the quality reporting program to include more relevant measures such as transport refusals, delays, transport times, waiting times, and cash fee schedules for ambulance providers licensed to pick-up within the District. Require ambulance providers to identify the number of vehicles used within the District for non-FEMS services daily.
- e. Evaluate the regulations allowing facility-to-facility transfers to use FEMS resources via 911.

**Background:**

The Committee has found issues with the delivery of reliable and rapid private ALS and BLS ambulance services within the District, which slows down the timely and safe transportation of patients. The number of EMS units inspected and licensed in the District does not reflect the current system's needs. For example, there is a lack of ALS providers with the ability to transport ventilator assisted patients. Gaps in the ALS and BLS services are being filled

by inappropriate use of 911 services. Transfers of patients from the acute care hospital setting to post-acute facilities including psychiatric hospitals, skilled nursing facilities (SNFs), and long-term acute care hospitals are often delayed due to the lack of ALS/BLS resources exacerbating issues related to discharge and planning. Currently, in the District, long-term acute facilities are forced to call 911 for transfers, involving scheduled (non-acute) routine procedures. These facilities are often left with no other option, due to overly burdensome regulations and a private ambulance market that is not equipped to meet the market's needs.

The true scope of the unreliable and delayed transportation system is hard to capture due to EMS regulations which do not require the reporting of response times, ALS and BLS refusals, cancellations, or delays in responding to requests. There have been reports of ambulance providers being unwilling to schedule transportation more than 24 hours in advance, and companies being unwilling to schedule roundtrip transportation from SNFs to diagnostic studies or follow up appointments, all of which creates a strain on resources, staff, and patients.

It is recommended that the EMS regulations be reviewed. The development of ED protocols that prioritize FEMS ALS and BLS will allow FEMS units to return to service more quickly. The protocols would recognize the competing challenges of EDs, which have additional volume from walk-ins. In addition, real-time information sharing on ED loads through regulatory changes in case management requirements, as well as maximizing the use of health information exchange capabilities to the extent possible, are also recommended.

**Expected Impact:**

This recommendation will improve the timely transfer of care and allow providers more options. Greater availability of private ambulances will reduce the need to utilize 911 for non-acute patient transfers. This will also improve care by reducing missed or delayed specialty appointments for nursing home residents, and assisting with timely transportation to and from the hospital.

**Budget Implications:**

There are budget implications for a departmental review of the regulations. However, such a review could lead to the reduction of unnecessary days patients spend in hospitals due to lack of transportation, offering net savings for the system as a whole. An improved transportation system would reduce the use of 911 calls



and will improve the care provided to patients in need of critical care transportation. The elimination of “late-night” transfers to nursing facilities should have a positive impact on patient satisfaction.

**Risk Factors:**

Increased high utilization of the EDs could be a barrier to implementing a program.

**Equality Implications:**

The Committee did not identify any equality implications for this recommendation.

**Social Impact  
& Sustainability:**

This should result in transportation processes being more efficient and responsive to the current needs of the system.

**Legislative Action:**

Legislative and regulatory action might be needed to standardize licensing regulations across the DMV region, and to hold ambulance providers accountable to these standards.

### **Recommendation #5:**

Fund a pilot program with District skilled nursing and long-term acute care facilities in order to determine how telemedicine consultations might reduce unnecessary ED visits and 911 calls.

#### **Background:**

MedStar Health has been utilizing telemedicine consultation between MedStar Washington Hospital Center emergency physicians and several MedStar PromptCare Urgent Care sites with success in reducing ED visits from the urgent care sites. It is believed that the same services can be utilized by nursing homes with similar success. Telemedicine has also been used for several years at MedStar Washington Hospital Center, as part of the advanced triage team. During peak hours, patients are “seen” after nurse triage by a remote physician via telemedicine. The triage physician can quickly assess the patient and initiate diagnostic and treatment orders within minutes of nurse triage; whereas without telemedicine triage, these patients would need to wait much longer to have their condition evaluated. Because telemedicine triage is far more efficient than in-person provider triage, this can be scaled to serve more than one ED with a single provider, as has been demonstrated successfully by MedStar Health in a pilot program.

A key issue with the use of telemedicine concerns reimbursement. Medicaid pays for specific CPT codes. Medicare does not pay for telemedicine.

#### **Expected Impact:**

Telemedicine would result in fewer logistical barriers to care for nursing home, urgent care clinic and community clinic patients who can be evaluated onsite, thus reducing unnecessary ED visits.

#### **Budget Implications:**

While the reimbursement for telemedicine consults would be an additional DCHF expenditure for expanded CPT codes, the overall result would be cost savings to DCHF, as the savings of reduced ED visits would outweigh the telemedicine reimbursement.

#### **Risk Factors:**

The Committee did not identify any notable risk factors associated with this recommendation.

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| <b>Equality Implications:</b>              | The Committee did not identify any equality implications for this recommendation.           |
| <b>Social Impact &amp; Sustainability:</b> | This would have a direct impact on Medicaid patients. There are no sustainability concerns. |
| <b>Legislative Action:</b>                 | DCHF may need to consider rule changes to cover expanded CPT codes.                         |

## **Recommendation #6:**

Establish a telecourt for involuntary commitment and probable cause hearings, and consider providing District funding for all District providers, which care for FD-12 (involuntary) individuals, to have a secure platform to interface with the courts in all commitment and probable cause hearings.

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| <b>Background:</b>                         | According to an article in Psychiatric Services, “[t]he use of videoconferencing for psychiatric involuntary commitment hearings is not a recent development. The courts ruled on the constitutionality of these proceedings as long ago as 1993. In 2004 University of Michigan Hospital began videoconferencing involuntary commitment hearings with Washtenaw County Probate Court. The experience of the University of Michigan Health System and the Washtenaw Probate Court with telecourt hearings for involuntary commitment has proven to benefit the safety and dignity of patients as well as the financial health of the medical center.” |
| <b>Expected Impact:</b>                    | Reduced transitions for patients from hospitals to court hearings, resulting in increased dignity for patients and uninterrupted care.  |
| <b>Budget Implications:</b>                | There would be budget implications for the capital investments needed to install the technology at each hospital along with the courts.   |
| <b>Risk Factors:</b>                       | The Committee did not identify any notable risk factors associated with this recommendation.  |
| <b>Equality Implications:</b>              | The Committee did not identify any equality implications for this recommendation.   |
| <b>Social Impact &amp; Sustainability:</b> | The Committee did not identify any sustainability concerns for this recommendation.   |
| <b>Legislative Action:</b>                 | Legislation will likely be necessary to amend the Ervin Act to allow for mobile court hearings for individuals undergoing involuntary commitment.   |

#### 4. Committee on Access to Critical and Urgent Care Services

##### **Recommendation #1:**

Ensure there is a single, easily accessible citywide healthcare advice line, staffed by clinicians, to provide medical advice, health care system navigation, and appointment scheduling to all residents.

##### **Background:**

When a District resident or their loved one isn't feeling well or has a minor injury, they often call 911 for fast and convenient care. This has resulted in crowded emergency departments, limited EMS resources for more severe emergencies, and residents receiving care that is often not coordinated with their primary providers. Many residents call 911 because they don't know where else to turn to or how best to receive timely care in their community. In order to shift away from a decades-long dependency on 911 for non-emergencies, residents need an alternative source of information and immediate care that is just as fast and convenient as calling 911.

The District has invested heavily in health care and social resources for its residents. Health clinics across the city accept walk-ins and many are open in the evenings and weekends. The Department of Behavioral Health operates a 24/7 Access Helpline to assist individuals experiencing behavioral health issues. The Fire and Emergency Medical Services Department's Nurse Triage Line helps some 911 callers provide self-care or coordinate transportation to clinics that are open. The Department of Health Care Finance is partnering with the DC Primary Care Association to develop a community resource inventory of social service organizations and is investing in technology to allow medical providers to refer to patients to those resources.

Despite the volume of services available, they are difficult to navigate, especially when someone is sick, and there is no single point of entry for a resident to seek advice.

##### **Expected Impact:**

A citywide health advice line will reduce the dependency on ambulances and ED care and help residents answer their non-emergent health care questions. Cities like Reno, Nevada have

pioneered [similar advice lines](#) and have shown significant community savings.

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| <b>Budget Implications:</b>                    | Start-up costs for this service would depend on whether it was housed within a government agency, such as the Office of Unified Communications, or was operated by an NGO through a grant or partnership. Start-up costs could range between \$1-2 million dollars. In Reno, health plans invested in a citywide Nurse Health Line that resulted in a <a href="#">150-200% return on investment to payers</a> . |
| <b>Risk Factors:</b>                           | The advice line should utilize protocols and medical direction to ensure that callers experiencing medical emergencies are quickly transferred to 911.  |
| <b>Equality Implications:</b>                  | The Committee considered issues of equality arising from this recommendation.   |
| <b>Social Impact<br/>&amp; Sustainability:</b> | The Committee discussed how partnerships with health plans, health systems, and grant funding could sustain the citywide health advice line.  |
| <b>Legislative Action:</b>                     | Legislative action may be required to appropriate start-up funding for this program.  |

## **Recommendation #2:**

Implement a health literacy campaign focused on *when* and *how* to access care.

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| <b>Background:</b>            | Research has highlighted that individuals with low health literacy are more likely to delay accessing care. Patients with low health literacy tend to use the emergency department (ED) more often and are also more likely to return to the ED after two weeks. Supporting a health literacy campaign can be instrumental in reducing health disparities. For example, the campaign could use strategies identified in the AHRQ Health Literacy Universal Precautions Toolkit, which include: simplifying communication; confirming comprehension for all patients to minimize risk of miscommunication; making the health care system easier to navigate; and supporting patient's efforts to improve their health. |
| <b>Expected Impact:</b>       | Patients will have a clearer understanding of health information communicated at their primary care home (or by their provider). Patients will have a better understanding of how to navigate the health care system and understand what care options are available to them. Patients will have a higher utilization of accessing health at their primary care home versus hospital EDs.  |
| <b>Budget Implications:</b>   | The program, funded by the DC government, will have a direct cost, however, it should generate budget savings by helping residents understand their health care choices and reduce unnecessary utilization of EMS, ED care, and other Medicaid/Alliance spending.   |
| <b>Risk Factors:</b>          | If the program is not appropriately targeted and tailored, it will not generate benefit to residents or create budgetary savings. This can be mitigated by careful study of appropriate interventions, population affected, and locations.  |
| <b>Equality Implications:</b> | The recommendation was designed to help level the playing field with respect to information on and access to appropriate care, so will help to improve equality in care.  |

**Social Impact  
& Sustainability:**

The recommendation was designed to enhance the well-being of the community, so will generate a positive social impact if appropriately targeted and tailored. If effective, the program will be sustainable due to its budget neutrality.

**Legislative Action:**

If sufficient funding does not currently exist within the Department of Health Care Finance's budget, funding must be included in the Fiscal Year 2021 Budget Support Act.



### **Recommendation #3:**

Conduct surveys and focus groups to understand residents' healthcare decision-making priorities.

|  |   |
|--|---|
| <b>Background:</b>                         | Today's challenges in accessing care are more about residents knowing when and how to seek care rather than about the availability of those services. Experiences of the Committee revealed that many residents choose to receive care at the ED instead of community access points for various reasons including convenience, variable health and health system literacy, unavailability of critical health services, and a general unfamiliarity of available health services. For the recommendations from this Committee to be successful, the District's healthcare leaders must understand the decision-making processes and priorities of their customers: District residents. |
| <b>Expected Impact:</b>                    | Government and private sector leaders will learn the preferences and decision-making processes of District residents when they are accessing health services. These continued insights will help guide health system interventions and implement the recommendations of the Commission.   |
| <b>Budget Implications:</b>                | The government should support the cost of a sustained, annual, health preferences survey and focus groups in the District. The cost should be less than \$1 million per year and could be administered by the State Health Planning and Development Agency.   |
| <b>Risk Factors:</b>                       | The Committee did not identify any risk factors to implementing this recommendation.  |
| <b>Equality Implications:</b>              | The Committee considered issues of equality arising from this recommendation.   |
| <b>Social Impact &amp; Sustainability:</b> | Consideration was given to how to make the proposal sustainable and the expected positive healthcare impact.  |
| <b>Legislative Action:</b>                 | No legislative action is required to implement this recommendation.   |

#### **Recommendation #4:**

Consider the final recommendations from the Health Information Exchange Policy Board, which proposes to make available necessary patient information from the electronic medical record and the minimum data set that should be transmitted upon discharge, to improve transitions of care.

#### **Background:**

Health Information Exchange (HIE) entities in the District allow health care professionals to access a patient's complete health information electronically, no matter where that person has received care in the past. When providers input information in electronic health records (EHRs) it is often incomplete and not timely. Without timely and complete recordkeeping, downstream providers will not have critical information to treat their patients best.

When a patient is discharged from a District hospital, the next care provider, which is often a nursing home, home health agency, behavioral health provider, or primary care provider, is notified in real-time by CRISP DC, a local HIE entity. More detailed transitions of care information are transmitted several days later when a provider closes the record. Hospitals send detailed discharge information an average of five (5) days post-discharge, but it can take over a month. The District should standardize what data is transmitted in a summary of care in a timely manner, so follow-up care is best informed.

This work should be coordinated with the DC Hospital Association, which recently completed a District-funded grant on improving transitions of care from hospitals. The [DC HIE Policy Board](#) is considering recommendations and conducting a study on the average timeliness of completing summaries of care and the final recommendations from this work should be implemented.

#### **Expected Impact:**

If hospital discharge summaries are standardized, follow-on care providers will begin to expect complete information will be delivered to them electronically within hours of a patient's discharge. This information will help inform that follow-on care and potentially reduce the incidence of readmissions.

|  |   |
|--|---|
| <b>Budget Implications:</b>                    | No immediate budget implications were identified by the Committee, though hospitals may require technical assistance to improve their workflows and transmit complete discharge summaries in faster timeframes. |
| <b>Risk Factors:</b>                           | The Committee did not identify any risk factors associated with this recommendation.  |
| <b>Equality Implications:</b>                  | The Committee considered issues of equality arising from this recommendation.   |
| <b>Social Impact<br/>&amp; Sustainability:</b> | Consideration was given to how to make the proposal sustainable and the expected positive healthcare impact.  |
| <b>Legislative Action:</b>                     | No legislative action is required to implement this recommendation.   |

## **Recommendation #5:**

Exchange electronic advance directive forms among providers.

### **Background:**

The District of Columbia enacted the Health Care Decisions Act (HCDA) in 1989, which provides for the creation of advanced directives and/or durable powers of attorney by individuals while they are competent, and through which individuals indicate their medical or behavioral health decisions (advanced directives) or identify a substitute decision-maker to make decisions on one's behalf during periods of incapacitation. These documents can then be used by medical professionals to guide treatment during periods when an individual is incapacitated. In 2015, the Council of the District of Columbia amended the HCDA to create the Medical Orders for Scope of Treatment (MOST) Program governing end of life decision-making by terminally ill patients.

During the 1990's psychiatric advanced directives (PADs) developed a track parallel to medical advanced directives, and have been seen as a way to facilitate engagement of persons in directing their care during times of incapacity, but differ somewhat from medical advanced directives in that they are generally based upon past treatment experiences and are often limited in emergency situations where the doctor retains clinical judgment despite the PAD. However, studies have shown that barriers to completion of PADs remain, and that they are underutilized to a significant degree.<sup>16</sup>

Facilitating completion of PADs through unstructured open-ended interviews by trained individuals has proved to be effective in increasing completion of PADs; in at least one controlled pilot, facilitated interviews resulted in 62% completion of PADs and only 3% completion where there was no facilitation.<sup>17</sup> At this time,

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<sup>16</sup> . Substance Abuse and Mental Health Services Administration: A Practical Guide to Psychiatric Advanced Directives, Rockville MD, Center for Mental Health Services. Substance Abuse and Mental Health Services Administration 2019 at page 9,  
[https://www.samhsa.gov/sites/default/files/a\\_practical\\_guide\\_to\\_psychiatric\\_advance\\_directives.pdf](https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf)

<sup>17</sup> Id. at p. 9.

there is no reliable data on the number of mentally ill individuals in DC with PADs, though anecdotal information suggests it is on a small percentage.

The Committee therefore recommends that DBH with DC Health develop a training program to train facilitators in working with mentally ill persons in developing PADs, and then implement the program in community settings including community mental health providers, shelters, day programs, and hospitals. PADs and MOST forms should be captured electronically and shared among providers through the District's health information exchange.

|  |  |
|--|--|
| <b>Expected Impact:</b>                    | Research shows that persons who complete PADs “tend to experience significant improvement in working alliance with their clinicians, fewer coercive crisis interventions, better correspondence between preferred and prescribed medication over time and increased perception that their personal needs for mental health services are being met.” <sup>18</sup> Implementing facilitated interviews with mentally ill persons using evidenced based practices will likely increase completion of the PADs, and may improve short-term and long-term outcomes |
| <b>Budget Implications:</b>                | There are costs associated with getting facilitators trained and in meeting with targeted groups, but long term, cost may be offset by savings in hospitalizations.  |
| <b>Risk Factors:</b>                       | The Committee did not identify any risk factors associated with this recommendation.   |
| <b>Equality Implications:</b>              | The Committee considered issues of equality arising from this recommendation.  |
| <b>Social Impact &amp; Sustainability:</b> | Provides opportunities for mentally ill persons to have more say in their treatment, respecting their rights and may improve outcomes  |
| <b>Legislative Action:</b>                 | No legislative action is required to implement this recommendation.  |

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<sup>18</sup> *Id.* at page 8.

## **Recommendation #6:**

Incentivize the assessment and sharing of social determinants of health during a first prenatal visit.

### **Background:**

Understanding a patient's housing status, food accessibility, income security, and other social determinants of health (SDOH) are critical as health care providers aim to improve patient outcomes, decrease healthcare costs, and reduce unnecessary utilization. This is especially true for pregnant women whose birth outcomes can rely heavily on non-clinical factors.

Providers in the District have articulated the need to standardize the assessment of SDOH and incorporate and exchange this information within their existing electronic health records (EHR) systems. To do so, providers across the District must agree on baseline assessments of SDOH. This could begin with maternal health providers. Recent investments by DHCF in health information exchange (HIE) will allow SDOH data to be exchanged with other providers so a patient does not need to *tell their story* multiple times or experience repeat assessments.

Maternal health providers should be incentivized to perform these assessments during the first prenatal visit and to refer patients to social service organizations as needed.

### **Expected Impact:**

Key birth outcome indicators have not improved significantly in the last generation. There is a growing understanding that birth outcomes are dependent on a number of life-circumstances in addition to the quality and timeliness of medical care. Identifying life circumstances that could lead to poor outcomes and addressing them early in a pregnancy should help mother and baby thrive.

### **Budget Implications:**

Incentives to perform SDOH assessment during prenatal visits may be funded by health plans, including MCOs.

### **Risk Factors:**

There are security and privacy concerns when exchanging health information. These are addressed through the governance and regulations of the [DC Health Information Exchange](#).

|  |  |
|--|--|
| <b>Equality Implications:</b>                  | The Committee considered issues of equality arising from this recommendation.                                |
| <b>Social Impact<br/>&amp; Sustainability:</b> | Consideration was given to how to make the proposal sustainable and the expected positive healthcare impact. |
| <b>Legislative Action:</b>                     | No legislative action is required to implement this recommendation.  |

## **Recommendation #7:**

Increase the capacity of primary care providers to treat substance use disorders.

### **Background:**

The impact of substance use disorder (SUD) in the District is profound. The District had the highest percentage of residents 12 and older reporting SUDs in the past year (11.2%), compared to all states. The District also has the highest reported levels of unmet needs for SUD (10.4%); the highest age-adjusted opioid death rate per capita among all urban counties; and the third highest opioid death rate in the nation. There is a need to expand the number of providers who identify and treat SUD, especially in the primary care and community settings.

This effort should include education to reduce the impact of negative treatment bias among community providers and a competency-based approach to enhance Medicaid providers' ability to diagnose and treat SUD.

Another key issue is the sharing of SUD and mental health information among providers. Federal law and regulation limit the exchange of this information without the express consent of a patient. There is a need for infrastructure to enable structured data collection and communication among District behavioral health providers, as well as the development and implementation of consent management tools to facilitate appropriate exchange of 42 CFR Part 2 data.

### **Expected Impact:**

This recommendation will result in the growth of District Medicaid provider capacity to diagnose SUD and provide treatment and recovery services. Metrics should include the number of Medicaid providers treating patients with SUD and the proportion of providers authorized to treat opioid dependence with buprenorphine.

### **Budget Implications:**

The Department of the Health Care Finance recently received an 18 month grant award of \$4.6 million from CMS to conduct a comprehensive needs assessment of Medicaid provider capacity to diagnose and treat SUD, provide technical assistance and education to primary care providers, and invest in information



technology infrastructure to allow the exchange of SUD data among providers.

**Risk Factors:** The Committee did not identify any risk factors associated with this recommendation.

**Equality Implications:** The Committee considered issues of equality arising from this recommendation.

**Social Impact & Sustainability:** The CMS grant award has the potential to be extended by three years (through 2024) and allow DHCF to draw down 80% federal funds to pay for additional work.

**Legislative Action:** No legislative action is required to implement this recommendation.

**Recommendation #8:**

Incentivize the establishment of new Comprehensive Psychiatric Emergency Program (CPEP) sites and endorse the Department of Behavioral Health proposal for a comprehensive waiver to redesign the CPEP.

**Background:**

The Comprehensive Psychiatric Emergency Program (CPEP) is operated by the DC Department of Behavioral Health (DBH). It operates 24 hours per day, seven days per week, 365 days per year. CPEP provides emergency psychiatric assessment, treatment, and referral to residents and visitors to the District, regardless of their ability to pay. In FY18 CPEP had 3,795 encounters or visits from 2,464 individuals that otherwise would have gone to local emergency departments (EDs) for treatment of their psychiatric emergencies. Individuals presenting at CPEP are treated immediately. The length of stay at CPEP is 23 hours or less. If an individual needs a longer hospital stay, they are transferred to one of the DBH contracted acute care hospitals. In FY19, 79% of the individuals seen were discharged to the community following treatment.

In addition, the District should explore options to address behavioral health services for pediatrics to address the serious challenges that exist around psychiatric hospitalization for youth.

**Expected Impact:**

CPEP could divert a larger number of individuals from EDs if additional sites were established throughout the District. It is currently located in the southeast quadrant of the District of Columbia. This makes it less accessible to the individuals in other parts of the District. An expansion of this successful intervention strategy for residents in psychiatric crisis is a cost-effective strategy for addressing this critical need in our community.

**Budget Implications:**

The Committee recommends more in-depth study of the costs associated with establishing new CPEPs.

**Risk Factors:**

No risk factors were identified.

**Equality Implications:**

The Committee considered issues of equality arising from this recommendation.

**Social Impact  
& Sustainability:**

CPEP facilities should be sustainable by billing for medical services, including reimbursable services allowed under DHCF and DBH's 1115 waiver.

**Legislative Action:**

No legislative action is required to implement this recommendation.

## Recommendation #9:

Open Sobering Centers as an alternative care site for intoxicated individuals who do not require acute medical attention.

### Background:

In 2017, District Emergency Departments (EDs) cared for 10,821 patients with acute intoxication. In the same year, three to five percent of FEMS (or AMR) transports to District EDs were for intoxication, representing a potentially significant diversion from hospital EDs for a subset of patients who typically do not require acute care. These patients tied up finite ED resources for hours without requiring significant medical resources.

Nurse-staffed, protocol-driven sobering centers are proven to provide a safe, appropriate, and respectful non-ED setting for allowing individuals to sober for up to 6-8 hours. Sobering centers have been set up in approximately 40 cities in the U.S., in an effort to divert these patients to care outside the emergency department (ED) setting. In the first comprehensive review of such a center, only four percent of the patients were transferred to an ED after admission to a sobering center.<sup>19</sup> The Committee's initial research into the sobering center model found it to be cost effective and resource efficient and the Committee believes that such centers should be opened urgently as they can make a significant difference in the care received for people in need of substance use disorder (SUD) services, as well as those receiving care in EDs.

Figure 2. ED data for individuals that had substance use as their primary diagnosis for 2017.

|            | Alcohol | Opioid | Cannabis | Sedative,<br>Hypnotic,<br>anxiolytic | Cocaine | Other<br>stimulant | Hallucino<br>genic | Inhalant | Other<br>Psychoac<br>tive | Total |
|------------|---------|--------|----------|--------------------------------------|---------|--------------------|--------------------|----------|---------------------------|-------|
| Hospital A | 31      | 1      | 53       | 2                                    | 0       | 2                  | 1                  | 0        | 15                        | 105   |
| Hospital B | 510     | 39     | 23       | 7                                    | 4       | 5                  | 2                  | 0        | 67                        | 657   |
| Hospital C | 611     | 18     | 19       | 4                                    | 6       | 3                  | 7                  | 9        | 83                        | 760   |
| Hospital D | 2081    | 121    | 122      | 7                                    | 47      | 17                 | 144                | 0        | 362                       | 2901  |
| Hospital E | 1299    | 94     | 38       | 9                                    | 25      | 3                  | 62                 | 86       | 478                       | 2094  |

<sup>19</sup> Smith-Bernadin S, Carrico A, Max, W., "Utilization of a Sobering Center for Acute Alcohol Intoxication," *Acad Emerg Med*. 2017;24(9):1060-1071.

|                   |      |     |     |    |     |    |     |    |      |       |
|-------------------|------|-----|-----|----|-----|----|-----|----|------|-------|
| <b>Hospital F</b> | 876  | 195 | 162 | 1  | 60  | 4  | 270 | 0  | 244  | 1812  |
| <b>Hospital G</b> | 1555 | 103 | 74  | 6  | 32  | 11 | 62  | 0  | 649  | 2492  |
| <b>Total</b>      | 6963 | 571 | 491 | 36 | 174 | 45 | 548 | 95 | 1898 | 10821 |

*Source: DC Hospital Association.*

|  |  |
|--|--|
| <b>Expected Impact:</b>                    | A sobering center would allow the Fire and Emergency Medical Services Department to divert these patients to a safe, nurse-staffed site. Accepting referral for treatment for SUD varies widely per city and per substance but ranges from 20-22% for alcohol to approximately 50% for Meth in San Diego. The DC Sobering Center should be modeled after the San Francisco Sobering Center (SFSC), following their protocols. Performance metrics should be based on the largest published study listed under the section on risk factors. |
| <b>Budget Implications:</b>                | The SFSC's per client cost is calculated every year via a San Francisco Department of Public Health algorithm and is estimated at \$200-\$275 per patient. Total budget for facilities, supplies, and staffing (24/7 registered nurse coverage, one full-time medical assistant, and non-clinical peer support) is approximately \$1.1 million. SFSC typically sees anywhere from 3,700 to 5,500 total encounters per year.  |
| <b>Risk Factors:</b>                       | 4.4% of the 11,596 visits over three years in San Francisco were transferred to an ED, which is considered very safe. <sup>20</sup>  |
| <b>Equality Implications:</b>              | Sobering centers serve an inherently vulnerable population with alcohol and substance use disorders and without consideration for ability to pay.  |
| <b>Social Impact &amp; Sustainability:</b> | The social benefit would be in freeing up ED beds and referring these patients for treatment of their SUD. Financial sustainability could be achieved by charging the patient's insurance for their sobering treatment. In addition, the city could consider grant funding to establish the sobering center(s).  |
| <b>Legislative Action:</b>                 | No legislative action is required to implement this recommendation.  |

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<sup>20</sup> See Ann Emerg Med. 2019; 74:112-118. <https://doi.org/10.1016/j.annemergmed.2019.02.004>

## **Recommendation #10:**

Increase the capacity of health clinics to provide urgent care services.

### **Background:**

In order to enhance access to care where it is needed and reduce the burden on EMS and emergency departments (EDs), the Committee encourages the establishment of urgent care services to meet the needs of underserved patients and to enhance access to appropriate care. Key issues in establishing new urgent care services include:

- Start-up costs;
- Space constraints;
- Financial viability, including reimbursement rates; and
- Staffing needs, especially during nights and weekends.

### **Expected Impact:**

Increase access to appropriate services and decrease unnecessary ED visits and hospital admissions.

### **Budget Implications:**

Implementing this recommendation may reduce the overall cost to Medicaid and the healthcare system by providing appropriate and timely services that are less costly. The government should support the start-up costs of urgent care services in areas where the payer mix cannot adequately sustain those services.

### **Risk Factors:**

There are no known risks to establishing urgent care services; however, the risk of not establishing Urgent Care Centers is that patients will not have the opportunity to access needed services in their communities. Urgent care facilities should develop relationships with other healthcare providers in order to ensure continuity of care for patients.

### **Equality Implications:**

The recommendation will improve the equitable distribution of services and provide access to the underserved population.

### **Social Impact & Sustainability:**

Consideration was given to how to make the proposal sustainable and the expected positive healthcare impact.

### **Legislative Action:**

No legislative action is required to implement this recommendation.

## **Recommendation #11:**

Implement cultural competence and implicit bias training for clinicians.

|  |   |
|--|---|
| <b>Background:</b>                         | Given the diversity in the District’s population, clinicians need to appreciate how an individual’s social or cultural background shapes the way they manage their health and the way they interact with provider staff and the health care systems. Additionally, a clinician’s own implicit bias can negatively impact the patient care experience. Training clinicians on providing culturally competent care and the impact of implicit bias are key factors in addressing health care disparities impacting many District residents. |
| <b>Expected Impact:</b>                    | Patients will have improved health outcomes. Patients will access the health care system more regularly and earlier in a disease process. Providers will provide appropriate and culturally competent patient care.   |
| <b>Budget Implications:</b>                | If the recommendation is implemented as a mandate for provider board certification, there is no budgetary impact but rather potential cost savings due to more appropriate care being provided to Medicaid and Alliance members.  |
| <b>Risk Factors:</b>                       | The cultural competence training must be designed based on the demographic factors specific to the District in order to realize the potential social impact and budget savings.   |
| <b>Equality Implications:</b>              | The cultural competence training must be designed based on the demographic factors specific to the District in order to realize the potential social impact and budget savings.   |
| <b>Social Impact &amp; Sustainability:</b> | The recommendation was designed to enhance the well-being of the community, so it will generate a positive social impact if appropriately designed.   |
| <b>Legislative Action:</b>                 | The Department of Health should explore whether legislative action is necessary to change the initial licensure and continuing education requirements for all healthcare providers in the District.   |

## 5. Committee on Allied Health Care Professionals and Workforce Development

### Recommendation #1:

Establish a health careers training consortium to strategize around and guide health workforce training investments to accelerate the expansion of training programs for position shortages and emerging roles (e.g., telehealth, data analytics); expand early career education; recruit English as a Second Language (ESL) residents; and otherwise ensure training programs are responsive to resident and health system needs.

**Background:** To deliver transformed care, we need to have a well-trained labor pool for new and newly-reimbursable services. Training institutions are not necessarily offering programs for in-demand and emerging roles.

**Expected Impact:** See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

**Budget Implications:** See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

**Risk Factors:** See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

**Equality Implications:** See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

**Social Impact & Sustainability:** See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

**Legislative Action:** See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.



## **Recommendation #2:**

Conduct a quality improvement review of the licensure process to address delays in all aspects of clinical licensing, and develop and implement process improvement plans to reduce turnaround times.

### **Background:**

Regionalism means that practitioners have options regarding the jurisdiction in which they practice. Barriers and perceived barriers to practicing in the District include:

- Licensing delays;
- Malpractice insurance that is the highest in the region, specifically for obstetrics;
- Higher costs of living and doing business in the District;
- Reimbursements that do not cover the costs of practice, including low Medicaid reimbursement;
- Physician mobility within the District that is limited by non-compete clauses and malpractice tail costs; and
- Quality of local candidates for staff positions.

Workplace violence at hospitals (spill-over from the community) results in burnout and staff injury, and safety concerns at community sites is a barrier to recruitment.

### **Expected Impact:**

See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

### **Budget Implications:**

See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

### **Risk Factors:**

See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

### **Equality Implications:**

See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

**Social Impact  
& Sustainability:**

See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

**Legislative Action:**

See Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.

### **Recommendation #3:**

Ensure value-based purchasing initiatives calculate the actual costs of and include sufficient reimbursement to support non-clinical patient care positions, such as care coordinators, discharge planners, community health workers, etc.

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|--|--|
| <b>Background:</b>                         | Non-clinical patient care positions perform critical functions in a transformed health care system that are not generally reimbursable, such as patient literacy, navigation, interpretation, treatment adherence, and home visitation. Such positions are funded only for discrete population groups. |
| <b>Expected Impact:</b>                    | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.   |
| <b>Budget Implications:</b>                | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.   |
| <b>Risk Factors:</b>                       | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.   |
| <b>Equality Implications:</b>              | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.   |
| <b>Social Impact &amp; Sustainability:</b> | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.   |
| <b>Legislative Action:</b>                 | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93.   |

#### **Recommendation #4:**

Establish a center for health care workforce analysis to systematically gather, link, and analyze national and local data on current and projected workforce supply and demand and training needs; and develop policy documents and recommendations for District agencies, Council, and funders (e.g., shortages to be addressed, emerging industries, data to be collected through the licensure process, common core skill sets, training resources needed, career pathways, etc).

|  |  |
|--|--|
| <b>Background:</b>                         | There are limited health care workforce planning efforts for long-term sustainability.   |
| <b>Expected Impact:</b>                    | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93. |
| <b>Budget Implications:</b>                | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93. |
| <b>Risk Factors:</b>                       | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93. |
| <b>Equality Implications:</b>              | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93. |
| <b>Social Impact &amp; Sustainability:</b> | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93. |
| <b>Legislative Action:</b>                 | <u>See</u> Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action beginning on page 93. |

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### **Collective Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, and Legislative Action**

#### **Expected Impact:**

The collective goal of the recommendations is to ensure a workforce that is able to support a transformed health care system. The long-term impact of the recommendations is two-fold: improved health care and increased economic well-being of District residents, which are both key determinants of health.

Measurable outcomes that the recommendations intend to impact include the following:

- Short-Term Outcomes:
  - Increased responsiveness of training to industry needs
  - Increased practical experience and hirability of trainee graduates
  - Increased entrance of District residents into health care careers
  - Increased pool of candidates for in-demand roles
  - Increased support for individuals pursuing and advancing in health care careers
  - Increased capacity to deliver non-clinical services
  - Reduced barriers to practicing in the District
- Medium-Term Outcomes:
  - Increased employment of District residents
  - Increased representation of District residents at all levels of the health care workforce
  - Increased cultural competency of providers
  - Increased workforce retention
  - Reduced costs of recruitment and training
  - Increased diversity of practice types
  - Increased modes of delivering health care
  - Increased capacity to address population health
  - More equitable distribution of providers

#### **Budget Implications:**

While some of the recommendations will require up-front investment, the long-term return on investment (ROI) could potentially be realized through reduced health care spending and increased employment rates. The cost-saving associated with technology, such as telehealth, is still to be determined, but is likely to be cost-neutral. Delineating clear scopes of practice could lead to cost savings.

For the up-front investments, there are a range of potential funding sources from the following sectors: health care, health technology, education, and labor. Specific sources include, but are not limited to: Workforce Investment Opportunity Act (WIOA) funds and Department of Labor grants, hospital community benefit investments, US Department of Education funding, Medicaid FMAP, and local appropriations. As the returns on investment will accrue to both the private and public sectors, both sectors should be responsible for the up-front investments.

**Risk Factors:**

Risks to effectively implementing the recommendations include:

- The need for sustained long-term investment;
- The challenge of establishing and maintaining partnerships across multiple sectors;
- Variable sector capacity to implement recommendations;
- Reduced federal funding to support efforts;
- Initiatives being deprioritized if not required;
- Major changes in technology that have large up-front costs and change rapidly, resulting in a low ROI;
- Inherent challenges with value-based purchasing (VBP) approaches and incentives (for example, aligning financial risk with opportunity for realized savings), as the policymaking process can be slow and may not keep pace with needed market adjustments; and
- Concerns about excessive risk, such as costly changes with low ROI, which may deter provider participation in VBP.

**Equality Implications:**

These recommendations aim to increase equitable access to quality health care, employment opportunity, and related employment benefits such as loan repayment and other recruitment and retention incentives. Currently, the type of care, quality of care, customer service may differ based on location, and improved training and standards could lead to more consistent care regardless of location. Further, these recommendations could potentially improve patient experiences, including better care and equality, at provider visits.

**Social Impact  
& Sustainability:**

As with the equality implications, the social impact will take the form of improved health and improved economic well-being, including better care, improved access to services, and lower barriers to care for the working population, as well as stay-at-home parents and caregivers.

Sustainability is unclear given the need for private investment or government engagement, which might change over time. Several key factors support sustainability: enhanced partnerships, the continued growth of the health care industry, ongoing sources of revenue to support education and innovation, and the industry's continued and evolving need to develop and retain the workforce.

**Legislative Action:**

The report includes recommendations for which legislative action will be required, those for which legislative action will enhance success, and those for which no legislative action is needed.

There may be a role for government in promoting standardized guidelines or incentive targets for change, potentially as a convener or by establishing benchmarks for improvement by a target timeframe. Also, government has a regulatory role in policy changes for Medicaid such as telehealth, if needed, or value-based purchasing.

## 6. Committee on Value-Based Purchasing of Health Care Services

### **Recommendation #1:**

Engage the community for the road ahead.

- a. Survey patients and caregivers about current behaviors and perspectives informing access to care choices.
- b. Share total cost of care information for specific populations by payer with all stakeholders.
- c. Engage patients and other key stakeholders (i.e., health care groups, payers, and government) in ongoing community dialogue about current value-based purchasing (VBP) and accountable care models, and potential options for the District of Columbia.
- d. Conduct operational readiness assessments of all major health care groups for VBP.

### **Background:**

The Committee believes that there is a critical need for an extended community conversation on what it means to move to an accountable care system. There is also a need for more information about what drives patients' current behaviors and choices in seeking care. There is a need to better understand the total cost of care for specific populations within the community. Finally, there is a need to assess the readiness of major health care groups to move to such a system. Such work must be completed to inform the District of Columbia's system planning and design efforts for the future.

See additional background in Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.



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|--|--|
| <b>Expected Impact:</b>                        | <u>See</u> Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106. |
| <b>Budget Implications:</b>                    | <u>See</u> Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106. |
| <b>Risk Factors:</b>                           | <u>See</u> Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106. |
| <b>Equality Implications:</b>                  | <u>See</u> Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106. |
| <b>Social Impact<br/>&amp; Sustainability:</b> | <u>See</u> Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106. |
| <b>Legislative Action:</b>                     | <u>See</u> Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106. |

**Recommendation #2:**

Expand quality measurement to capture more data on health system effectiveness and to inform care delivery, payment incentives, and population health. Measures should align with existing measures required by federal and other partners.

- a. Refine the core measure set of health priorities.
- b. Engage health care groups to achieve multi-payer alignment.
- c. Adopt public reporting to disseminate performance on the core measurement set.

**Background:**

The Committee believes that a community-wide performance measurement system is the cornerstone of any accountable care system. Such a system generates value through a collective focus on a defined set of priority measures, transparency through public reporting, and ultimately more accountability to District residents for outcomes. This system should engage all payers operating in the District of Columbia as that is the best way to drive change among all health care groups. The system should be developed with input from patients and other key health care stakeholders. Where applicable, this system should incorporate measures from national standards (i.e., HEDIS), regional efforts (i.e., CRISP), and commercial insurers' initiatives in the marketplace. Where applicable, the system should include District-specific measures derived from sources such as the "Health Equity Report for the District of Columbia 2018," latest epidemiology, morbidity and mortality data analysis, and community efforts at identifying social determinants of health.

In order to refine the core measure set of health priorities, the District of Columbia should hold a convening of payers and other stakeholders within the next two years to refine the core measure set developed in the State Innovation Model (SIM) design process to further align with existing performance reporting initiatives as other measure sets are changed and updated. The Department of Health should serve as an advisor as part of the selection process

to ensure the consideration of findings from the 2018 Health Equity Report, current access to care patterns, latest epidemiology, morbidity and mortality data analysis, community efforts at identifying social determinants of health, and commercial payers' initiatives in the marketplace. Measures should be nationally-recognized and validated.

It is critical that we develop measure sets that are meaningful to patients, consumers, and physicians, while reducing variability in measure selection, collection burden, and cost. Therefore, the Committee believes that the District should establish broadly agreed upon core measure sets that can be harmonized across payers. Within the next five years, payers should use the core measure set in designing their value-based purchasing initiatives and other quality improvement activities.

Finally, in efforts to increase transparency to promote a more accountable health system, the District of Columbia should invest in a public reporting platform to disseminate performance on the core set as well as other actionable information pertaining to access and pricing.

See additional background in Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Expected Impact:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Budget Implications:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Risk Factors:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Equality Implications:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Social Impact  
& Sustainability:**

See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Legislative Action:**

See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Goal 3:**

Make key investments and policy changes to promote system integration for accountable care transformation.

- a. Invest in practice transformation capacities.
- b. Ensure alignment and integration to enable accountability.

**Background:** Over the next two years, the District of Columbia government and stakeholders should explore options for requiring all health plans operating in the District to use the core measure set.

See additional background in Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Expected Impact:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Budget Implications:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Risk Factors:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Equality Implications:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Social Impact & Sustainability:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Legislative Action:**

See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Goal 4:**

Align payments with value-based care goals to move towards a risk-based model encouraging care coordination and health promotion.

- a. Expand current value-based purchasing measures into other appropriate provider settings.
- b. Establish a Medicaid accountable care organization (ACO) certification.
- c. Adopt value-based purchasing models.

**Planning Considerations:**

The Committee believes that the District of Columbia, as a major payer for Medicaid, has unique opportunities to expand value-based purchasing (VBP) strategies on the road to accountable care. The District of Columbia currently operates a managed care organization (MCO) program that serves nearly 200,000 persons enrolled in Medicaid or Alliance programs. Recently announced plans indicate that, beginning October 1, 2020, an additional 22,000 Medicaid fee-for-service beneficiaries who do not require long-term care services will be enrolled in the MCO program. This expansion will require a new procurement process to select entities to participate in the expanded program. Through this or future procurement processes, the District of Columbia could incentivize different types of community partnerships to form in order to bid on the MCO program.

For example, the District of Columbia could define an eligible managed care entity to include an accountable care organization (ACO), clinically integrated network, or other strategic health care partnership. Regarding the formation of an ACO, the Committee notes that the Department of Health Care Finance completed a request for information (RFI) process in 2017. Findings from that RFI process identified five key factors for establishing such an entity: adequate time to prepare for change, startup funds, better HIT/data exchange, financial transparency, and defined service population.

In the next two years, the District of Columbia Department of Health Care Finance should require the Medicaid Managed Care Organizations to use the measures used in the FQHC and MCO VBP pay-for-performance programs to develop incentive programs with other providers at the appropriate care setting and for the appropriate populations.

Within the next five years, the District of Columbia's Department of Health Care Finance should create Medicaid ACO certification. ACO certification is a formal process that delineates criteria required to become an ACO and the selection process through which provider's readiness to provide ACO services is assessed. Certification typically addresses 1) organizational and governance structure; 2) scope of services and patient population; 3) quality measurement and assurance; 4) payment model and financial strength; and 5) care management expectations. The Department should give careful consideration to the findings and key factors from its 2017 ACO request for information process. Those factors are adequate time to prepare for change, startup funds, better HIT/data exchange, financial transparency, and defined service population.

Within five years, Medicaid will expand VBP requirements across the program. Core set measures should be used in these models.

See additional background in Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Expected Impact:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Budget Implications:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Risk Factors:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.



**Equality Implications:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Social Impact & Sustainability:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

**Legislative Action:** See Collective Background, Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline beginning on page 106.

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## **Collective Background Expected Impact, Budget Implications, Equality Implications, Social Impact & Sustainability, Legislative Action, and Recommended Timeline**

### **Background:**

The Committee identified an overarching goal for the **District of Columbia government to embark on a multi-year transformation beginning in 2020, with the explicit goal of operating a more accountable, equitable, and integrated system of care for all District residents.**

The Committee recognizes such transformation is a bold and complex undertaking. We are fully aware, based on available data, that there is significant spending on health care in the District of Columbia, yet such spending is not generating desired health outcomes. We acknowledge that this report is the product of an abbreviated, yet important first step in the efforts to plan and design accountable care and that there is more work to be done over time. We are committed to putting the patient at the center of this new system which will reward pay for performance across all health care groups. We appreciate that this transformation will require change for patients and their caregivers, health care groups, payers, and government over time. We believe this will require a sustained commitment of will from the District's leaders, as well as investments from public and private sources. Finally, we embrace a core set of guiding principles (see below) to influence our collective words and actions on the road to accountable care.

### **(a) Transparency Builds Accountability**

An accountable care system in the District of Columbia requires more transparency. Greater accountability can be achieved when patients and other key stakeholders (i.e., health care groups, public and private payers, and government) have access to meaningful performance information on access, quality, and price. Such transparency is critical to performance improvement, care coordination, and accelerating the integration of programs and services cross the entire community.

### **(b) We Are What We Measure**

An accountable care system must address a finite list of high priority measures that impact the greatest number of District

residents. Where possible, these measures should be based on national, evidence-based standards. The selected measures, both pediatric and adult, drive how we implement change to existing policies and procedures, programs and services, information systems, reporting, and ultimately payment. Improved health outcomes can be achieved over time when all health care groups, payers, and government focus their collective efforts on such measures.

**(c) Performance Improvement Always Takes More Time**

An accountable care system will take more time to improve performance across all health care groups than we think. Current patterns of care reveal that many individuals and families seek care outside of their neighborhood and through multiple health systems, often not receiving care at the appropriate place, time, or treatment. Individuals, organizations, and government all have perspectives and judgments about the quality of care available within the community. These realities will not change overnight but rather only with the significant passage of time and actual experience with accountable care.

**(d) Community Partnerships Are Essential to An Integrated System**

An accountable care system must be built on community partnerships which place the patient at the center of their work and can coordinate services across the full continuum of care. Such partnerships are essential for improving health outcomes for District residents. They also act as change agents that can effectively manage clinical and financial risk of patients in community. Such partnerships can include but are not limited to accountable care organizations, clinically integrated networks, and integrated health and supportive services models.

**(e) Performance Measurement and Payment Models Must Be Aligned to Achieve Real Value**

An accountable care system must fully align clinical and financial incentives across all health care groups and with the patient at the center of the system. Greater alignment of performance incentives focuses health care groups to provide the right care at

the right time and place. Such alignment will accelerate the move from volume to value.

The Committee believes that a projected target date of operations is needed to focus all program planning, design and implementation efforts for transformation. Given the complexity of this work and the many uncertainties that lie ahead, we do not believe that this transformation can be successfully completed within five years. Our macro planning assumption is based on an eight year project timeline. We believe this is a prudent starting place for discussion and expect that there will be different views about this timeline—and whether it is realistic and/or achievable—within the Commission.

The Committee believes that the transformation process should be based on a publicly available roadmap that outlines the journey to accountable care. To that end, we believe that the State Innovations Model (SIM) grant, funded by the Centers for Medicare and Medicaid Services (CMS) and completed in 2016, is a good starting place for such a roadmap. Specifically, the SIM model focuses on three key pillars or foundations—care delivery reform, payment reform, and community linkages—and highlights the importance of stakeholder engagement, health information technology, workforce development, and quality performance improvement to each one of the pillars. Lastly, the SIM model provides a conceptual multi-year timeline for change. The Committee also notes that there are a number of state learning collaboratives supported by CMS and/or private health care foundations that could be informative to the District's system planning and design efforts.

### **Assessment of Current Realities in Local Health Care Sector**

While the District of Columbia has successfully addressed the issue of health insurance coverage for its residents over the past 10 years, it has yet to make significant progress in improving overall health outcomes and moving towards more accountable, equitable, and integrated community care for all residents.

There are numerous contributing factors to the current state of the local health care sector. Data presented to the Mayor's Commission reveals the following:

1. Many patients and health care groups are unaware of what resources are available to them—both in terms of accessing and coordinating services across the care continuum;
2. A fundamental misalignment of services—notably in hospital care, specialty care, and behavioral health—continues to create real and perceived barriers for patients to access care in a timely manner;
3. Persistent patterns, behaviors, and perspectives about quality continue to fuel higher than expected low-acuity emergency room and other hospital-based utilization--even when lower cost, more accessible alternatives are available in the community;
4. Significant connectivity and integration challenges exist to fully implement the myriad of health information technology and data exchange initiatives across our local health care sector;
5. The existing healthcare workforce faces two existential challenges--the urgent need to recruit and retain thousands of physicians, nurses, and other licensed professionals over the next 10 years, and the formal acceptance and recognition of the importance of community health and other allied health workers in the team-based workforce model of the future;
6. Current financing of health care remains largely driven by volume and, even in those instances where value-based purchasing (VBP) initiatives do exist, they are not integrated across nor include all payers (Medicaid, Medicare, and Commercial) and do not offer significant return on investment for health care groups to invest in changes to their operations.

Beyond these contributing factors lays an even more persistent dynamic to overcome. That is the political culture that surrounds health care access and service delivery. There are many stakeholders, all of whom are working in good faith and with good intentions to advance change on behalf of patients. Key stakeholders have different views and opinions on what should be

changed, how change should occur, and when change should happen. These perspectives will take time to reconcile. We do not seek to pass judgment here on individual organizations nor government officials who must live and work in this reality. This is truly a case of “don’t blame the player, blame the game.” The only antidote to this culture, however, is a powerful vision of transformation that transcends an individual organization’s interests and places the highest priority on the overall health and well-being of all residents. Absent such a vision, the past is prologue.

### **Assessment of Medicaid Innovation Efforts in the District of Columbia**

Since the passage of the Affordable Care Act (ACA), the District of Columbia government has pursued a number of federal innovation initiatives in Medicaid to support health care groups as they begin to move their operational focus from volume to value. These initiatives include implementation to two Health Homes programs as well as completion of a State Innovation Models planning grant. These Medicaid innovation efforts are noteworthy as they recognize and embrace the need of transformative change now.

Yet these efforts are limited in community-wide impact and economic value. They are oftentimes only made available to a small subset of DC residents, focused on a specific group of health care providers and institutions; focused on a finite number of key quality or performance measures; and/or do not apply across all payers in the community. From an economic value perspective, these initiatives are challenged by the basic return on investment (ROI) question that all health care groups must assess when considering changes to their existing operations. Put another way, there is only so much ROI to achieve under smaller, more incremental VBP initiatives. In many instances, the actual costs to change existing care model operations for any one health care group exceed the potential financial gain from the VBP initiative. This is the fundamental limitation with such VBP efforts. Ultimately, they do not possess significant market power and/or financial incentive to motivate a large number of health care groups to make significant new investments in care operations.

## **Current VBP Efforts in the District of Columbia**

Regarding Medicaid, current VBP efforts largely focus on reducing low-acuity hospital admissions and readmissions as emergency department visits in both the MCO and fee-for-service programs. Such initiatives are in the first few years of implementation yet are producing favorable preliminary results. These efforts are structured as nominal financial withholds that impact no more than 2% of total projected annual payments to Medicaid MCOs and DC-based federally qualified health centers. These organizations can earn such withholds back by meeting and/or exceeding specific utilization targets each year.

Over the past 4 years, the Department of Health Care Finance has implemented two Health Homes initiatives—one for persons with behavioral health needs and the other for persons with two or more chronic health conditions (MyHealthGPS). There are important lessons learned from both of these efforts which are payer-specific and based on voluntary enrollment. Such lessons include the overall resource investments needed by individual health care groups to meet participation requirements in these programs; the overall financial/economic incentive to participate in the programs (the ROI question); and the overall efficacy of such intensive care management programs on individual patients that community health care groups currently serve.

Regarding Medicare, there are 5 Shared Savings Program ACOs with service areas that include the District of Columbia. As background, the Shared Savings Program offers two tracks for participating ACOs—the first that offers one-sided financial upside (ACOs can only realize shared savings if they lower Medicare Parts A and B fee for service costs against set targets and if they meet quality performance measures) and a second that provides a two-sided financial model (ACOs assume accountable for both savings and losses and can retain a greater portion of savings than under the first track).

In 2019, CMS implemented its second-generation Medicare ACO program known as Pathway to Success initiative. This is CMS' latest effort to accelerate the movement towards accountable care whereby participating ACOs take on more financial responsibility than that under the Shared Savings Program. As of

July 1, 2019, there are no participating entities operating in the District of Columbia.

Regarding commercial payers, CareFirst offers two regional VBP efforts since 2011 known as Patient Centered Medical Home (PCMH) and Total Cost and Cost Improvement (TCCI) initiatives. These programs have reduced projected costs of care by 3-4% per year largely through reductions in hospital admissions and readmissions as well as lengths of overall stays. As background, CareFirst's PCMH initiative provides network primary care groups with one-time care planning fees and enhanced primary care payment rates in exchange for coordinating services via CareFirst's technology platform. Nearly 90% of eligible network primary care groups participate in PCMH. CareFirst' TCCI program is a supporting module of PCMH and provides network primary care groups with access to specific care management, behavioral health, home care, and pharmacy coordination tools.

#### **National Data on Medicare and Medicaid Accountable Care Initiatives**

As of July 2019, there are 559 Medicare accountable care organizations (ACOs) serving more than 12.3 million beneficiaries. Only 2 of every 5 Medicare ACOs are participating in the Pathway to Success initiative. This data point reflects an overall reluctance or uncertainty for many ACOs participating in the Shared Savings Program to move towards greater clinical and financial accountability under the Pathway to Success Initiative.

As of state fiscal year 2018, 14 different states (CO, CT, IA, ME, MA, MN, MO, NE, NV, NJ, NV, PA, RI, and VT) have approved CMS waivers for ACO programs. In general, Medicaid ACO efforts are largely driven by individual states' appetite for health care reform and annual budget considerations. A majority of these states are in the early stages of implementing ACO initiatives. These states are sharing lessons learned through a number of learning/technical assistance collaboratives supported by CMS and national health care foundations (i.e., The Commonwealth Fund and Robert Wood Johnson Foundation's Centers for Health Care Strategies).

While the District of Columbia does not currently operate a Medicaid ACO program, the Department of Health Care Finance



did complete a request of information process in 2017 regarding the establishment of such an ACO. Based on its assessment of RFI responses, the Department identified five factors needed to successfully start a Medicaid ACO. Those factors are adequate time to prepare for change, startup funds, better HIT/data exchange, financial transparency, and defined service population.

Lastly, one consistent message emerges from this external review of Medicare and Medicaid accountable care initiatives. At the federal government level, CMS is aggressively investing in more initiatives for Medicare and with state Medicaid programs in pursuit of greater accountability. Overall, CMS currently believes that the pace of change in both Medicare and Medicaid programs is simply not fast enough. This is not a partisan view but rather one based on actual experience with specific innovation efforts authorized under the Affordable Care Act. This federal perspective on the pace of change has major implications for the Committee's deliberations and its final recommendations.

### **Perspective on Change--Incrementalism vs. Transformation**

Incrementalism has an important place and time in public policy--especially when existing programs, structures and systems in community largely meet societal expectations. Why? Because key stakeholders are fundamentally satisfied with core outcomes of the current system. When faced with the prospect of incremental change, key stakeholders seek nominal improvements that do not threaten their current interests. Their overall message is "first doing no harm" to the current system. They next naturally gravitate to "win-win" solutions that require little if any sacrifice of their interests.

Regarding VBP initiatives in the District of Columbia, the most obvious reason for incrementalism is to offer all health care stakeholders sufficient time to adapt to new care and financial realities. Change ultimately generates uncertainty and loss before it produces long-term value for the community. It is therefore reasonable to assume that patients and their caregivers, payers, providers, and government all need time to navigate change.

Transformation, however, is needed when societal expectations are not being met by existing programs, structures, and systems. In those rare moments, key stakeholders are willing to sacrifice

their interests for the opportunity at something greater than themselves. They recognize that the status quo is broken, and that change is inevitable. They do not arrive at this place lightly or without serious reflection.

The most obvious reason for transformation is to respond directly to a compelling and urgent need that warrants immediate societal change. In the Committee's view, that need exists right now with the District of Columbia's local health care sector. There is no more compelling case than to aggressively attack the emotional, physical, economic, social, and spiritual costs that poor health has on our entire community. It is this fundamental view that shapes the Committee's recommendations and considerations.

### **Policy, Program, and Infrastructure Considerations to Moving to Accountable Care**

The Committee wants to highlight a number of policy, program, and infrastructure considerations for building a more accountable, equitable, and integrated system of care of all District residents.

#### **Population Health**

There is a fundamental need for a community-wide population health focus throughout the entire transformation process. Serious consideration should be given to selecting a limited number of priorities—no more than 10—to focus the efforts of all health care groups, payers, and the District government. The priorities should include both pediatric and adult measures. Data suggests that cardiovascular disease, diabetes, obesity, behavioral health, substance use disorders, and trauma-informed care warrant discussion during any community-wide, priority-setting process. Consideration should also be given the findings from the Department of Health's report on health equity and from DC PACT work to identify key social determinants of health that are negatively impacting DC residents' access to care.

#### **Health Information Exchange/Data Analytics**

There is a fundamental need for greater utilization and integration of technology, information exchange, and data analytics to support transformation. The building blocks of such an HIT infrastructure exists with DC HIE, CRISP, and

other EHR/practice management systems. Consideration should be given to establishing a single cloud-based data warehouse that supports any future accountable care efforts in the District of Columbia.

### **Care Model Learning Collaboratives**

There is a fundamental need for establishing a “best practices” learning and technical assistance to advance this transformation. Consideration should be given to the following topics—cultural humility and competency, care model operations, population health strategies, budgeting and financial management, and data analytics.

### **New Types of Community Partnerships**

There is the need for thoughtful discussion and reflection about the new types of accountable community partnerships that will serve District residents in the future. Such partnerships could be formed by existing hospital or health systems, payers, clinical integrated networks, or other strategic health and social services collaboratives. Regardless of actual corporate or legal structure, each partnership should include a defined set of services and/or facilities such as acute care hospital(s) with trauma level care, ambulatory specialty care services, urgent care services, primary care services, and community behavioral health services, and long-term care support (either facility-based or in home or community).

### **Total Cost of Care**

There is a fundamental need to shift current financial incentives from volume to value, and to fully align incentives for health care groups, payers, and the District government. There is a great need to better understand the total cost of care for specific populations by payer in the District of Columbia. Such cost analyses would inform future discussions about performance measures and payment models to support accountable care.

### **Investment in Infrastructure**

There is a fundamental need to build new and/or expanded infrastructure in the local health care sector to support transformation. Investments will be needed to build capacity across health care groups in areas such as

practice transformation, population health management, health information exchange and data analytics, and workforce development.

**Expected Impact:**

The recommendations will create a more accountable, equitable, and integrated health care system for all residents of the District of Columbia. As such, they dramatically scale up a number of existing or planned VBP efforts over time.

The recommendations will create a compelling and urgent case for transformation within our local health care sector. They do so by publicly owning the current limitations of this sector and less than optimal health outcomes for District residents.

The recommendations will provide sufficient time for all stakeholders to actively engage in transformation. A multi-year roadmap for change offers all parties—patients and caregivers, health care groups, payers, and government—time to adapt attitudes, perceptions, and behaviors needed for transformation.

The recommendations will reflect the latest thinking in health care reform, which emphasizes value over volume and accountability over access. They do so by taking into account the District of Columbia government's keen interest in moving more accountable care over time.

**Budget Implications:**

The Committee notes that new investments will be needed to build the infrastructure for an accountable care system. Investments will support various initiatives and/or infrastructure related to practice transformation, population health management, health information exchange and data analytics, and workforce development. The exact amount of such investments will be determined in the future by the actual program design of an accountable care system.

Over the next five years, the District of Columbia should consider investing a minimum of \$20 million in new funding from public and private sources to ensure that mission-critical infrastructure is built to advance accountable care. Priority investments are needed in population health, health information exchange and data analytics, and care model learning collaboratives and other practice transformation capacities to ensure the overall success of this transformation.

The recommendations, if fully implemented, will realize annual health care cost savings in the range of 1-2% across all payers. The projected annual savings range is based on actual experience from individual states which have implemented major VBP strategies and/or accountable care initiatives.

Regarding possible investment funding, we identified the following public and private sources—Medicaid DSH payments; dedicated real estate tax revenues from District of Columbia government’s redevelopment priorities (i.e., Reservation 13 and St. Elizabeths East Campus projects); increased sales tax revenue on beer and alcohol, cigarettes, and e-cigarettes/Juul/vaping devices; etc.

**Risk Factors:**

The major risk factors that will impact the success and/or failure of any transformation effort in the District of Columbia are as follows:

**Community Response to Transformation**

Patients, health care groups, payers and District of Columbia government will all have an active role and voice in shaping transformation over time. Inevitably there will be moments of disagreement over policy, care operations, selected population health measures, and budget and payment methodologies. There will be resistance and pushback from key stakeholders throughout the entire process. That is inevitable with transformation.

**Infrastructure Investment**

There is little--if any--likelihood of success if the transformation does not receive new and sustained financial investments over time.

**Mayoral—Council Relationship**

The relationship between Mayor Bowser and the Council of the District of Columbia will have a direct bearing on the outcome of these processes. Recent public debates over the proposed new hospital at the St. Elizabeths East Campus, as well as the future of United Medical Center, highlight just how complex major health care policy issues are in the District of Columbia. The Mayor and the Council will need work closely over time to finalize related budgets, draft implementing legislation (if needed), and

promulgate regulations for transformation. This Commission is a vital first step in that collaboration.

### **District of Columbia's Planning and Implementation Capacities**

A transformation of this size, scale and complexity will test the planning and implementation capacities of the District of Columbia and its government--especially the Departments of Health Care Finance and Health. The planning and implementation deliverables will not be met by simply adding additional responsibilities to District government officials. As such, consideration should be given to establishing a formal planning/implementation commission with dedicated staff to oversee the transformation.

### **Health Care Groups' Readiness and Capacity of Care Model Change**

Individual health care groups are in various stages of readiness for movement towards accountable care. They will need to navigate numerous changes in administrative, care, and financial policies and procedures at the same time that they are caring for current patients. Additionally, a strategy to effectively address current and future workforce shortages, along with embracing a movement to non-traditional care providers will be a critical factor to any successful health system transformation effort.

#### **Equality Implications:**

The recommendations will support a more equal and just health care system for all District residents. All residents will be included in this transformation and have access to enhanced access to care, care coordination, and social determinants of health supports as needed. A community-wide focus on population health will improve health outcomes over time for more District residents.

#### **Social Impact & Sustainability:**

There will be additional but yet defined social value of this transformation—notably in terms of employment (significant number of new jobs generated via the transformation), public health, and public safety.

#### **Legislative Action:**

The District of Columbia government should consider whether formal legislation and implementing regulations are needed to advance the transformation. In some instances, the District of Columbia may need to secure specific waivers with the Centers

for Medicare and Medicaid Services (CMS) to advance major elements of the transformation.

## **IV. CONCLUSION**

The 42 recommendations contained in this report seek to create a more equitable, robust, and integrated system of care for all District residents. While we recognize that new challenges will arise, these recommendations will help address some of the most pressing issues facing the District of Columbia at this time. Additional work from Commission members may be warranted in the future and members have indicated their interest in continuing this work, as needed.

The Commission hopes that these recommendations will guide the work of Executive agencies, the Council of the District of Columbia, and stakeholders throughout the health care system as they look for ways to ensure positive health outcomes for all District residents. Mayor Bowser should assign these recommendations to appropriate members of her administration for consideration and implementation. Key investments, policy changes, and the development of partnerships will be necessary for them to come to fruition, but the alignment achieved through the work of this Commission provide an excellent starting place for this work.



## V. APPENDIX A: COMMISSION & COMMITTEE MEETINGS

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|---|---|
| <b>Mayor's Commission on Healthcare Systems and Transformation</b><br><br><i>Meeting agendas and minutes for all full commission meetings are available <a href="#">here</a>.</i> | <ul style="list-style-type: none"> <li>• June 25</li> <li>• July 30</li> <li>• August 27</li> <li>• September 24</li> <li>• October 29</li> <li>• November 26</li> <li>• December 17</li> </ul>                       |
| <b>Committee on the Equitable Geographic Distribution of Acute, Urgent, and Specialty Care</b>  | <ul style="list-style-type: none"> <li>• August 7</li> <li>• August 26</li> <li>• September 9</li> <li>• September 23</li> </ul>  |
| <b>Committee on Emergency Room Overcrowding &amp; General Reliance on Inpatient Hospital Care</b>   | <ul style="list-style-type: none"> <li>• July 24</li> <li>• August 8</li> <li>• August 23</li> <li>• September 5</li> <li>• September 16</li> </ul>   |
| <b>Committee on Discharge Planning and Transitions of Care</b>  | <ul style="list-style-type: none"> <li>• August 1</li> <li>• August 15</li> <li>• August 29</li> <li>• September 12</li> <li>• September 26</li> </ul>  |
| <b>Committee on Access to Critical and Urgent Care Services</b>   | <ul style="list-style-type: none"> <li>• July 30</li> <li>• August 6</li> <li>• August 13</li> <li>• August 20</li> <li>• August 27</li> <li>• September 3</li> <li>• September 17</li> <li>• September 24</li> </ul> |
| <b>Committee on Allied Health Care Professionals and Workforce Development</b>  | <ul style="list-style-type: none"> <li>• August 14</li> <li>• August 26</li> <li>• September 12</li> <li>• September 23</li> </ul>  |
| <b>Committee on Value-Based Purchasing of Health Care Services</b>  | <ul style="list-style-type: none"> <li>• July 25</li> <li>• August 6</li> <li>• August 20</li> <li>• September 4</li> <li>• September 18</li> <li>• September 25</li> <li>• September 27</li> </ul>                   |