



District of Columbia
Department of Health

**COVID-19
PANDEMIC HEALTH
AND HEALTHCARE
RECOVERY
REPORT
SUMMARY**

May
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Post-Pandemic Recovery Framework

The impact of the COVID-19 pandemic will have long-lasting impacts on the health needs of District residents. As of Spring 2021, COVID-19 vaccine coverage continues to increase in the District and across the U.S., and with that comes optimism of a deceleration of the current pandemic. DC Health, as the state health agency and the primary public health responder for this emergency, has devised a framework for the post-pandemic recovery of the District’s health ecosystem.

The DC Health framework for addressing post-pandemic needs (Figure 1) aims to assess the pre-pandemic, pandemic, and potential post-pandemic landscape of five functional areas critical to addressing the health needs of District residents: Health Planning, Workforce, Health Information Technology, Healthcare Facilities, and Community Health Services with equity in programming and policy as a foundation. DC Health is utilizing this framework in an effort to not return to the “pre-pandemic” normal. However, the aim is to return to a health ecosystem prepared to not only address another global pandemic, but to better address all health needs in the District through integration and a focus on health equity. While the pandemic has caused a significant amount of suffering and negative impacts on health outcomes, it has also come with some instrumental, positive lessons learned.

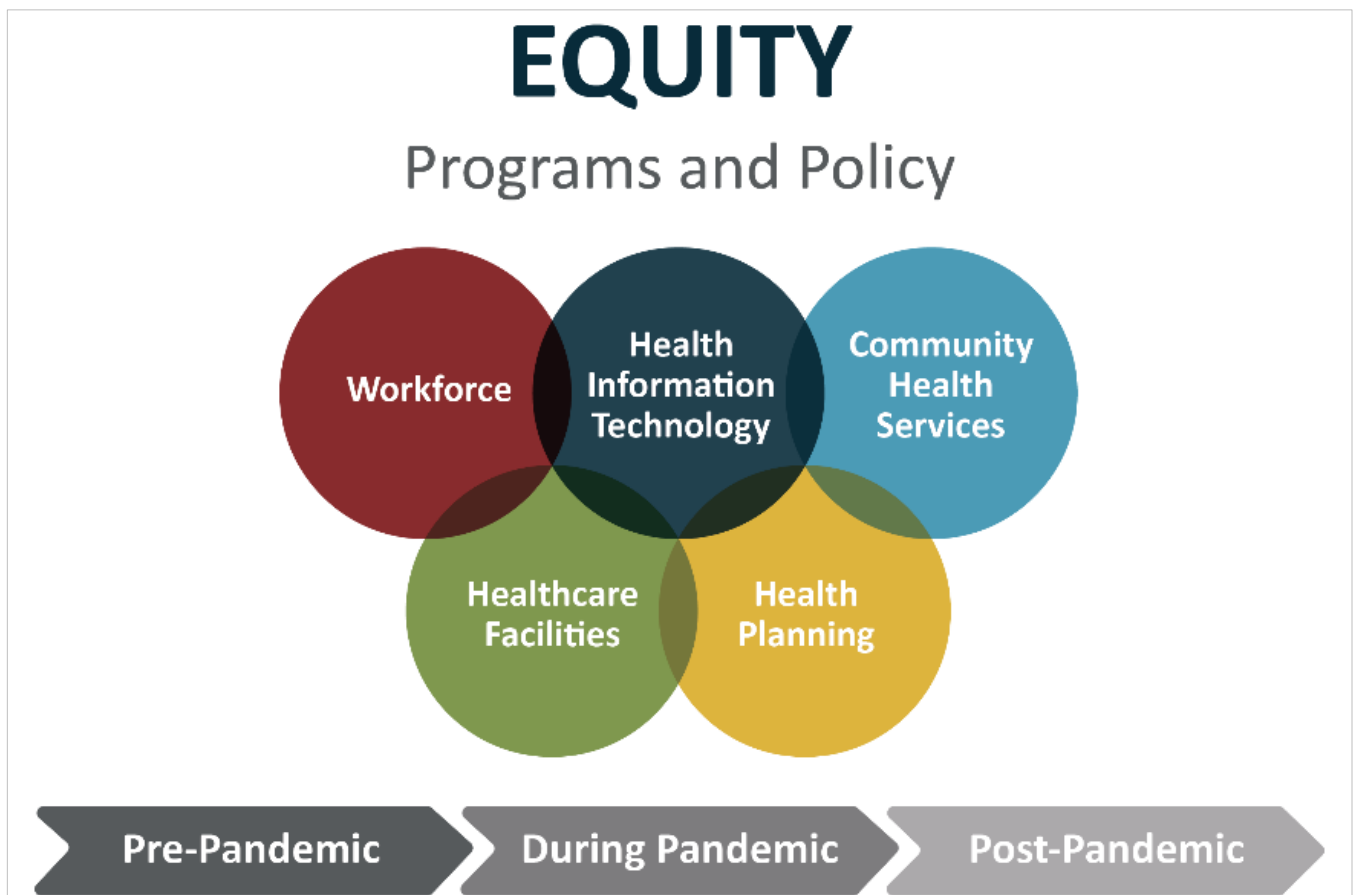


Figure 1. Framework for Addressing Post-Pandemic Health Needs

Pandemic Lessons Learned and Recommendations for Post-Pandemic Recovery and Beyond

Health Planning



FUTURE DIRECTIONS AND RECOMMENDATIONS

Health planning, assessment, analysis, and action in a post-pandemic world necessarily includes acknowledgment of the extensive impact of COVID-19 on mortality, short and long-term clinical outcomes, mental health and wellness, community engagement, partnerships and policy.

Recommendations include:

- **Proactive Strategic Alignment and Engagement:** Post-pandemic recovery should include more strategic alignment and proactive engagement with partners, especially non-traditional partners to ensure inclusion of public health priorities, equity, and coordination with resident perspectives. Additionally, increased alignment with already-published recommendations (i.e. the Mayor's Commission on Healthcare Systems Transformation), D.C. Agency or Cluster strategic plans is critical to minimize duplication of efforts and resources.

- **Expanded Home/Patient-Centered Model:** The regular use of telehealth and in-home visits should become a standard of practice model. With this model, providers can be located locally or nationwide.
- **Expanded Scope of School-Based Health Providers:** School-Based Health Providers need to expand the scope of services provided and develop enhanced care coordination among different providers within a family’s health ecosystem.
- **Increased Influence in Policy:** Utilize the COVID-19 Pandemic thought-leadership and regulatory levers to continue promoting bold public health action into post-pandemic public health priorities.
- **Formal Assessments of Current Health Status:**
 - Disproportionate COVID-19 Outcomes Among Populations: There is a need to review COVID-19 rates, clinical outcomes, and impact on social needs among populations disproportionately affected by the pandemic.
 - Pandemic Impact on:
 - Grief and Trauma
 - Substance Use Disorders
 - Academic, Social, and Emotional Growth in Children
 - Mental and Behavioral Health: Increased demand for mental and behavioral health services suggest the need to expand access in multiple settings as recommended by the Mayor’s Commission on Health Care Transformation as well as an enhanced role for Department of Behavioral Health (DBH) partners.
- **Update the Certificate of Need Process:** The Certificate of Need process should be revised, especially in light of a fundamental shift in the healthcare model (on-site vs. home-based). The State Health Planning and Development Agency (SHPDA) currently reviews health services providers regardless of the primary site of service (i.e., in-home and facility-based hospice services, home-based and facility-based dialysis). The SHPDA has not treated telemedicine as a new health service that is subject to certificate of need review. The review has been captured where providers were subjected to certificate of need review as a facility or clinic that offers telemedicine.
- **Optimize Team-based Care Models:** Creation of pipelines to ensure quality and efficient healthcare delivery through the utilization of non-clinical team members (e.g. Community Health Workers and Care Coordinators) that resonate with communities can be an important and sustainable strategy in health planning, promotion and community engagement. Telehealth options should be assessed in the Community Health Worker and Care Coordinator context.
- **Maximize Information Technology Infrastructure and Information Sharing:** Broad interagency data sharing agreements should be composed to allow for easier communication between agencies. Resource allocation and TA for data reporting and data quality should be emphasized among stakeholders, which in turn supports population health data collection, management, analysis, and sharing by DC Health.

Public Health and Healthcare Workforce



FUTURE DIRECTIONS AND RECOMMENDATIONS

Trust and Diversity in the Healthcare System

- **Implicit Bias Training and Policies:** Diversification efforts aimed at increasing the percent of physicians who identify as people of color can serve as a longer-term strategy, however there is also an immediate opportunity to put more effort into implicit bias and discrimination training for health care providers and institutions. Mandatory implicit bias training should be implemented for new health workforce employees, also as core competencies for medical and public health curriculums. Organizational policies should also be reviewed and revised to ensure they are supportive of a positive patient experience regardless of the race/ethnicity, insurance status, or socio-economic status of patients.

Licensure

- **Compacts vs. Reciprocity:** Several professions (e.g., Nursing, Medicine, Psychiatry, and Psychology) already have compacts, but these agreements still have their own downsides. Reciprocity laws should be expanded to allow for the expedient licensure of individuals already licensed in other jurisdictions in good standing, similar to the requirements of the licensure waiver, without compromising each jurisdiction's authority to implement disciplinary actions.

- **Utilize Digital Credentials:** This will allow for greater portability of credentials between jurisdictions. Digital credentials (i.e., school transcripts) that are self-validating would eliminate the need for issuing institutions to send copies, further reducing application processing times.
- **Potential for Different Licensure Categories:** With the shift from facility-based care to home-based care, licensure categories may need to be updated to reflect telehealth-specific credentialing, as compared to in-person, or both, or temporary ability to provide telehealth services, etc.
- **New Models of Oversight:** Given the shortage of health providers, certain procedures, processes or interventions that traditionally require specific oversight (i.e. cardiac rehabilitation) may need to be re-examined for more flexible supervision options.

Scopes of Practice

- **Scope of Practice Definitions:** Scopes of practice will need to be assessed and potentially redefined by training or supervision level with an emphasis on level of supervision truly required for safe patient care. Some professions can provide certain services, but only if supervised (e.g., Physician Assistants).
 - Active vs. Passive/Direct vs. In-Direct: The pandemic has shown that some of those services may not need direct supervision, either at all or to a lesser degree.
- **Telehealth and Interstate Care:** The increase in use of telehealth will require common scopes of practice across state lines.
- **Emergency Modifications:** An inventory of scope of practice changes should be taken to assess the full scope of changes in the context of the pandemic emergency. For example, there may be new professions that need to be created in response to the new healthcare system.

Health Information Technology (IT)



FUTURE DIRECTIONS AND RECOMMENDATIONS

Local governments and health systems should critically leverage data across their jurisdictions to improve population health management. Maximizing the use of digital health tools in case and care management, as well as disease self-management should be implemented to improve population health outcomes. The District and other jurisdictions must leverage the expanded use of telehealth services in primary and behavioral health to promote right care, right time, and right place approaches. DC Health and other District agencies should continue to streamline applications and databases, minimizing the number of disparate applications in use, especially if they are not federally mandated.

Data Collection Strategy Informed by, and Aimed to Address Health Equity

Data collection is a core competency of the Department of Health, and quality data reporting to DC Health should be a core competency of strategic partners. By law, the Department of Health, similar to others across the country, has the ability to, and collects much raw health data.

- **Data Collection as a Core IT Competency including Standardized Monitoring and Evaluation of Programs and Services:** To help inform decision-making and guidance for health planning, programs, and services.
- **Data Dashboards:** To operationalize data for decision-making, the use of data dashboards and related visualizations of data should be more regularly integrated health systems work.
- **Enhance Capacity to Collect Neighborhood-Level Data:** DC Health has embarked on efforts to collect and present health outcome data (i.e. life expectancy, educational attainment, etc.) for over 50 neighborhood groups in the District, which allows for comprehensive assessment of health status. We hope to increase the availability of data collected at this level and encourage other states and jurisdictions to utilize this granular level data.

Digital Health Tools

- **Incorporate the Use of Applications (Apps) and Tools:** To enhance delivery of health services through telemedicine.
- **Provide Consumers with Instruments (and training) for Telehealth Monitoring:** Examples include fetal monitoring for pre-natal visits and blood pressure monitoring for pre- and hypertensive patients.

Database Integration

- **Integration with District Agencies and Community Partners:** Should include all labs, pharmacies, and electronic health record systems (EHRs) to allow for easier data sharing. Formalizing integrations must occur with agencies with crucial data sources for local health departments, for example the Chief Medical Examiner (OCME), Fire and Emergency Medical Services (FEMS) and the Public Health Laboratory (PHL).
- **Maximize Integration of Regional Health Information Exchanges:** Comprehensive assessment on the capabilities of the regional health information exchange (CRISP for the DC metro area) to support patient-center healthcare service delivery as well as population health management.
- **Enhanced Engagement on Social Media:** The ability to manage social media feeds should be used as a way to reduce the dependency on phone calls and broaden reach to the public.
- **Enhance Virtual Options for Consumers/User-Friendly Public-Facing Websites:** Enhancement in the navigation and functionality of public-facing websites may help address customer needs, lessening the need for troubleshooting through phone calls. Additional functions on websites could include: live chats, will-call features and virtual calling.

Health Care Facilities



FUTURE DIRECTIONS AND RECOMMENDATIONS

- **Rulemaking Proposals:** Increased Health Regulation and Licensing Administration (HRLA) oversight of certain health care facilities should be considered. Regulatory oversight of new provider types, i.e. primary care services provided through clinics (FQHCs) and urgent centers may have helped identify weaknesses in emergency plans and strengths in clinics' capabilities to provide services during the pandemic.
- **Study of Health Care Facility Types and Needs:** Thoroughly assess the utilization of urgent centers - some are underutilized, and residents may not know of their availability. Businesses may need to enhance branding to highlight location, quality services, hours, etc. to decrease improper use of emergency rooms as the 24-hour/7-day a week option. More assisted-living facilities may be needed post-pandemic.
- **Expanding Administration of Services for Medicaid-eligible Populations through Telehealth, Assisted Telehealth or Home-based Models:** Incentivizing entities to offer services for Medicaid-eligible populations, for example, through more accessible means other than visiting brick-and-mortar health care facilities.

- **Increased Need for Home Health Aides/Support Services:** Care models are changing to include increased home care options and necessitate additional supply of home health aides and home services.
- **Establishing Supply and Equipment Networks:** Health care facilities need to maximize the use of critical supply chains by enhancing networks among health care facilities.
- **Ongoing Infection and Outbreak Reporting:** DC Health should continue to evaluate technology to capture information requested from multiple administrations within DC Health, for the same health care facilities.
- **Emergency Preparedness:** DC Health should continue to provide technical assistance to facilities on emergency preparedness including health care facility coordination with the State Health Planning and Development Agency (SHPDA). In order for health care facilities to receive Certificates of Need (CON), Emergency Preparedness plans should be included as a “reasonable conditions” requirement.
 - Department of Corrections: Assist with an environmental scan for emergency preparedness needs and provide technical assistance as determined.
 - Federally Qualified Health Centers: Assist in streamlining processes and protocols, in particular, concerning infection control protocol and provide operational technical assistance.
 - School-Based Health Centers: Develop a centralized place to locate preparedness plans for schools and assist with developing a toolkit for emergency response.
- **Data Experts:** Data Analysts should be embedded in health care and social services organizations to ensure data analysis capacity.
- **Workplace Flexibility/Reimagine Workplace Offices:** The nature of the coronavirus and spread necessitates a reimagining of how workspaces will be laid out and how common spaces will be utilized and revamped to optimize safety.

Community Health Services



FUTURE DIRECTIONS AND RECOMMENDATIONS

- **Consider the Benefits of a Shift to Telehealth for Community Health Services:** The shift to telehealth brought with it a removal of barriers for patients that typically have difficulty taking time off work or travelling to a facility for appointments. This should expand not only to healthcare providers but community-based organizations services as well.
- **Expand Reach to Meet Communities Where They Are:** Ensure healthcare delivery systems are easily accessible.
 - Expanded Schedule/Hours: Utilizing regulatory and grantmaking authority to create expanded access for in-person services, in addition to telehealth services.
 - Cultural Sensitivity: Recognition that cultural sensitivity and affirmation have been inconsistent in health settings is critical. Individuals who experience this lack of sensitivity will be less likely to re-engage with providers, in essence the provider has put himself out of reach of the individual.
- **Federal & Local Partnerships, Clinical Community Linkages:** These relationships can be enhanced and strengthened to help expand and facilitate services. Continued investments in appropriately designed Community Health Worker (CHW) programs, mobile services and community-based partnerships to improve equitable service delivery is needed. In addition:

- Federal and local food access programs can be used to build partnerships with healthcare partners, increasing clinical community linkages, and strengthening referral pathways to such food access programs.
- Federal and local partnerships can ensure an integrated systematic approach to community linkages which include both clinical and non-clinical needs.
- These partnerships can place an enhanced focus on care coordination, alignment and integration across programs and across different levels of the health system.
- **State Agency Technical Assistance and Capacity Building Scale Up:** State agencies need to take a high-level view to determine the scale of comprehensive technical assistance and capacity building they can provide to public and private entities. This may include:
 - Cultural Sensitivity and Affirmation Training Among Clinicians and Non-Clinical Staff: There is a need for this type of capacity building in provider settings. This includes an intentional effort on the part of providers to have staff that reflect the community, in-setting language capacity (including capacity in health terminology), and meaningful community engagement to inform services;
 - Providing support and technical assistance to enhance telemedicine for delivery of community health services;
 - Providing funding needed to support technology, advanced instruments (and training) for telehealth monitoring (i.e., fetal monitoring for pre-natal visits, blood pressure monitoring for pre- and hypertensive patients);
 - Providing funding support to perinatal providers to provide transportation and child-care services for women with difficulty going to prenatal (or post-partum) appointments, i.e. mass transit waivers, Uber/Lyft partnerships.
 - Assisting community-based organizations with varying levels of resource development in terms of grant writing and fundraising, with development of future sustainability of programming.
- **School Health Services:** State agencies and health systems must address how these school-based systems may experience an uptick in services given the increased level of trauma post-pandemic. Significant adaptations to how services should be delivered should be considered, for example:
 - Implementing walk-in clinics for mental health services (or other given services), similar to mass vaccinations sites to help alleviate the weight of trauma and/or stressors faced by providers in trying to link students to services/mental health providers;
 - Increasing services to reach a broader audience, for example utilizing feeder schools, dual enrollment in SBHCs, extending hours to accommodate surrounding schools for access.

