DISTRICT OF COLUMBIA
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

2021 ANNUAL IMPLEMENTATION PLAN FINAL REPORT

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE
DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Acknowledgements

The 2021 Annual Implementation Plan was developed by the District of Columbia's Department of Health (DC Health) and its State Health Planning and Development Agency (SHPDA) with advice and guidance from the Statewide Health Coordinating Council (SHCC). The leadership at DC Health and SHPDA would like to acknowledge the tremendous work and commitment of the SHCC, SHPDA's staff, and staff at DC Health who guided this report's development and reviewed numerous drafts. Special thanks and appreciation go to Dr. C. Anneta Arno (Director, Office of Health Equity), Dr. Fern Johnson-Clarke (DC Health Senior Deputy Director, Center for Policy, Planning and Evaluation Administration), Dr. Vanderpuije Makeda (Public Health Analyst, Office of Health Equity), Lauren Ratner (Special Advisor to the Director, Office of Health Care Transformation), Rebecca Winter (Health Statistician, Data Management & Analysis Division, Center for Policy, Planning & Evaluation) and Dr. Jacqueline Watson (DC Health Chief of Staff).

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The SHPDA was supported in this work by John Snow, Inc. (JSI), a public health management consulting and research organization dedicated to improving the health of individuals and communities. The SHPDA appreciates the contributions that JSI has made in analyzing data, interviewing stakeholders, and conducting research throughout the Plan development process. Special thanks are due to Mr. Alec McKinney for playing a leading role in producing the document.

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Dear District Residents and Partners:

The District of Columbia's Department of Health (DC Health), the State Health Planning and Development Agency (SHPDA), and the Statewide Health Coordinating Council (SHCC) are pleased to present the 2021 Annual Implementation Plan (AIP). This plan is a companion document to the District's Health Systems Plan (HSP), last published in 2017, and is part of SHPDA's commitment to strengthen the healthcare systems in the District of Columbia (District). The 2021 AIP was designed to build on the 2017 HSP and set the stage for the District's next HSP, the development of which will begin in 2022.

The HSP serves as a guide for public and private investments in public health and healthcare delivery systems to promote the health and wellbeing of residents across the District. The annual implementation plans developed in the years between published HSPs are designed to support SHPDA's goals and the health systems planning process by:

1. Providing additional, more in-depth information on a particular area of community need,
2. Developing detailed action plans on specific priority or topic areas drawn from the prior HSPs,
3. Coordinating health planning within the District, and
4. Working with SHPDA to build its internal infrastructure and systems in ways that support its goals and statutory charge

To this end, the 2021 AIP presents information in three important areas. First, the AIP provides a Health Systems Strengthening Framework designed to facilitate SHPDA's ongoing assessment, planning, and communication work. The Framework is meant to catalog and clarify the concepts that are critical to the development of a comprehensive, accessible, equitable healthcare system capable of providing the highest quality services in a cost-effective manner. Second, the AIP provides detailed guidance and action plans related to improving care transitions and primary care engagement in the District, two areas that were identified in the 2017 HSP as critical to a strong, effective healthcare system. Third, the AIP provides guidance and articulates lessons learned from the COVID-19 public health crisis, drawing on information provided by those interviewed across the District, peer-reviewed literature, and the District's COVID-19 Pandemic Health and Healthcare Recovery Report published in May 2021. Our hope is that this information will provide vital information to stakeholders across the District that will improve health outcomes, promote system improvements, and prepare us for upcoming public health emergencies.

Finally, we would like to thank all of those who were involved in the development of the 2021 AIP through interviews, community forums, and planning meetings. DC Health is committed to engaging the community and all its public and private healthcare partners. The AIP would not have been possible without the time and effort of the community stakeholders and residents that were involved in this process. This HSP and its associated plans are living documents. We look forward to your continued engagement as we work collaboratively to create a patient-centered, high quality, equitable, accessible health system that enables all District residents to live happy, healthy, and fulfilling lives.

Sincerely,

Terri A. Thompson
Director, State Health Planning and Development Agency

Council Members
SHPDA Statewide Health Coordinating Council

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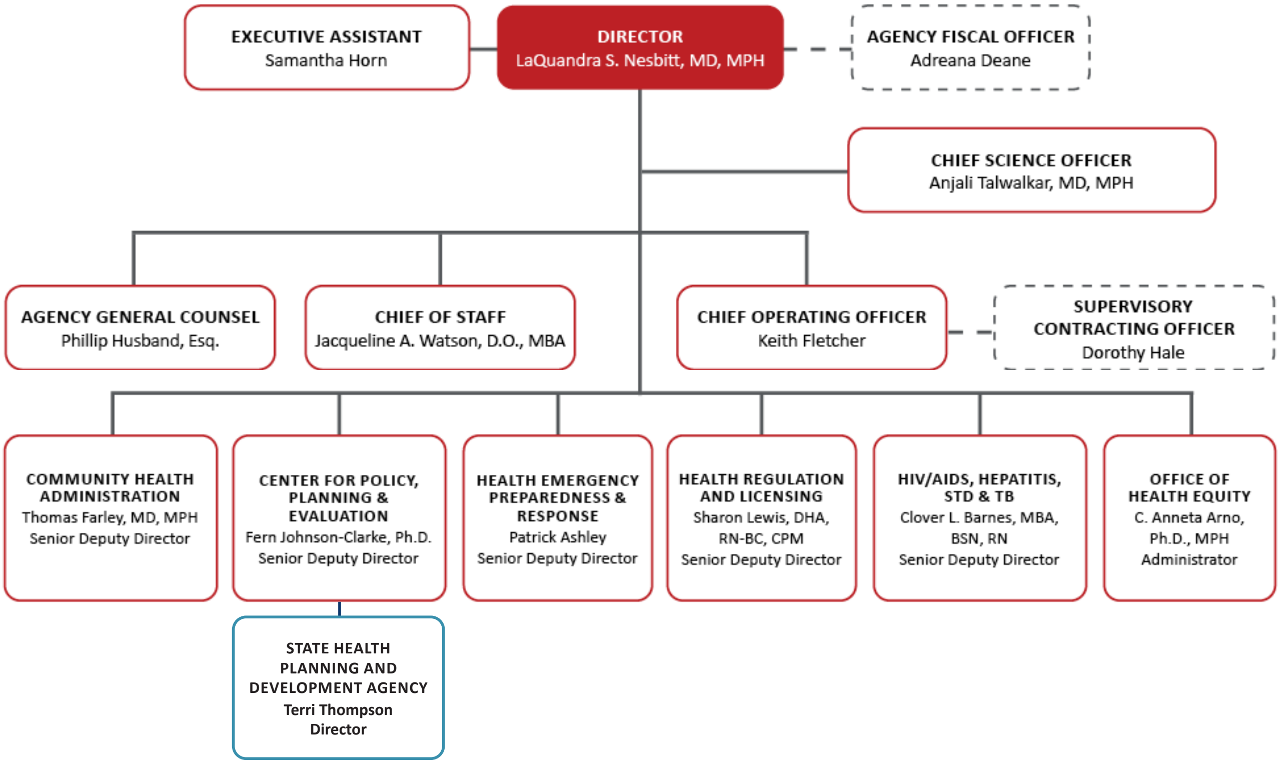
CHAPTER 1: Background, Purpose, and Approach

BACKGROUND

The State Health Planning and Development Agency (SHPDA), established by the Health Services Planning Program Re-establishment Act of 1996, effective April 9, 1997 (D.C. Law 11-191; D.C. Official Code § 44-401 et seq.) (the "Act"), is responsible for ensuring the availability of quality, affordable and accessible healthcare services to all residents. Specifically, SHPDA, with the assistance and support of the Statewide Health Coordinating Council (SHCC), is responsible for the: (1) development and implementation of a Health Systems Plan (HSP), including Annual Implementation Plans (AIP); (2) establishment of a Health Data and Information Program; and (3) administration, operation, monitoring, and enforcement of the Certificate of Need (CON) Program, including the establishment of requirements and standards regarding the amount of uncompensated care provided to residents of the District of Columbia (DC or District) by healthcare facilities that receive a CON.

SHPDA is an independent agency that operates within the DC Department of Health's (DC Health) Center for Health Policy, Planning and Evaluation (CPPE). SHPDA is a critical component to the District's efforts to support and strengthen the District's health system and is supported by the SHCC, an advisory body, appointed by the Mayor, which provides recommendations to the Director of SHPDA.

DC HEALTH ORGANIZATION STRUCTURE



The HSP, conducted every five years, is the foundation of SHPDA's work.[1] It is to serve as a roadmap for the development of a comprehensive, accessible, equitable healthcare system capable of providing the highest quality services in a cost-effective manner. The HSP is informed by a comprehensive needs assessment that clarifies community need, barriers to care, unmet service need, provider capacity, and service gaps across health service categories. The HSP also guides DC's CON program by providing a source of objective, refined, and data-driven information to assist SHPDA and the SHCC to determine if the investments proposed through the CON application process reflect community need, show public health value, and support District priorities. More broadly, the HSP is used to drive SHPDA's planning function by:

1. Clarifying issues related to community characteristics, community need, barriers to care, service gaps, unmet need, and other health-related factors,
2. Prioritizing a discrete set of health system strengthening, capacity development, community health improvement ideas, and
3. Educating stakeholders and promoting investment in SHPDA priorities through the CON process, community benefits investment, or other mechanisms.

The HSP is augmented by SHPDA's Annual Implementation Plans (AIP), which are developed in years when there is no HSP. AIPs are designed to support SHPDA's goals and the HSP in targeted ways by:

1. Providing additional, more in-depth information on a particular area of community need,
2. Developing detailed action plans on specific priority or topic areas drawn from the prior HSP,
3. Coordinating health planning within the District, or
4. Working with SHPDA to build its internal infrastructure and systems in ways that support its goals and statutory charge

PURPOSE, GOALS, AND APPROACH OF THE 2021 ANNUAL IMPLEMENTATION PLAN

In accordance with the detail provided above, the content of this 2021 Annual Implementation Plan embraces all four of the major ways that AIPs can be applied to support DC's HSP and includes two major elements.

The first element of the 2021 AIP is the presentation of the SHPDA Health System Strengthening Framework (The Framework). This Framework, created by SHPDA and approved by the SHCC as part of the 2021 AIP development process, has been designed to facilitate SHPDA's ongoing assessment, planning, and communication work. The Framework, presented below in Chapter 2, is meant to clarify, and organize the concepts that are critical to the development of a comprehensive, accessible, equitable healthcare system capable of providing the highest quality services in a cost-effective manner. Specifically, the Framework identifies four areas that are the building blocks of a strong health system. The Framework is used to organize and disseminate a broad series of recommendations, drawn primarily from the 2017 HSP and a series of other assessments conducted in the District since 2017. This Framework, along with its associated recommendations, are meant to serve as both a reference tool and a roadmap for the strategic and tactical initiatives that SHPDA and the SHCC believe are most likely to strengthen the District's Health System. As conceived, these recommendations will play a critical role as they will help to promote new or enhanced policies, resource investments, capacity building activities, and other programmatic initiatives. The SHPDA and the SHCC will use the Framework to support the CON review process, guide community benefit and other health system investments, inform any recommendations it makes with respect to health system strengthening, and help align strategies across the District.

The second element of the 2021 AIP is a series of HSP Action Plans that provide contextual information along with specific action-oriented recommendations on how the District should address three high priority areas of inquiry, drawn primarily from concepts outlined in the 2017 HSP. Specifically, this AIP presents action plans related to: (1) Care Transitions, (2) Primary and Urgent Care Engagement, and (3) COVID-19, Post Pandemic, and Emergency Response. The Care Transitions as well as Primary and Urgent Care Engagement topic areas were identified by SHPDA staff, with input from the SHCC, after a review of the core findings from the 2017 HSP. These topics were seen as central to strengthening the system, improving outcomes, and addressing some of the leading disparities and systemic inequities in the District. The COVID-19, Post Pandemic, and Emergency Response topic area was identified at the outset of the process, soon after COVID-19 emerged in early 2020. This topic area replaced another topic area highlighted by SHPDA and the SHCC, which will be revisited in the next AIP.

APPROACH AND METHODOLOGY

The 2021 AIP was developed through a four-pronged process conducted in 2020 and 2021. The first step in the process was a review of a broad array of assessments conducted in the District over the past five years. Following is a listing of the assessments that were reviewed.

- 2017 District of Columbia Health Systems Plan (HSP) **2017 DC HSP**
- 2018 District of Columbia Health Equity Report (HER) **2018 DC HER**
- 2018 District of Columbia State Medicaid Health IT Plan **2018 DC SMHP**
- 2019 Live.Long.DC Report (Plan to Reduce Opioid Use) **2019 Live. Long. DC.**
- 2020 District of Columbia Healthcare System Transformation Report **2020 DC HCST**
- 2020 ReOpen DC Report **2020 Re-Open DC**,
- DC Healthy People 2020 **DC HP 2020**
- 2021 District of Columbia Substance Use Disorder Needs Assessment 2021 DC SUD NA
- 2021 COVID-19 Pandemic Health and Healthcare Recovery Report **2021 COVID-19**

The goal was to catalog key findings, lessons learned, and recommendations from these reports. The identified recommendations were then organized into SHPDA's Health System Strengthening Framework to consolidate, highlight, and help to ensure the appropriate application and dissemination of recommendations from these reports. This work was specifically designed to fulfill one of SHPDA's statutory roles as a coordinator of health planning in the District.[2]

The next step was to conduct an extensive review of the academic, peer reviewed, and professional literature related to the three HSP Action Plan areas of inquiry. This review helped to ensure that this effort drew on the body of research and experience related to the three areas of inquiry (Care Transitions, Primary and Urgent Care Engagement, and COVID-19, Post Pandemic, and Emergency Response), and helped to put DC's experience in a broader context. Additionally, a series of interviews with key stakeholders across the District were conducted to better understand the three areas of inquiry. Stakeholders represented a broad range of providers and different sectors of the health system. Finally, DC Medicaid claims data was analyzed to inform its primary care and urgent care engagement analysis. This data was used to clarify which segments of DC's population were more or less likely to be engaged in appropriate primary and urgent care services by geography, demographic and socio-economic characteristics, and by type of service. It was also used to better understand the extent to which DC residents were using the District's hospital emergency departments for care that is preventable or better provided in other primary care or outpatient settings. With this information in-hand, SHPDA, with input from the SHCC developed the Health System Strengthening Framework and the three HSP Action Plan documents.

HEALTH EQUITY IN DC

Now more than ever there is a deep appreciation for the importance of framing SHPDA's work in the context of the racial and other health inequities that are at the heart of disparities in quality of life, health status, and healthcare access.

The Health Equity Report: District of Columbia 2018 utilizes the definition of racism developed by Dr. Camara Jones as a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race'), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.[3]

The Health Equity Report outlines six health equity insights from public health literature and practice:

1. Health is more than healthcare.
2. Health inequities are neither natural nor inevitable.
3. Your zip code may be more important than your genetic code for health.
4. The choices we make are shaped by the choices we have.
5. Structural racism acts as a force in the distribution of opportunities for health.
6. All policy is health policy.

All these insights are important and for the purpose of this report and SHPDA's reflections on its planning function, our focus will be on the fifth key insight: *"Structural racism acts as a force in the distribution of opportunities for health."* This insight has a direct bearing on one's ability to access and take advantage of health-related opportunities that promote health and well-being.

Figure 1 illustrates the idea that health equity is not fully achieved when members of society are afforded the same opportunities (center image), but rather when the ground, or "structure," is changed to ensure that disparities are eradicated at the root level (far right image) to promote equitable outcomes. Achieving health equity involves addressing structural racism.

Figure 1: The Process of Equity (Drawn from the Vermont Department of Public Health)

Structural racism is defined as the macro-level systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups.[4] Racism is not simply a result of private prejudices held by individuals, but is also produced and reproduced by laws, rules, and practices sanctioned and even implemented by various levels of government, and embedded in the economic system as well as in cultural and societal norms.[5,6]

To demonstrate how structural racism has manifested in the United States and more specifically the District of Columbia, the following sections provide examples on the inception and impact of structural racism on the health and well-being of communities of color. In providing this context, the hope is that the gravity of addressing racism is clear and communicated. As a planning agency, SHPDA is committed to understanding how structural racism currently impacts the well-being of DC residents, not only through the study and awareness of history, but also by understanding the lived experience of DC residents.

The two examples below focus on healthcare and housing. These were chosen to show how racism has infiltrated multiple sectors of society, making it important to consider all sectors when desiring to root out racism within healthcare.

Historical Context of Structural Racism in the United States Healthcare System

There are multiple examples of how structural racism has historically impacted the health of Black, Indigenous, and People of Color (BIPOC) in the United States; the example we will focus on to provide historical context is that of unequal healthcare as explained by Zinzi Bailey et al.[7] We will begin by discussing the racist and inhumane medical practices from the 20th century that lead to the modern racialized conceptions of susceptibility to disease that have led to unequal treatment of communities of color within the healthcare system throughout the United States.

In the early 20th century, the modern eugenics movement swept through the United States, leading to laws prohibiting "miscegenation" and the forced sterilization of undesirable "races" to create a better, more intelligent, Whiter nation.[8] A part of this movement was founded on the belief that the application of eugenic knowledge, through legislation and community practices, would eliminate mental illness, physical disabilities, crime, and even physical illness. Many universities embraced this study in the early 1900s, investing in research with the hopes of improving humanity through controlled reproduction, all with the goal of promoting "desirable" heritable characteristics and suppressing the supposedly undesirable ones.[9] This thought process impacted how medical providers treated people of color under the guise of scientific objectivity. Overtime, women, and people of color increasingly became the target of sterilizations. The Sterilization and Social Justice Lab uncovered that the sterilization rates for Black women rose as desegregation got underway.[10] By the 1970s, federal programs like Medicaid also began funding nonconsensual sterilizations that impacted more than 100,000 Black, LatinX and Indigenous women.

Racialized conceptions of susceptibility to disease persist to this day. In the 2003 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* the Institute of Medicine reviewed more than 100 studies and concluded that bias, prejudice, and stereotyping contributed to widespread differences in healthcare by race and ethnicity.[11] In addition, in 2018 the National Healthcare Quality and Disparities Report documented that Black, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander patients continued to receive poorer care than White patients on 40% of the quality measures included, with little to no improvement from decades past.[12]

This unequal treatment could be found in enduring racist cultural beliefs and practices. For example, in a 2016 study to assess racial attitudes, half of White medical students and residents held unfounded beliefs about intrinsic biologic differences between Black people and White people. These false beliefs were associated with assessments of Black patients' pain being less severe than that of White patients and with less appropriate treatment decisions for Black patients.[13]

As this example shows, addressing inequitable treatment and dismantling structural racism in healthcare is not only an issue of addressing individual prejudice and discrimination, but requires the need to reflect on accepted practices that treat the social construct of race as an intrinsic biological difference, thereby exemplifying and contributing to a broader system of structural racism. The systematic disinvestment in public and private sectors within BIPOC communities has resulted in under-resourced facilities with fewer clinicians, which makes it more difficult to recruit experienced and well-credentialed primary care physicians and specialists, which thereby affects access and engagement.[14]

Historical Context of Structural Racism in DC Through Housing

The District of Columbia has a unique experience with structural racism. For this report, the example of structural racism that will be the focus for this report is unequal housing, as described by Wendell E. Pritchett in their article, "A National Issue: Segregation in the District of Columbia and the Civil Rights Movement at Mid-Century." Although home to a large and influential free Black population shortly after the Civil War, by the early 20th century, residents began to experience barriers to economic and social progress. As segregationists in Congress began to accumulate more power, many desired to create an example out of the District as the nation's capital and focused on the separation of races as they continued to manage the District.[15]

The report, "Segregation in Washington", written by the National Committee on Segregation in the Nation's Capital in 1948, stated that Black DC residents experienced complete exclusion from most eating establishments in the downtown, restrictions in drug stores and other commercial operations and discrimination in local hotels.[16] This report also outlined the impact of segregation on DC residents. For example, when segregation was imposed with increasing force in the first half of the 20th century, this resulted in the creation of what is referred to in the report as a "black ghetto that formed a crescent around the seat of government and the business district."[17] This forced a majority of Black residents to live in the declining and overcrowded interior of the District leading to poor health outcomes such as 69% of the District's tuberculosis deaths.[18]

Rather than being the result of "natural" forces, the report argues that the system of segregation was imposed by powerful interests, particularly those in the real estate sector. The 1948 Washington Real Estate Board Code of Ethics stated that "no property in a white section should ever be sold, rented, advertised or offered to colored people."[19] Segregation was maintained by resident associations and the Federation of Citizens' Associations that policed the city's racial borders. The result was that Black residents in DC were forced to pay higher rents in limited areas to which they had access, and in these areas, housing became overcrowded and deteriorated in quality.

Although the District has a strong history of advocacy against racist policies, the ramifications of segregationist policies can still be felt even with the myriad of efforts made by residents. For example, the Kathryn Zickuhr article, "Discriminatory housing practices in the District: A brief history", shows that one effect of these policies has been the intergenerational transfer of housing wealth, as home equity allowed white residents to build economically stable lives.[20] Another effect has been to "establish residential patterns of segregation and disinvestment", which place an additional burden on families of color, beyond income. Today, middle- and high-income Black families are far more likely to live in low-income neighborhoods than white families with similar income levels, and Black Americans continue to experience lower rates of upward economic mobility than white Americans."[21] It is clear that healthcare, housing, education and economic mobility are all closely intertwined to the overall well-being of communities.[22] Therefore, as the DC Department of Health continues to prioritize the health and well-being of their residents, a focus must be placed on "equity-informed collaborative actions for change" that are "cognizant of how historical and contemporary policies, programs and practices, including laws, produce inequities in health outcomes."[23]

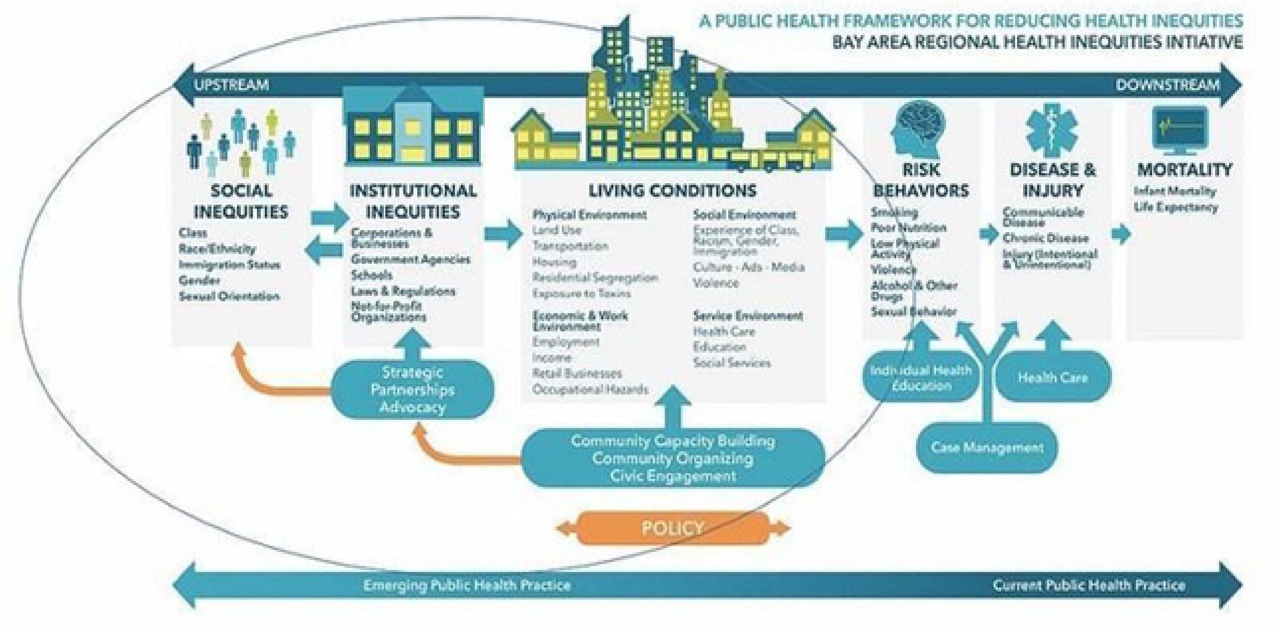
Addressing Structural Racism and Social Determinants of Health

Throughout this project's research, with respect to both the targeted areas of inquiry and the review of existing reports, racism was named as a force that influences the distribution of other social determinants of health, such as safe affordable housing, employment opportunities, and education. Within each of the identified priority areas identified below, SHPDA and all its public and private partners should ask themselves: "How is racism operating here?" and acknowledge that racism is a system not a person or an individual act.

Furthermore, moving forward, SHPDA and all its public and private partners should delve deeply to identify and evaluate the structures, policies, practices, norms, and values that perpetuate racism and inequitable health outcomes. SHPDA is well positioned to stand alongside the DC Health's Office of Health Equity and other stakeholders to encourage the development and implementation of a multi-sector plan to identify the structural factors within DC that create and perpetuate health disparities.

Figure 2, developed by the Bay Area Regional Health Inequities Initiative, draws the critical connection that upstream factors such as social inequities, institutional power dynamics, and living conditions have on the health risk factors, disease or injury, health status, and mortality. For many, racism is at the heart of the social and institutional inequities that impact living conditions' ultimate upstream health impacts. Therefore, to wholly address the social determinants of health, the underlying roots of structural racism must first be contended.

Figure 2: The Social Determinants of Health



CHAPTER 2:

SHPDA Health System Strengthening Framework and Recommendations

SHPDA'S HEALTH SYSTEM STRENGTHENING FRAMEWORK

The following is SHPDA's Health System Strengthening Framework. As discussed above, the Framework is meant to clarify, and organize the concepts that are critical to the development of a comprehensive, accessible, equitable health care system capable of providing the highest quality services in a cost-effective manner. This Framework, along with its associated recommendations (included in Appendix A), is meant to serve as both a reference tool and a roadmap for the strategic and tactical initiatives that SHPDA and the SHCC believe are critical to strengthening the District's Health System. The Framework presents four strategic priority areas – 1) Heath System and Workforce Capacity, 2) Health Systems Strengthening, 3) Social and Economic Factors and the Physical Environment (inc. Structural Racism), and 4) Health Education and Communication. A discussion of the rationale and breadth of ideas that are aligned with these priority areas is included below.

The recommendations that are associated with each priority area of the Framework were drawn from the 2017 HSP and a series of other assessments, white-papers, and reports that have been conducted or developed since 2017. A listing of these seminal documents was included in the Approach and Methods section above. The Framework provides a structure to organize the recommendations that are part of these reports and helps to fulfill one of SHPDA's statutory charges to support the coordination of health planning and policy within District. Overall, the Framework and the recommendations are intended to guide SHPDA, the SHCC, the District's public agencies, and service providers across the continuum to build system capacity and strengthen DC's health system. SHPDA and the SHCC will use its statutory powers with respect to the CON, HSP, and other functions to disseminate, promote, and implement the recommendations in this Framework.

Figure 3: SHPDA Health System Strengthening Priorities

Health System & Workforce Capacity

Health System Strengthening

Social and Economic Factors and the Physical Environment
(inc. Structural Racism)

Health Education and Communication

THE ROLE OF DC HEALTHY PEOPLE 2020

It should be noted that anyone exploring any health-related policy, program, capacity building, or system strengthening investments should consider them in the context of the findings and recommendations that are part of **DC Healthy People 2020** (DC HP2020). DC Healthy People 2020 was informed by the and serves as the District's shared agenda and Community Health Improvement Plan. The Plan sets goals, objectives and targets for a prioritized selection of population health outcomes. Any efforts to develop system or workforce capacity or strengthen DC's health system should be developed and implemented with these goals and objectives in mind. The DC HP2020 Framework, along with the Community Health and serves as the District's shared agenda and Community Health Improvement Plan. The Plan sets goals, objectives and targets for a prioritized selection of population health outcomes. Any efforts to develop system or workforce capacity or strengthen DC's health system should be developed and implemented with these goals and objectives in mind. The DC HP2020 Framework, along with the Community Health Needs Assessment, and the **Action Plan and Leading Health Indicator Data Dashboard** is referenced and described in more detail below.[24]

The following are summary descriptions of each of the four core pillars that are part of SHPDA's Health System Strengthening Framework.

SHPDA Priority Area: Health System & Workforce Capacity

SHPDA is responsible for ensuring the availability of quality, affordable and accessible healthcare services to all DC residents across the full continuum of health-related services. Critical to this responsibility is to ensure that the supply of services across the continuum can meet the underlying need as well as the resulting demand for services that these needs require. Also critical to this responsibility is understanding the barriers/challenges and assets/strengths that may either promote or limit access to care. Key to this consideration is how well-distributed services are across DC to ensure that distance or the time it takes to travel to services does not place an undue burden and that care is equitably and appropriately distributed across DC.

Geographic distribution and transportation, however, is only one of many factors that impact access. Other major issues relate to cost, language access, and sensitivity to race and culture. Finally, central to this discussion is the extent to which actual workforce gaps or shortages inhibit service providers from recruiting the necessary staff who can provide services across the continuum. In some cases, gaps or shortages in services relate to the need for additional or more appropriately distributed services by location, while in other cases gaps and shortages may relate more to an underlying workforce shortage. Underlying workforce shortages can lead to inappropriate competition for the limited, existing workforce, which can increase the cost of care and lead to challenges retaining staff who are adequately trained and able to provide quality services.

Within this priority area, SHPDA's Health System Strengthening Framework further segments the continuum into six critical service and workforce related areas, which are thought to be critical to developing a health system capable of ensuring the health and well-being of those who live, work, and visit DC:

- Primary and Urgent Care
- Ambulatory Specialty Care
- Behavioral Healthcare
- Hospital Care
- Post-acute Care
- Medical Transport and EMS

SHPDA's Health System Strengthening recommendations are designed to promote the strength of DC's health system in these six areas.

SHPDA Priority Area: Health System Strengthening

Addressing gaps or shortages across the health service or workforce continuum is critical, but simply ensuring the services exist and are well distributed does not necessarily guarantee the strength of a health system and its ability to deliver integrated, well-coordinated, high-quality services effectively, efficiently, and equitably. The complex network of services that are required to ensure the health of a community rely on a broad range of systems and structures that together facilitate information sharing, support care coordination, reduce fragmentation of services, facilitate organizational partnership and the integration of services, promote consumer engagement, and help to ensure that regardless of where one enters the system they are assessed and linked to the full breadth of services they need to stay healthy and thrive. Service providers and administrators also need to have access to a broad range of training and technical assistance that allows them to design, manage, implement, and sustain their operations and provide the highest quality, most innovative care possible. Finally, service providers need to be fairly compensated and supported by service delivery and payment mechanisms that incent them to provide high quality, comprehensive services. All of these system-related factors joined help to ensure that the existing service and workforce capacity is fully leveraged.

Within this priority area, SHPDA's Health System Strengthening Framework further segments recommendations into six critical health system strengthening areas, which are thought to be critical to developing a health system capable of ensuring the health and well-being of those who live, work, and visit DC:

- Health information technology and health information exchange;
- Service integration, care coordination, and engagement;
- Quality and performance improvement;
- Network development and partnership;
- Training and technical assistance; and
- Reimbursement and payment reform.

SHPDA's Health System Framework recommendations are designed to promote system strength across these six areas.

SHPDA Priority Area: Social and Economic Factors and the Physical Environment

Social and economic factors *(including structural racism)* and the physical environment are critical elements to maintaining and improving the health and well-being of individuals, families, and communities. While SHPDA's CON process focuses primarily on managing the supply of clinical services, SHPDA's planning and development responsibilities must be focused more broadly on the social, economic, and environmental factors that are known to impact health, well-being, and the quality of life. The 2017 DC HSP and the 2018 DC Health Equity Report, along with nearly every assessment reviewed as part of AIP process, discussed the impact that social, economic and environmental factors, commonly referred to as the social determinants of health, have on healthcare access, health status, and existing disparities. These assessments called out a broad range of factors but particularly identified gaps with respect to safe affordable housing, transportation, employment opportunities, food security, education, job training, and structural racism. As discussed above, in this report's discussion of health equity, there is broad agreement that the District needs to continue to work collectively to address the social determinants of health and racial inequities, as well as the underlying social determinants of racism. The complexity and inherent challenges related to addressing these underlying social, economic, and physical factors will require collective action as well as sustained investment and cross-sector collaboration.

Within this priority area, SHPDA's Health System Strengthening Framework further segments recommendations into a series of critical factors, which are thought to be critical to developing a health system capable of ensuring the health and well-being of those who live, work, and visit DC:

- Primary and Urgent Care
- Ambulatory Specialty Care
- Behavioral Healthcare
- Hospital Care
- Post-acute Care
- Medical Transport and EMS

SHPDA's Health System Framework Strengthening recommendations are designed to enhance and build the capacity of services that will help to ensure that residents are not negatively impacted by these factors.

SHPDA Priority Area: Health Education and Communication

Multi-faceted health education and awareness campaigns that factor in health literacy and are promoted through comprehensive communication plans are critical to overall health and well-being in the District. Well-designed education materials and campaigns in multiple languages that are culturally sensitive can help to address access barriers and raise awareness about health risk and protective factors. These campaigns also help to ensure that people are empowered to navigate the health system, engage in appropriate preventive, acute, and follow-up care, just to name a few of the most important ways that health education is important.

Education and messaging campaigns are particularly important during emergencies, as was clearly shown during the COVID-19 public health emergency, as they help people to navigate the health system and respond to the emergency at hand. Once again, the 2017 DC HSP and nearly all of the assessments drawn on to inform this AIP cited the importance of health education and messaging campaigns as critical elements to addressing the District's leading health issues, promoting engagement in appropriate care, and ensuring that all DC residents have access to the necessary breadth of quality, affordable and accessible healthcare services.

CHAPTER 3:

2021 Annual Action Plans

A. RECOMMENDATIONS TO PROMOTE SEAMLESS, SAFE, EFFECTIVE CARE TRANSITIONS

Introduction

The following are a series of recommendations related to promoting effective, seamless, and timely care transitions. These recommendations have been compiled based on three major research and assessment activities conducted in 2020 and 2021.

1. First, a formal review of recent assessments conducted in the District over the past five years to identify key findings, lessons learned and recommendations related to care transitions.
2. Second, an extensive review of academic, professional and peer-reviewed literature was conducted, related to how to facilitate seamless, safe, and effective care transitions across different settings and types of transitions. This body of literature helped to define care transitions and ensure that the ideas and recommendations were rooted in the evidence and informed practice.
3. Finally, a series of interviews with key stakeholders across the District were conducted to better understand the DC-specific factors and circumstances affecting care transitions. These stakeholders spanned different types of providers and different sectors of the health system.

I. Background

What are care transitions?

According to the National Transitions of Care Coalition (NTOCC), the term "care transitions" refers to the movement patients make between healthcare practitioners and settings as their condition and care needs change.[25, 26] These transitions can occur when care is transferred from one member of a care team to another, between departments, wards, or clinics within a single facility, or between organizations as one transitions or steps up or down from one care setting to another. There is infinite variation with respect to the nature, complexity, and context related to any given care transition. Some care transitions are focused and time limited as a patient or consumer moves through the care path and recovers from an acute illness or injury. For those with complex and/or chronic illnesses or injuries, care transitions may span a lifetime, as they work to stabilize their conditions, cope with difficult rehabilitation, develop new or reinforce existing self-management support skills, build self-efficacy, and adapt to long-term recovery processes.[27, 28, 29]

Care transitions are commonly discussed in the context of patients transitioning from the hospital inpatient settings to post-acute settings (e.g., nursing home, rehabilitation facilities). However, care transitions are relevant to patients with a full spectrum of health conditions and acuity, and include transitions between home, hospital, post-acute settings, residential services, ambulatory specialty services, primary care, urgent care, and medical transport or emergency medical services. There is a clear and growing appreciation for the importance of understanding a patient’s social and economic needs and addressing the challenges they may face in each care setting. When these challenges are recognized, patients may require linkages to a broad range of non-clinical supportive services or service settings, such as housing supports, employment or job training, nutrition services, family support services, and others. For those who are working to recover from or manage an illness or injury, care transitions and/or linkages are critical to success.

Why are care transitions important?

The factors associated with safe and timely care transitions, and ultimate recovery from an acute or chronic illness, are multi-faceted. Seamless transitions require considerable preparation and planning, and a range of systems and processes that support the patient, caregivers, and service providers.

Many factors contribute to successful, high-quality transitions:

1. Strong communication and complete transfer of information
2. Adequate education for the patient/consumer and their caregivers
3. Timely access to essential clinical or non-clinical services
4. The presence of a single point person or agency that is responsible for ensuring the coordination and continuity of care.

It is also critical that the patient or consumer is served by people who speak their language and appreciate their cultural perspectives on illness, health, and recovery.[30]

Poor care transitions contribute to escalation of illness, adverse health effects or death, emotional trauma, loss of quality of life, or relapse for those with behavioral health or certain medical conditions. Poor care transitions can also be costly for individuals, employers, health systems, managed care organizations, payers, and the healthcare system overall. This is particularly true if poor transitions lead to readmissions, loss of employment, and lost productivity in workforce and educational settings. In 2019, avoidable hospital readmissions were estimated to have cost the US health system approximately $26 billion.[31]

While all care transitions are important and should be handled with thoughtfulness and attention, not all are equally likely to go awry. Successful transitions are especially important for those with complex, chronic, or persistent illnesses or injuries. For these individuals, recovery is often a long-term endeavor; the consequences of an ineffective transition or relapse may be dire as hard-fought advances are lost, or recovery is derailed. These individuals often receive care from several providers and frequently move between healthcare settings — increasing risk and challenges.

Care transitions are especially important for patients or consumers who are advanced in age, have a disability, or face mental health challenges. Patients and consumers with these characteristics may need additional supports, particularly with respect to communication, education, and transportation. Transitions are also impacted by social, economic, physical, or environmental factors, such as material poverty, unstable housing, limited family/social/caregiver support, and transportation. If one is disproportionately challenged by these factors, then it is especially important that care transitions are well supported. Figure 1 provides examples of several more common, high-risk care transitions.

Figure 1: Common High-Risk Care Transitions

Child Newly diagnosed with diabetes.

A 12-year-old girl with fatigue, frequent urination, and increased thirst is seen in the primary care setting and newly diagnosed with diabetes. The primary care physician provides initial education and guidance to the child and parent and then refers the patient the same day, through a "warm-handoff" to an in-house certified diabetes educator. The diabetes educator provides additional education and self-management support to the child and parent, works with the primary care provider to develop a follow-up plan, and schedules an appointment for the patient for follow-up care and management.

Care Transition Challenges: (1) Hand-off from primary care provider (PCP) to diabetes educator, (2) Scheduling follow-up appointments and facilitating engagement with the PCP, the diabetes educator, or medical specialist, (3) Establishing partnerships with community- based providers and services to address health and social needs, (4) Communicating the status of diabetes self-management education, plan of care, and medication reconciliation to the child/parent, and next provider or site of care, and (5) Coordinating family, social, and psychological support after initial diagnosis.

Older adult falling at home.

After a serious fall, an older adult is taken to a hospital emergency department by ambulance for what is likely a broken leg. The patient is then transitioned to the hospital inpatient setting where they received surgery and were stabilized before transitioning to a skilled nursing facility. Ultimately, they transitioned back home, where they received care from a visiting nurse or from family/friends.

Care Transition Challenges: (1) Meaningfully engaging patient in meetings to plan future care needs, (2) Information flow and care coordination between the hospital staff and the skilled nursing facility, (3) Scheduling follow-up appointments and facilitating engagement with the PCP, medical specialists, and home healthcare staff, (4) Information flow and care coordination between the skilled nursing facility and the home care staff, and (5) Coordinating family, social, and psychological support after discharge from the skilled nursing facility.

Figure 1: Common High-Risk Care Transitions (continued)

Someone surviving an opioid overdose.

A young adult who recently survived an opioid overdose is seen in a hospital emergency department, assessed for an opioid use disorder, managed for opioid withdrawal, started on a Medication-Assisted Treatment, and linked to outpatient therapy before being transitioned home. In the emergency department (ED), the patient is seen by a Recovery Specialist / Case Manager prior to discharge who works to support the assessment, education, and referral process, and links the patient to community services.

Care Transition Challenges: (1) Hand-off from ED Provider to the Recovery Specialist / Case Manager, (2) Meaningfully engaging patient to plan future care needs, (3) Scheduling follow-up appointments and facilitating engagement with the outpatient Substance Use Disorder (SUD) provider, (4) Information flow and care coordination between the ED providers and the outpatient SUD provider, and (5) Coordinating family, social, and psychological support after discharge from ED.

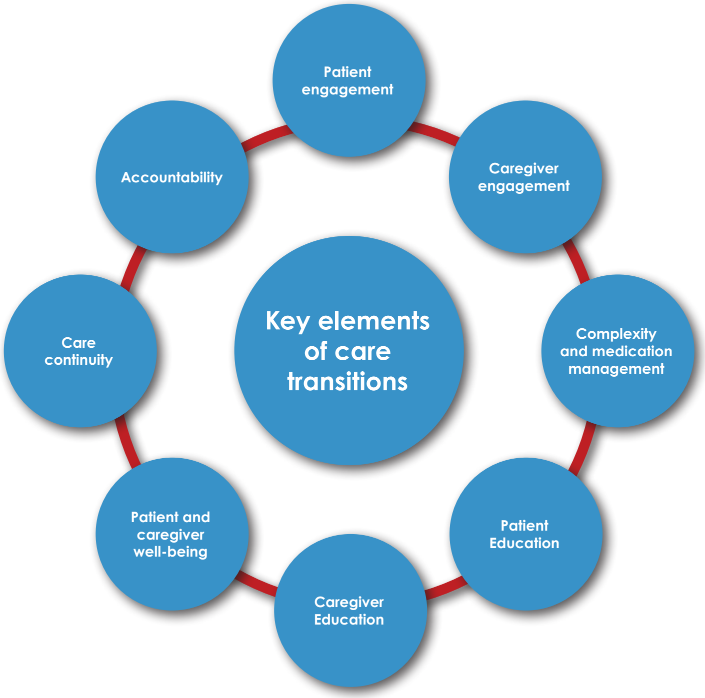
What are the key elements of care transitions?

Figure 2, drawn from a national study funded by the Patient-Centered Outcomes Research Institute (PCORI), called Project ACHIEVE, identified nine factors thought to be central to improving care transitions, which are indicative of the breadth of research on this topic. The PCORI initiative concluded that health systems need to address all components to help facilitate optimal care transitions.

The body of literature regarding care transitions consistently cites a broad range of factors that fundamentally relate to the sharing of information between patients, providers, and caregivers, and between different provider types. These factors affect the way information is shared, how complete it is, whom it is shared with, and how it is acted upon. Common factors include:

- Cultural and language barriers[32]
- Clear discharge plans and follow-up instructions[33]
- Limited, untimely primary care physician involvement[34]
- Poor care coordination[35]
- Ineffective patient education and medication instructions[36]
- Lack of patient and caregiver empowerment[37]
- Limited technology to support timely, broadly accessible sharing of information[38]
- Lack of understanding of patient needs and appropriate accommodations for the social, economic, and environmental factors that could impact transition[39]

Figure 2: Factors important to improving care transitions



II. Recommendations by SHPDA Health System Strengthening Priority Area

Seamless, effective, and timely care transitions rely on factors that span SHPDA's Health System Strengthening Framework related to: 1) service and workforce capacity, 2) health systems issues, 3) social, economic, and environmental factors, and 4) communications and messaging. The recommendations below focus primarily on the first two areas of SHPDA's Framework, service / workforce capacity and health systems factors, but all four components of the Framework are important to promoting improvement.

The recommendations below are organized according to this Framework and each recommendation includes a brief discussion that is meant to provide the evidence, context and rationale for the recommendation. These recommendations are meant to be used as a guide for policy makers, DC public agencies, community-based organizations, and especially service providers across the continuum as they explore actions that they can take to promote improvement with respect to care transitions. While the recommendations might apply broadly across the United States and throughout the world, care was taken to prioritize the recommendations and ensure that they reflected the specific needs, service system context, and capacity in the District.

Recommendations

SHPDA Priority Area: Health System and Workforce Capacity

The 2017 Health Systems Plan and numerous studies since, including the research conducted to develop this Annual Implementation Plan, identified specific service capacity as well as workforce gaps related to care transitions that need to be addressed if DC's health system is to improve care transition outcomes across different care settings. Service capacity gaps may at times fully prevent or hinder organizations from effectively transitioning patients to the most appropriate, timely, person-centered services necessary to promote rehabilitation and recovery. For example, a female consumer transitioning from residential SUD services may need transitional housing dedicated to women, but there are no slots currently available. Workforce gaps on the other hand may work to prevent organizations from hiring the staff with the skills and experience necessary to effectively operate an existing service site. In this case, there may be enough service sites, but the workforce shortages may hinder recruitment and impact staff retention in ways that limit their ability to operate efficiently and meet existing demand for services. In either case, these gaps can have a substantial impact on care transitions outcomes, leading to adverse health effects for consumers, consumer relapse, hospital or treatment readmission, duplication of screening and diagnostic tests, and frequent, preventable or avoidable emergency department visits, just to some of the possible impacts.

It is important to note that it is not enough to merely add service or workforce units and assume that outcomes will flow easily. Care must be taken to ensure that these services are properly designed, operated, and integrated with the broader system of care and that staff who are engaged are properly trained and supported by evidence-informed policies, procedures, and care standards. The following are the leading gaps in service and workforce capacity identified by SHPDA that need to be addressed to improve DC's care transition outcomes.

Service Capacity

Service Domain	Recommendations	Supporting Documentation
Primary and Urgent Care Ambulatory Care	Invest in comprehensive, evidence-informed chronic disease programs such as the **Chronic Care Model (CCM)**, the **Chronic Disease Self-Management Program (CDSMP)**, and **Community Health Worker Programs** that include the application of certified chronic disease educators, case managers, and community health workers in ways that empower patients to work with their providers to develop and understand their care plan, navigate follow-up referrals, gain self-management support skills, and support proper management and recovery from their illness or injury.	2017 DC HSP

Evidence/Rational: SHPDA's 2017 Health Systems Plan provided ample evidence and rationale for the importance of high quality, patient-centered, and accessible primary/urgent care services. These services are critical to one's ability to prevent, identify, and manage illnesses before they become severe and impair health status. The availability of a strong, accessible primary care system that includes comprehensive, evidence-informed chronic disease management has been shown to reduce preventable hospital emergency department visits and inpatient stays, as well as the need for costly tests and specialty care services. These services have also shown to increase work productivity and school performance, and improve quality of life. A critical component of high-quality primary care services is the ability of an individual primary care or urgent care provider, clinical practice, or community-based organization to support successful care transitions, especially for those who are identified with a new or existing complex or chronic condition. Specifically, the care transition support must help patients and/or caregivers to understand their conditions, initiate treatment, including self-management supports, and transition to the breadth of services that are necessary for them to manage or promote their recovery.

There are a broad range of evidence-informed, proven models that have shown to support chronic disease management and effective care transitions, including programs such as the **(CCM)**, Stanford's **(CDSMP)**, and CDC efforts to promote the use of **Community Health Worker Programs**. One of the common and most critical factors associated with these models is the existence of trained, experienced health educators, case managers, or community health workers who work directly with patients to develop trust and support patients as they work with patients to help them develop and understand their care plan, navigate follow-up referrals, gain self-management support skills, and learn to manage their illness or recovery from their injury. Effective care transitions in primary or urgent care settings rely on these evidence-informed models and should be promoted across the District.

Service Domain	Recommendations	Supporting Documentation
Behavioral Healthcare	Ensure that the numerous policies and programs designed to encourage DC Medicaid providers in the District to furnish care transition services (e.g., **My Health GPS**, **My DC Health Homes program**, **transition planning services**) can be used by Department of Behavioral Health (DBH) certified SUD providers.	2017 DC HSP 2018 Live.Long.DC 2021 DC SUD NA

Evidence/Rationale: In 2020, the DC Department of Healthcare Finance conducted a SUD Community Need and Capacity Assessment aimed at developing a broad range of recommendations that would strengthen DC's SUD system. One of the core findings from this assessment was that there were shortages with respect to the availability of care transition services and inconsistencies in the quality of existing services geared to supporting clients as they "stepped down" from one level of care to another. These shortages and inconsistencies in quality were reported despite the numerous policies and programs designed to encourage Medicaid providers in the District to furnish care transition services, including DC's My Health GPS and My DC Health Homes program, transition planning services, and other strategies implemented through the District's Managed Care Organization (MCO) contracts. DC DBH's quality improvement efforts geared to improving their Residential Step-Down Key Performance Indicator also identified barriers related to licensure, accreditation, availability of staffing, and lack of knowledge on how to use existing programs, policies, or managed care benefits that hindered services and provider's ability to facilitate seamless care transitions.

With this in mind, efforts need to be made to promote the use of these policies and programs, including alleviating any barriers that may exist that prevent providers from using these programs, policies, and service benefits. This will be especially important as DC's network of Medicaid Managed Care Organizations begin to fully rollout and implement various policies and service-related benefits to improve care transition outcomes.

Service Domain	Recommendations	Supporting Documentation
Behavioral Healthcare	**Expand access to a range of person-centered SUD transitional and supportive housing services geared to supporting consumers in their on-going recovery as they step-down from residential treatment services.**	2017 DC HSP 2018 Live.Long.DC 2021 DC SUD NA

Evidence/Rationale: The DC Department of Healthcare Finance's **(**DHCF) 2020 SUD Needs Assessment also identified major gaps in capacity with respect to transitional and supportive housing. In fact, nearly every assessment conducted in the past five years has referenced the challenges in DC related to a range of safe, affordable housing options, including therapeutic, supportive options for those with mental health and substance use issues. These issues are particularly challenging for those in DC who face material poverty or are in lower- and middle-income brackets. Nearly everyone interviewed as part of the SUD Needs Assessment reflected on the need for transitional and supportive housing options as well as safe, affordable housing more generally. Gaps in this area hindered successful care transition for many SUD clients, particularly as clients stepped down from SUD residential services to lower levels of care. In FY 2020, the Department of Behavioral Health reported that only 50% of all SUD residential treatment clients successfully stepped down to a lower level of care. SUD consumers and service providers who participated in the DHCF assessment, cited that the existing gap often forces clients to transition from residential treatment program to the same unsafe, unsupported housing situations that they were in prior to their admission. This greatly impacts one's ability to sustain their recovery and anecdotally was cited as a leading factor in DBH's relatively low step-down percent. The DHCF assessment also identified the need for a greater a variety of safe, affordable housing options more generally, as people transition from residential SUD services to outpatient services and opt to live in the community.

Once again, effective care transitions from residential services, SUD withdrawal management, and other forms of SUD treatment often rely on the availability of these housing options. The strength of the SUD service network depends to some extent on their being an unbroken continuum of services. Therefore, the development of transitional and supportive housing should be promoted across the District.

Service Domain	Recommendations	Supporting Documentation
Behavioral Healthcare	**Expand access to a range of person-centered SUD outpatient and Recovery Support services specifically Medication-Assisted Treatment (MAT), intensive outpatient programs (IOPs), and other community-based programs geared to supporting those with mental health and substance use disorders to address their conditions to maintain their recovery. (Emphasis should be placed on promoting the development of multi-service agencies capable** (as appropriate and desired by clients) **of making internal referrals and supporting care transitions from one of their programs to another).**	2017 DC HSP 2018 Live.Long.DC 2021 DC SUD NA

Evidence/Rationale: Numerous assessments conducted across the District, including DBH's 2018 Live.Long.DC initiative, DHCF's 2021 SUD Needs Assessment, and the research conducted for this Annual Implementation Plan, identified gaps in the availability and variety of behavioral health outpatient and recovery support services. These assessments determined that access to a variety of tailored, person-centered services in this area were integral to promoting long-term engagement in care as consumers transitioned or stepped down from one level of care to another. Specifically, these assessments reflected on the need for additional service capacity with respect to medication-assisted treatment, intensive outpatient SUD service programs, peer support groups, and multi-service agencies geared to promoting recovery. In this regard, stakeholders described a need for a broader range of SUD services for specific segments of the SUD client population (e.g., veterans, men-only, women-only, mothers with children); different service types (e.g., peer groups, community centers, housing first models, one-on-one or coaching programs); and services with different requirements and philosophies (e.g., sober and non-sober living, 12-step, SMART Recovery, faith-based or secular). The following are a number of specific ideas with respect to outpatient and recovery services that clarify the gaps identified.

- **Medication-Assisted Treatment.** Many MAT providers struggle to link their patients to the resources they need to adhere to challenging medication regimens and/or sustain their engagement in recovery. This was true particularly for MAT providers who practice independently in small or solo medical practices. These providers often lack the support of providers who operate in SUD provider settings or in multi-service clinics with co-located behavioral health services. These types of recovery services are available in the District, but there are shortages and barriers that hinder MAT providers' ability to easily link their patients to these resources.

- **Peer recovery groups.** Stakeholders described how successful and important peer groups were to those in recovery, but shared that those operating the groups were often not well-supported and that the groups were inconsistently administered. There is a need for more robust training and technical assistance provided to the individuals facilitating the groups as well as the organizations who are responsible for organizing these groups. There is also a need for best practice manuals or operating procedures to help ensure the quality and effectiveness of these groups.

- **Multi-service Centers.** The body of experience suggests that multi-service centers geared specifically to those with SUD that offer peer recovery groups, specialized case management, housing and employment supports, as well as opportunities to stay active and engaged with their social networks are particularly effective.

Service Domain	Recommendations	Supporting Documentation
Hospital Care Post-Acute Care	**Expand and enhance the implementation of comprehensive, evidence-informed care transitions programs, such as Transitional Care Model (TCM), BOOST, and Project Re-engineered Discharge (RED), as well as other policies and programs that improve transitions from the hospital and other acute care settings and often ultimately back to the home.**	2017 DC HSP
Evidence/Rationale: There is ample research and experience that supports the need for comprehensive, evidence-informed models to support care transitions from the hospital to post-acute service settings and ultimately, at least for most, back to the home. There is significant variation across these programs based on the unique context or challenges that a hospital and their core post-acute partners may be experiencing, but there is a range of common elements. These common elements relate to how patients are assessed and supported through the hospital discharge process as well as how information flows after discharge to guide on-going recovery, medication reconciliation, self-management support, and proper follow-up to all relevant settings. Most often, these models include a coach or case manager that supports clients through the discharge process who then often follows the consumer during the transition process to help ensure a smooth transition. These evidence-informed models have shown to improve patient outcomes, reduce hospital readmissions, reduce medication errors, and improve appropriate, timely primary care and specialty care follow-up. Specifically, these models support assessment and planning prior to discharge, communication and information sharing after discharge, and guide follow-up and transfer of responsibility/accountability.		

Workforce Gaps

Service Domain	Recommendations	Supporting Documentation
Primary and Urgent Care Behavioral Healthcare Hospital Care Post-Acute Care	Expand access to transition coaches, recovery specialists, peer coaches, and specialized case managers to support care transition and recovery for those with chronic or complex medical and behavioral health conditions.	2017 DC HSP 2021 DC SUD NA

Evidence/Rationale: There is a growing body of research and experience that supports the integration of peer coaches, specialists, and navigators as well as specialized case managers into multi-disciplinary teams, across nearly all healthcare settings and sectors, as an effective way of supporting consumers to understand, cope, manage, and/or recover from chronic or complex health conditions. Typically, these specialists are deployed as peers with lived experience and expertise with a given condition or with a specific cultural background or language proficiency. As such, these peer specialists form strong, trusting relationships and share information in ways that are highly effective. These specialists are invaluable parts of teams and have been shown to be extremely effective at supporting consumers to address barriers to care, promote appropriate engagement, facilitate care transitions, and learn to manage complex, chronic conditions, or cope with a new disability. Peer cancer navigators with consumers who have recently diagnosed with cancer, peer recovery coaches for those with SUD, care transition coaches for older adults being discharged from the hospital to post-acute rehab, community health workers supporting families with children newly diagnosed with asthma are just some of the most common applications of these peer specialists.

Many of the recent assessments that were reviewed for this report along with numerous people who were interviewed spoke of critical workforce gaps related to these peer specialists that are hindering the adoption of proven strategies. Efforts need to be devised to support the recruitment, retention, and development of this critical resource.

Service Domain	Recommendations	Supporting Documentation
Post-Acute Care	Expand access to home health aides, personal care attendants, and other certified and uncertified staff workers to support home healthcare services.	2017 DC HSP
Evidence/Rationale: In DC and across the nation, the home healthcare industry is experiencing increasing challenges with respect to recruiting and retaining a skilled workforce. Given the current trends with respect to the aging of the US population, the prevalence of chronic disease, and older adults continued interest and ability to "age in place" at home, there is a growing need for a strong home health workforce. The 2017 DC HSP combined with recent investigations at SHPDA and work conducted to develop this AIP, identified gaps in the home health workforce that have led to high-turnover rates, skills gaps, financial instability due to increasing wages, and challenges with respect to some home health providers ability to meet demand. A strong, qualified home healthcare workforce is an essential element to quality, patient satisfaction, and effective, seamless care transitions. Workforce shortages are leading to increased wages and competition for the limited number of available workers. Service providers are increasingly challenged with respect to their ability to attract qualified, quality staff and to retain them once they have them.		

SHPDA Priority Area: Health System Strengthening

As discussed previously, addressing service gaps or shortages across the health service or workforce continuum is critical, but simply ensuring that there is ample service and workforce capacity does not necessarily guarantee the strength of a health system and its ability to deliver integrated, well-coordinated, high-quality services effectively, efficiently, and equitably. This idea is particularly relevant when considering care transitions.

The complex network of services that are required to ensure the health of a community rely on a broad range of systems and structures that together facilitate information sharing, support care coordination, reduce fragmentation of services, facilitate organizational partnership and the integration of services, promote consumer engagement, and help to ensure that regardless of where one enters the system they are assessed and linked to the full breadth of services they need to stay healthy and thrive. At its core, the most significant and persistent challenges related to care transitions are system challenges pertaining to the flow of information, responsibility, and accountability from either a service provider to the patient/consumer or from one practitioner or service setting to another. Service providers and administrators also need to have access to a broad range of training and technical assistance that allows them to design, manage, implement, and sustain their operations and provide the highest quality, most innovative care possible. Finally, service providers need to be fairly compensated and supported by service delivery and payment mechanisms that incent them to provide high quality, comprehensive services. All of these factors joined help to ensure that the existing capacity of services is fully leveraged to ensure the effectiveness and efficiency of the system and its ability to provide high quality, equitable services to all.

Below are a series of recommendations geared specifically to developing systems to support effective care transitions and that will support the District to fully leverage and maximize existing service and workforce capacity.

Recommendations	Supporting Documentation
Promote assessment and careful transition planning (including the development of a patient-centered transition plan) to support seamless, safe, timely care transitions from one setting or level of care to another.	2017 DC HSP 2020 DC HCST

Evidence/Rationale: Seamless, effective care transitions rely on the development of a comprehensive, fully completed care transitions plan or Summary of Care document. At a minimum, a care plan must include a description of the problem, the goal or target outcome, and any instructions that have been given to the patient related to treatment and follow-up. The creation of this plan further relies on comprehensive assessment and careful documentation, as well as knowledge related to follow-up such as whether a patient has an existing primary care provider and other relevant information about the patients labs, tests, x-rays, and prior utilization, including provider visit or discharge summaries. There is also an increasing appreciation of the importance of including information about the patient's social, economic, and environmental context as a way of ensuring that the transition is well supported and is able to make accommodations that help to ensure the success of the transition. Too often service providers are unable to capture and document the breadth of information they need prior to discharge or transition in ways that ensure the completeness of the care transition plan or Summary of Care document. In this regard, the transition process needs to start at the outset of the admission and the results of various assessments and tests need to be thoroughly documented so that the discharge planner, case manager, coach, or specialist who is responsible for the transition plan has the information they need to facilitate the transition.

According to the Center for Medicare and Medicaid Services, the Summary of Care document needs to include:

- Demographic information (preferred language, sex, race, ethnicity, date of birth).
- Care plan field (problem, goals, and instructions)
- Care team (including primary care provider and any additional known care team members)
- Reason for referral / care transition
- Current problem list (Including social, economic, and environmental factors)
- Current medication list
- Current medication allergy list
- Patient name
- Referring or transitioning provider's name
- List of procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status (Activities of Daily Living (ADL), cognitive and disability status)

Recommendation	Supporting Documentation
Promote the development and use of evidence-based, person-centered standardized, guidelines, protocols, operating procedures, and tools across the service continuum (e.g., primary and urgent care, ambulatory specialty care, behavioral health, hospital care, and post-acute care) to promote seamless, safe, timely care transitions.	2017 DC HSP

Evidence/Rationale: Many of the prior assessments, information compiled through the literature review, and the interviews conducted for this AIP reflected on the need for service providers to focus on improving the quality and consistency of the work related to care transitions. Specifically, participating service providers and clients reported on the limited use of program guidelines, evidence-based protocols, procedure manuals, or documentation of standard operating procedures.

Given high staff turnover rates, particularly in some fields of service, it is important to develop clear guidelines, protocols, and workflows detailing what has been shown to be most effective and efficient. These guidelines or protocols need to be rooted in the available literature on proven practice but regardless need to be well documented so that organizations can use them to maintain quality, promote efficiency, and reduce inappropriate variation. Furthermore, organizations need to have access to robust training and technical assistance resources to ensure that these guidelines and protocols are understood and being applied.

Recommendation	Supporting Documentation
Promote the adoption and use of HIT/HIE that facilitate documentation, and the exchange and use of patient information to support seamless, safe, timely care transitions.	2017 DC HSP 2018 DC SMHP

Evidence/Rationale: The 2018 State Medicaid Health Information Technology Plan (SMHP) provides ample evidence and rationale for the importance of organizations across the healthcare continuum, in strictly clinical and non-clinical settings, to adopt and use health information technology (HIT)[40] and health information exchange (HIE).[41] Several recently published strategic health documents and District-wide community needs assessments, along with the interviews conducted for this project, identified common themes that drive the need for HIT and HIE improvements. The 2018 SMHP specifically cited the lack of well-coordinated, person-centered care; the impact of social determinants on residents' care; disparities in health outcomes; and gaps in public health information. The 2018 SMHP further identified a range of opportunities to address these challenges including: Standardizing information exchange and promoting interoperability among organizations; Developing services and tools to promote high priority use cases; and Supporting organizations who may lag in health IT adoption and use. One of the use cases that the 2018 SMHP highlighted as an opportunity to improve health outcomes and strengthen the District's health system was related to HIT/HIE use to support care transitions as a way of facilitating communication and the sharing of consistently, quality data across care settings.

Recommendation	Supporting Documentation
Align incentives through proper reimbursement and enhanced payment mechanisms.	2017 DC HSP 2021 DC SUD NA

Evidence/Rationale: Service providers of all types (e.g., outreach workers, case managers, recovery specialists, discharge planners / coaches, social workers, physicians and many other providers are not properly reimbursed for coordinating care. Instead, the reimbursement policies often unduly limit who can be reimbursed for what types of services. While these policies are well intended as a way of helping to ensure the scope and quality of the services provided, they often serve to constrain organizations from providing the highest quality of care applying the resources they have in a timely, patient-centered, efficient manner. Public and private payers need to be more flexible about reimbursement, adequately compensate healthcare providers for care coordination and transitional care, and develop and test incentives that support family caregivers and improve the transition between levels of care across settings.

SHPDA Priority Area: Social and Economic Factors (including structural racism) and the Physical Environment

There is a growing appreciation in the healthcare setting broadly and with respect to care transition specifically regarding the importance of understanding and incorporating issues related to social, economic, and environmental factors when developing person or patient-centered care transition plans. As discussed above, a strong, comprehensive care transition or discharge plan must include information on the health problem, the desired goal or target health outcome, and clear instructions regarding treatment and follow-up. It also must include information about the patient’s social, economic, and environmental context as a way of ensuring that the transition is well supported and that those involved can make plans and accommodations that help to ensure the success of the transition. It is particularly important to address these issues as these issues are at the heart of the racial, ethnic, and cultural inequities that have led to the disparities in health outcomes that exist in DC.

When it comes to care transitions, no one type of social, economic, or environmental factor is more or less important than another. This guidance must be explored holistically and be patient-centered. In this regard, this action plan recommends broadly that the District continues to promote screening for social, economic, and environmental factors that could impact health status and access to care as well as continue to take actions to address structural racism and ensure that DC residents have access to safe, affordable housing, nutritious food, clean air and water, recreational space, reliable transportation, and safe communities.

SHPDA Priority Area: Health Education and Communication

Multi-faceted health education and awareness campaigns, harnessed by robust communication plans, are critical to promoting seamless, effective care transitions. In this regard, well-designed educational materials and campaigns in multiple languages that are culturally sensitive can help to raise awareness about health-related risk and protective factors, ensuring that people are engaged in the appropriate preventive, acute, and follow-up care to manage illness, communicate important information during a health emergency, and help people to navigate the complex healthcare system, just to name a few of the most important ways that health education is important.

Nearly all of the assessment drawn on to inform SHPDA's Health Strengthening Priorities have cited the importance of health education, health literacy, and messaging campaigns as critical elements to addressing the District's leading health issues, promoting engagement, facilitating care transition, and ensuring that all DC residents have access to the necessary breadth of quality, affordable and accessible healthcare services. In this regard, this action plan recommends broadly that the District continue to support improvements in health literacy and targeted health education and messaging about the leading health issues as well as information related to how consumers can best work with their service providers to help support seamless, effective care transitions as they move from one health provider or health setting to another.

B. RECOMMENDATIONS TO PROMOTE PRIMARY CARE AND URGENT CARE ENGAGEMENT

What is primary care and urgent care engagement?

Primary care and urgent care engagement focus on the utilization of healthcare services. Researchers have utilized various definitions, but engagement is generally defined as visits to a primary or urgent care provider. At a minimum, primary care engagement includes at least one visit to a primary care provider within the measurement period. This was the definition of primary care engagement used in the District's 2017 Health Systems Plan, which found that approximately 50% of Medicaid enrollees did not receive primary care and preventive services in a given year. Some researchers define primary care engagement as 2+ visits, with the same care provider, in a measurement period. Regardless of the definition used, primary care engagement is a critical component to achieving the triple aim of enhancing patient experience, improving population health, and reducing costs.

Primary care engagement consists of two critical components — access to care and patient engagement.

- Access to care allows individuals to easily find care that is effective, convenient, and affordable. Factors that impact access to care include the number and location of care sites/providers, hours/days of operation, and accessibility (i.e. near public transportation, ample parking). Access to a usual source of primary care is particularly important as it greatly impacts one's ability to receive regular preventive, routine, and urgent care, and chronic disease management services — especially for individuals and communities that have been historically marginalized.
- Patient engagement is a two-fold concept that combines patient activation with interventions that increase activation and supports health-promoting behaviors. Patient activation relates to an individual's knowledge, skills, and ability to manage their healthcare. Interventions that promote activation and encourage health-promoting behaviors include preventive care and healthy eating. More broadly, interventions include healthcare organizational structures that are designed to equitably address individual and the community needs and preferences.

Why is engagement in primary and urgent care important?

Primary care engagement leads to positive health outcomes. Primary care provides a usual source of care where providers can facilitate the early detection and treatment of disease, and support patients in management of chronic diseases like heart disease and diabetes. Primary care engagement also provides individuals and communities with preventive care services, including screenings (e.g., blood pressure, weight, cancer, mental health) and vaccinations. Primary care engagement facilitates relationships where individuals are active participants in their healthcare management, and providers respect and integrate their patient's values, preferences, and goals into decision-making.

Urgent care continues to be an important component of the healthcare continuum, providing outpatient treatment of acute illnesses and injury. Urgent care offers same-day services for a variety of health conditions that warrant immediate medical care but are non-life threatening. Services are typically offered outside of normal business hours and on weekends, and offer a source of care for those who lack or cannot access a usual source of primary care. Urgent care has been shown to reduce the burden on primary care practices and reduce inappropriate use of hospital emergency services.

While concern remains that urgent care can disrupt the continuum of care by preventing individuals from engaging in comprehensive primary care medical home services, the relationship between primary care and urgent care engagement should be considered in the context of whole system care. Together with emergency services, the three comprise the network of care delivery sites across the District that supports the continuum of care. The Urgent Care Association of America reports that only 60% of urgent care patients report a relationship with an external primary care provider (PCP). For those without a PCP, urgent care provides access to timely, appropriate care without reliance on the emergency room. Those who have a PCP may use urgent care over primary care because they experience barriers to understanding how to navigate the healthcare system, and delayed or deferred care.

What are the key elements of primary care and urgent care engagement?

Access to primary care is a key issue in Healthy People 2030's 'Health and Healthcare' domain, which is one of five place-based domains within the Social Determinants of Health (SDOH) Objective.

Key elements of access to care include affordability, accessibility, and availability. Barriers that inhibit these elements are well documented, and include lack of health insurance, language barriers, service hours, and geographic/transportation barriers. Further, disparities among people of color and other historically marginalized groups have persisted for decades, and continue to impact access to care, via insufficient health coverage and negative healthcare experiences based on race-based discrimination.[42]

Patient engagement includes five key elements, as noted in various research articles. These include:

- Active, meaningful, and collaborative interactions between patients (including family and caregivers) and providers
- Engagement/interaction across all stages of healthcare activity, including in design/planning, priority setting, operations, clinical care, and communication
- Patients as partners in decision-making, and
- Recognition of individual and community experiences, values and expertise.

Key informants identified barriers to primary care engagement in the District, including:

- Access-related issues (distance, transportation, hours of operation, cultural, linguistic, physical)
- Awareness / education regarding the importance of preventative care
- Navigational barriers (not knowing where or how to access care)
- Social and economic factors
- Perceptions of quality
- Lack of respectful, welcoming, courteous, friendly, person-centered services

Patient engagement should extend beyond engagement of the individual to also include communities. Health systems and organizations have the opportunity to solicit and use input on the design and delivery of primary care from the communities they serve, which is especially valuable to individuals and communities whose opinions, needs and preferences have been undervalued in the past.

The 2017 DC HSP identified five requirements for urgent care centers in the District, which underscore key elements that promote urgent care engagement within the context of the whole care system. The requirements are that urgent care centers:

- Provide high quality, well-coordinated care that is thoughtfully integrated into the broader health system
- Make services available to all, regardless of insurance status or a patient's ability to pay
- Have mechanisms in place to ensure continuity of care with full-service primary care medical homes
- Refer patients to specialty care providers and to other levels of care based on acuity
- Be responsive to community needs, augment the healthcare delivery system, and do not unduly burden components of the health system that are critical to its strength

How do you assess and measure the effectiveness and impact of Primary Care and Urgent Care Engagement?

The impact and effectiveness of primary care and urgent care engagement are ultimately demonstrated through positive health outcomes. This includes increased clinical health outcomes of individuals or populations within the community being served/assessed. Effective engagement in primary care should result in an increase in behaviors that prevent illness and disease and decreases in illness and chronic conditions. Both primary care and urgent care engagement should also result in decreases in hospitalizations and use of emergency departments.

Healthy People 2030's objectives include indicators used to measure engagement in primary care. These include data on the proportion of people with a usual source of primary care and the proportion of people who cannot get medical care when they need it.

As mentioned above, engagement in primary care is also accomplished through health systems and organizations ability to solicit and incorporate input from individuals and communities, and to engage the community in population-level efforts. Indicators that assess and measure these interventions could include partnerships with healthcare and non-healthcare, Social Determinants of Health (SDOH) related referrals, and engagement with efforts used to coordinate care, such as health information technology and team-based care.

> *The 2017 DC HSP analyzed Medicaid claims data to assess if and how frequently individuals with Medicaid received (billable) primary care services. A similar analysis is being performed for this report with further analysis by enrollee characteristics, including race.*

Currently, urgent care centers do not systematically track metrics or patient outcomes - because of this, it is challenging to accurately use claims-based data, including Medicaid claims data, to assess how many and how frequently individuals are engaging in urgent care. Recent recommendations from the Mayor's Commission on Healthcare Systems Transformation included the development of a "shared, central repository of urgent care (and emergency department) access data to promote understanding of shifts in the use of primary care, urgent care and the emergency department over time."

PRIMARY CARE UTILIZATION AMONG MEDICAID ENROLLEES

This report follows up on the 2017 HSP finding that large portions of DC residents did not utilize primary care annually, as evidenced by a review of Medicaid data related to primary care visits. Specifically, the 2017 HSP found that as much as 50% of DC Medicaid enrollees are not accessing primary care and preventive services in a given year.

For this assessment, Medicaid claims data were once again analyzed to assess utilization of primary care, however, the new data included greater detail to allow the nature of those not engaging appropriately to be explored in greater depth, and to be connected to data regarding use of other healthcare resources. This report expands upon that analysis by assessing utilization of primary care by demographic characteristics, including age, race and ethnicity, gender and geography. Medicaid claims information used for this analysis was based on a structured data request that was submitted near the beginning of the project. The analysis focused on claims data from 2019 to exclude anomalies created by access to care barriers during COVID-19.

The analysis found that **43% of Medicaid enrollees did not have a primary care visit** in 2019. Of the remaining 57% of Medicaid enrollees, 31% had one to two primary care visits and 26% had more than two visits. Table 1 in this section shows the percentage of Medicaid enrollees within each Ward that are utilizing (and not utilizing) primary care (Row %) and the proportion of Medicaid enrollees that are utilizing (and not utilizing) primary care that reside in each Ward (Column %). For this report, utilization rates are defined by utilization of primary care services. Similar to findings in the 2017 HSP, utilization rates among Medicaid enrollees in Southeast DC (Wards 5, 6, 7, and 8), where the most significant disparities in outcomes exist, are among the highest rates in DC. In these wards, 55–59% of Medicaid enrollees have at least one primary care visit. Alternatively, the utilization rates for Medicaid enrollees in Northwest DC (Wards 2, 3), where there is more affluence, are generally lower, ranging from 46–53%. This shows that Medicaid enrollees living in more affluent communities in Northwest DC are less likely to access care than those living in Southeast DC. The exceptions to this phenomenon are Wards 1 and 4 with 62% and 60% of Medicaid enrollees respectively engaging in primary care visits. Further analysis shows that of the Medicaid enrollees not engaging in primary care, a larger number reside in Wards 4, 5, 6, 7, and 8. Wards 7 and 8, in southern DC, have the highest proportion of Medicaid enrollees not engaging in primary care (17% and 22%, respectively).

Table 1. Medicaid Enrollees by Primary Care Visits by Geography

	Medicaid Enrollees with Zero Primary Care Visits			Medicaid Enrollees with One or More Primary Care Visits			All Medicaid Enrollees	
Ward	**Enrollees w/ Zero Visits**	**Percent Enrollees w/ Zero Visits (Row %)**	**Percent w/ Zero Visits (Col %)**	**Enrollees w/ 1+ Visits**	**Percent Enrollees w/ 1+ Visits (Row %)**	**Percent w/ 1+ Visits (Col %)**	**Total Enrollees**	**Percent of Total**
Ward 01	12,255	38%	9%	19,627	62%	11%	31,882	10%
Ward 02	9,168	47%	7%	10,526	53%	6%	19,694	6%
Ward 03	3,608	54%	3%	3,015	46%	2%	6,623	2%
Ward 04	19,620	40%	15%	28,904	60%	16%	48,524	15%
Ward 05	18,524	43%	14%	24,550	57%	14%	43,074	14%
Ward 06	13,014	45%	10%	15,644	55%	9%	28,658	9%
Ward 07	23,421	41%	17%	34,246	59%	19%	57,667	18%
Ward 08	29,721	43%	22%	39,566	57%	22%	69,287	22%
Outside DC	716	63%	1%	414	37%	0%	1,130	0%
Unknown	4,307	55%	3%	3,555	45%	2%	7,862	3%
Total	**134,354**	**43%**	**100%**	**180,047**	**57%**	**100%**	**314,401**	**100%**

The Medicaid claims data was further analyzed to better understand the demographic characteristics of individuals not engaging in primary care. Demographics of Medicaid enrollees not engaging in primary care was compared to the demographic characteristics of the overall Medicaid population in DC.

Race and Ethnicity

Medicaid enrollee data was analyzed to assess if race or ethnicity appear to be a distinguishing factor in the utilization of primary care. The percent of enrollees within each race and ethnicity group that are engaging, or not engaging, in primary care (Table 2. Row %). The table identifies the proportion of enrollees engaging, or not, in care by race and ethnicity (Column %). There are some differences in utilization with primary care by race and ethnicity, however, the greatest differences were in groups that make up smaller portions of the Medicaid population, such as Caucasians who were 16% more likely to not utilize primary care than the average, but make up only 4% of enrollees. The African American enrollees, who make up approximately two thirds of all enrollees, had utilization rates similar to most other racial/ethnic groups. As a result the proportion of Medicaid enrollees for each population was not significantly different among those utilizing and not utilizing care.

Table 2. Engagement in Primary Care by Race and Ethnicity

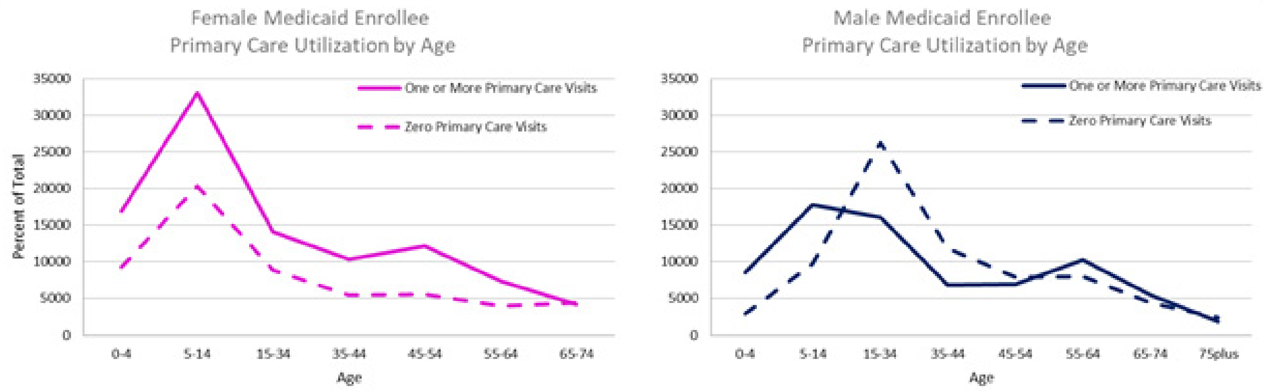
	Medicaid Enrollees with Zero Primary Care Visits			Medicaid Enrollees with One or More Primary Care Visits			All Medicaid Enrollees	
Race and Ethnicity	**Enrollees w/ Zero Visits**	**Percent Enrollees w/ Zero Visits (Row %)**	**Percent w/ Zero Visits (Col %)**	**Enrollees w/ 1+ Visits**	**Percent Enrollees w/ 1+ Visits (Row %)**	**Percent w/ 1+ Visits (Col %)**	**Total Enrollees**	**Percent of Total**
African American	90,378	43%	67%	117,960	57%	66%	208,338	66%
American Indian	103	40%	0%	153	60%	0%	256	0%
Asian	1,409	49%	1%	1,494	51%	1%	2,903	1%
Caucasian	7,262	59%	5%	5,056	41%	3%	12,318	4%
Hispanic	8,523	36%	6%	15,087	64%	8%	23,610	8%
Other	3,487	40%	3%	5,133	60%	3%	8,620	3%
Unknown	23,192	40%	17%	35,164	60%	20%	58,356	19%
Total	**134,354**	**43%**	**100%**	**180,047**	**57%**	**100%**	**314,401**	**100%**

Age and Gender

It is well known that primary care utilization varies notably by life cycle and gender overall. However the Medicaid data were analyzed to determine the degree to which utilization within each age and gender segment of the enrolled population was a driving factor in the overall phenomenon observed. The data were compared by age and gender among all Medicaid enrollees and significant differences in the pattern across the age range was observed for males vs females. As noted in Graph 1., females engaging in primary care represented a greater portion of total females within each age range, and the proportional difference remained relatively consistent across the age spectrum, with the gap closing only for elderly women. Among males, the pattern of engaging, or not, in primary care varied greatly across the age groups. Utilization in primary care is higher in youth and early teens, but falls sharply among adolescents.

Males are notably less likely to utilize care beginning in adolescence through the ages of 45–54. The full data set is available in Appendix B.

Graph 1. Medicaid Enrollee Primary Care Utilization by Gender (2019)

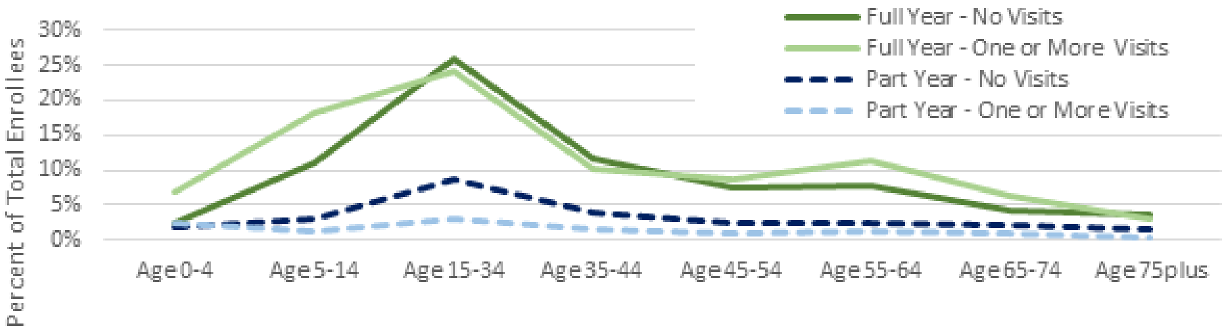


Enrollment Period

Enrollment in Medicaid is, for some, an inconsistent status, varying with changes in eligibility. This can be a driver of primary care utilization — both in terms of the direct decrease in likelihood of utilization resulting from partial year of enrollment, as well as the interruption in the process of establishing a stable relationship with a primary care provider. An analysis of Medicaid enrollment period length (full versus partial year) was performed to determine if enrollment length was a distinguishing factor in primary care utilization. Full-year enrollment is defined as 11–12 months of enrollment in the calendar year and partial year is 1–10 months. The full data set is available in Appendix B.

As shown in Graph 2., individuals enrolled in Medicaid for a full year (defined as 11–12 months) are considerably more likely to utilize primary care than enrollees with partial-year enrollment. This is less true for children ages 0–4 and the elderly, however, the phenomenon exists across the age ranges.

Graph 2. Medicaid Enrollee Primary Care Utilization by Age and Enrollment Length (2019)



Data were further reviewed to determine whether enrollment length was a contributing factor to observed patterns in primary care utilization across DC wards, as episodic enrollment may be more likely in areas where poverty and unemployment are not as persistent.

Table 3. Medicaid Enrollee Primary Care Utilization by Enrollment Length and Ward

	Full-Year Enrollment			Partial-Year Enrollment			All Medicaid Enrollees	
Ward	Enrollees w/Full Year	Percent Enrollees w/ Full Year (Row %)	Percent w/ Full Year (Col %)	Enrollees w/Partial Year	Percent Enrollees w/ Parial Year (Row %)	Percent w/ Partial Year (Col %)	Number of Enrollees	Percent of Enrollees
Ward 1	25,029	79%	10%	6,853	21%	12%	31,882	10%
Ward 2	15,904	81%	6%	3,790	19%	7%	19,694	6%
Ward 3	5,067	77%	2%	1,556	23%	3%	6,623	2%
Ward 4	37,430	77%	15%	11,094	23%	20%	48,524	15%
Ward 5	35,548	83%	14%	7,526	17%	13%	43,074	14%
Ward 6	24,115	84%	9%	4,543	16%	8%	28,658	9%
Ward 7	48,821	85%	19%	8,846	15%	16%	57,667	18%
Ward 8	59,466	86%	23%	9,821	14%	17%	69,287	22%
Unknown/ Outside DC	6,134	68%	2%	2,858	32%	5%	8,992	3%
Total	**257,514**	**82%**	**100%**	**56,887**	**18%**	**100%**	**314,401**	**100%**

Data revealed that some, but not all, of the wards with lower utilization in primary care (Ward 2 and 3) also have higher proportion of partial-year Medicaid enrollees (19% and 22% respectively) (Table 3.). The exceptions to this finding are Wards 1 and 4, which have higher utilization rates (62% and 60%, respectively) as well as a higher proportion of partial-year enrollees (21%, 23%).

Emergency Room and Primary Care Utilization Among Medicaid Enrollees

One response to barriers to primary care is increased or inappropriate use of emergency medical services, either out of necessity due to lack of options, or due to sequela from conditions that could be managed in the primary care setting but were not. To explore this relationship, Medicaid claims data for emergency department visits of full-year Medicaid enrollees (11–12 months enrollment) were analyzed and linked to the assessment of primary care utilization and the enrollee level. The analysis focused on the portion that had ED visits, or not, by age range and ward, compared to whether those individuals made primary care visits in that year, as well as the frequency of ED utilization (Table 4).

One key metric is the use of the ED without accessing primary care at all, which would include follow up as well as prevention. Across DC in 2019, 8.9% of Medicaid enrollees covered for at least 11 months had an ED visit without a primary care visit in 2019. Overall, it appears that there are geographical distinctions between the use of ED-only for care. Ward 8 had the highest rate, at 11.7% — nearly a third more than for DC overall. It should be noted that nearly a quarter of all Medicaid enrollees live in Ward 8, so the finding is significant. Conversely, the rate of ED-only utilization is only 5.7% in Ward 3 — less than half the rate for Ward 8 and a third lower than the rate for DC overall. Further analysis by ward reveals that enrollees in Wards 1, 2, 3, and 4 are less likely to have ED-only utilization than their counterparts in any of the other wards.

The analysis also looked at the frequency of ED visits depending on whether there was primary care utilization or not. Logically, though perhaps counterintuitively, enrollees having made a primary care visit were also considerably more likely to have visited the ER and with greater frequency, across all Wards and age groups. This is most likely due to health status or health issues, which are not controlled in this analysis. The visit frequency between those using the ED with or without primary care visits is instructive however. For example, in Ward 3 — where ED-only use is the lowest, enrollees are three times more likely to use both the ED and primary care than the ED-only, yet their overall rate of ED utilization is lower. This suggests a potentially more appropriate use of the healthcare system overall if ED visits are not being substituted for missed primary care. Conversely, in Ward 8, enrollees with primary care visits use the ED-only twice as often as those with ED-only utilization, yet the rate of ED utilization in Ward 8 is relatively higher.

Additional analysis of the ED data is planned to explore the underlying reasons that individuals visited the ED and whether those having ED-only visits are more likely to be visiting for reasons classified as Ambulatory Care Sensitive (ACS) diagnoses — conditions for which primary care access and quality can partially avoid ED and inpatient admissions.

Data were also analyzed by age range to determine if any distinctions exist in ED and PC utilization across age ranges: children/youth (ages 0–17), adults (ages 18–64) and the elderly (ages 65 and older). In DC, 6.3% of enrollees ages 0-17 had ED visits without any PC visits in the year. This percentage increases among adults to 10.2% and then declines to 8.5% for the aging population. This trajectory of ED-only utilization by age follows a similar trajectory of non-utilization in primary care by age depicted in Graph 2. Interestingly the data reveals less ED utilization by the elderly Medicaid population (over 65 years) compared to Medicaid enrollees in other age categories, with a smaller difference in utilization between those with a primary care visit vs. those with no PC visit. Further research is needed to understand this phenomenon, which could be related to billing practices for those with both Medicaid and Medicare eligibility/coverage — which would be true for all enrollees in this age range.

Table 4. Primary Care and Emergency Department Utilization by Age & Ward, Full-Year Enrollees (2019)

PC & ED Use by Age & Ward			ED Visits			% with 1+ ED Visits and no PC Visit	Avg ED Visits / Member			Ratio ED Visits (PC Yes/PC No)
Age Group	Ward	PC Visits	No	Yes	% with ED Visit		Total Members	ED Visits	Avg ED Visits	
All	Outside DC	No	302	80	21%	11.9%	382	188	0.49	3.0
		Yes	135	155	53%		290	424	1.46	
	Ward 01	No	6,968	1,505	18%	6.0%	8,473	2,734	0.32	2.5
		Yes	10,352	6,205	37%		16,557	13,107	0.79	
	Ward 02	No	5,393	1,289	19%	8.1%	6,682	3,093	0.46	2.5
		Yes	5,257	3,969	43%		9,226	10,840	1.17	
	Ward 03	No	2,218	291	12%	5.7%	2,509	549	0.22	3.1
		Yes	1,742	816	32%		2,558	1,722	0.67	
	Ward 04	No	10,914	2,437	18%	6.5%	13,351	4,455	0.33	2.3
		Yes	15,050	9,031	38%		24,081	18,186	0.76	
	Ward 05	No	10,816	3,069	22%	8.6%	13,885	5,987	0.43	2.2
		Yes	12,322	9,342	43%		21,664	20,662	0.95	
	Ward 06	No	7,656	2,345	23%	9.7%	10,001	5,241	0.52	2.2
		Yes	7,585	6,534	46%		14,119	16,071	1.14	
	Ward 07	No	13,417	4,508	25%	9.2%	17,925	8,859	0.49	2.1
		Yes	16,646	14,253	46%		30,899	31,562	1.02	
	Ward 08	No	16,495	6,931	30%	11.7%	23,426	13,868	0.59	2.0
		Yes	17,340	18,708	52%		36,048	43,067	1.19	
	Ward Unknown	No	2,076	526	20%	9.6%	2,602	1,007	0.39	2.6
		Yes	1,579	1,281	45%		2,860	2,898	1.01	
	All	No	76,255	22,981	23%	8.9%	99,236	45,981	0.46	2.2
		Yes	88,008	70,294	44%		158,302	158,539	1.00	
Age 0-17	Outside DC	No	70	10	13%	6.1%	80	17	0.21	4.4
		Yes	42	43	51%		85	79	0.93	
	Ward 01	No	1,421	284	17%	4.1%	1,705	404	0.24	3.0
		Yes	3,193	2,004	39%		5,197	3,686	0.71	
	Ward 02	No	936	167	15%	5.1%	1,103	280	0.25	3.2
		Yes	1,298	905	41%		2,203	1,797	0.82	
	Ward 03	No	258	29	10%	3.9%	287	47	0.16	3.6
		Yes	304	144	32%		448	263	0.59	
	Ward 04	No	2,554	521	17%	4.6%	3,075	787	0.26	2.8
		Yes	4,927	3,273	40%		8,200	5,877	0.72	
	Ward 05	No	2,266	509	18%	5.3%	2,775	788	0.28	2.6
		Yes	4,084	2,820	41%		6,904	5,119	0.74	
	Ward 06	No	1,360	350	20%	6.3%	1,710	544	0.32	2.5
		Yes	2,246	1,633	42%		3,879	3,121	0.80	
	Ward 07	No	3,326	929	22%	6.5%	4,255	1,413	0.33	2.3
		Yes	5,937	4,210	41%		10,147	7,851	0.77	
	Ward 08	No	4,589	1,711	27%	8.6%	6,300	2,779	0.44	2.2
		Yes	7,042	6,646	49%		13,688	13,268	0.97	
	Ward Unknown	No	417	96	19%	5.9%	513	147	0.29	2.7
		Yes	650	475	42%		1,125	872	0.78	
	All	No	17,197	4,606	21%	6.3%	21,803	7,206	0.33	2.4
		Yes	29,723	22,153	43%		51,876	41,933	0.81	

Table 4. Primary Care and Emergency Department Utilization by Age & Ward (2019) - continued

PC & ED Use by Age & Ward			ED Visits			% with 1+ ED Visits and no PC Visit	Avg ED Visits / Member			Ratio ED Visits (PC Yes/PC No)
Age Group	Ward	PC Visits	No	Yes	% with ED Visit		Total Members	ED Visits	Avg ED Visits	
Age 18-64	Outside DC	No	202	67	25%	14.5%	269	134	0.50	3.2
		Yes	87	105	55%		192	303	1.58	
	Ward 01	No	4,737	1,008	18%	6.8%	5,745	1,984	0.35	2.5
		Yes	5,644	3,396	38%		9,040	7,835	0.87	
	Ward 02	No	3,398	753	18%	8.3%	4,151	2,001	0.48	3.1
		Yes	2,602	2,275	47%		4,877	7,209	1.48	
	Ward 03	No	1,580	181	10%	5.5%	1,761	328	0.19	3.7
		Yes	1,047	494	32%		1,541	1,072	0.70	
	Ward 04	No	7,223	1,642	19%	7.4%	8,865	3,219	0.36	2.2
		Yes	8,451	4,900	37%		13,351	10,606	0.79	
	Ward 05	No	7,143	2,160	23%	10.1%	9,303	4,511	0.48	2.3
		Yes	6,568	5,562	46%		12,130	13,607	1.12	
	Ward 06	No	5,424	1,743	24%	11.0%	7,167	4,148	0.58	2.3
		Yes	4,342	4,291	50%		8,633	11,710	1.36	
	Ward 07	No	8,883	3,250	27%	10.7%	12,133	6,766	0.56	2.1
		Yes	9,168	9,000	50%		18,168	21,657	1.19	
	Ward 08	No	10,906	4,868	31%	13.5%	15,774	10,275	0.65	2.1
		Yes	9,170	11,217	55%		20,387	27,922	1.37	
	Ward Unknown	No	1,603	424	21%	11.4%	2,027	852	0.42	2.8
		Yes	891	789	47%		1,680	1,977	1.18	
	All	No	51,099	16,096	24%	10.2%	67,195	34,218	0.51	2.3
		Yes	47,970	42,029	47%		89,999	103,898	1.15	
Age 65+	Outside DC	No	30	3	9%	6.5%	33	37	1.12	2.9
		Yes	6	7	54%		13	42	3.23	
	Ward 01	No	810	213	21%	6.4%	1,023	346	0.34	2.0
		Yes	1,515	805	35%		2,320	1,586	0.68	
	Ward 02	No	1,059	369	26%	10.3%	1,428	812	0.57	1.5
		Yes	1,357	789	37%		2,146	1,834	0.85	
	Ward 03	No	380	81	18%	7.9%	461	174	0.38	1.8
		Yes	391	178	31%		569	387	0.68	
	Ward 04	No	1,137	274	19%	7.0%	1,411	449	0.32	2.1
		Yes	1,672	858	34%		2,530	1,703	0.67	
	Ward 05	No	1,407	400	22%	9.0%	1,807	688	0.38	1.9
		Yes	1,670	960	37%		2,630	1,936	0.74	
	Ward 06	No	872	252	22%	9.2%	1,124	549	0.49	1.6
		Yes	997	610	38%		1,607	1,240	0.77	
	Ward 07	No	1,208	329	21%	8.0%	1,537	680	0.44	1.8
		Yes	1,541	1,043	40%		2,584	2,054	0.79	
	Ward 08	No	1,000	352	26%	10.6%	1,352	814	0.60	1.6
		Yes	1,128	845	43%		1,973	1,877	0.95	
	Ward Unknown	No	56	6	10%	5.1%	62	8	0.13	6.9
		Yes	38	17	31%		55	49	0.89	
	All	No	7,959	2,279	22%	8.5%	10,238	4,557	0.45	1.7
		Yes	10,315	6,112	37%		16,427	12,708	0.77	

Table based on 2019 ED and PC claims data for Medicaid population enrolled for >=11 months of the year

Finally, while not shown in the chart, other demographic splits were also examined in the ED data. African American enrollees, who comprise 66% of all Medicaid enrollees, also had the highest percentage (10%) of ED visit(s) without primary care visits. In comparison, 5% of Caucasian enrollees have one or more ED visits without primary care visits, while Caucasians comprise 4% of all Medicaid enrollees.

The discussion included in this document is only a brief summary of a broader, on-going analysis. SHPDA continues to work with the Department of Health's Community Health Administration to refine the analysis of the Medicaid data that was provided for this report as well as to draw deeper conclusions as to how to respond to this data to promote utilization.

RECOMMENDATIONS

SHPDA Priority Area: Health System and Workforce Capacity

Recommendation	Supporting Documentation
Expand comprehensive primary care capacity at existing sites in communities that have been historically marginalized by expanding hours of operation, using patient-centered scheduling, and increasing access to urgent care.	• **2017 DC HSP** • **2020 DC HCST**
Evidence/Rationale: Key informants, the 2017 HSP, and 2020 Healthcare Systems Transformation (HCST) all note pervasive barriers that prevent District residents from engaging in primary and urgent care. These include lack of convenient transportation, limited hours of operation, inability to obtain appointments, linguistic barriers, lack of culturally responsive practices, perceptions of low-quality care, prioritization of basic needs such as food and shelter, and policies and practices that are not person-centered. Evidence-based practices to overcome engagement barriers focus on transforming clinical settings in order to keep patients at the center, such as patient-centered scheduling, while also forming relationships with community organizations and members to build trust and accountability. The HCST recommends increasing the capacity of health clinics to provide urgent care services to increase the equitable distribution of services and provide access to the underserved population.	

Recommendation	Supporting Documentation
Expand the use of community health workers, patient navigators, and/or community health educators who can engage with community members with cultural humility, address risk factors, and promote healthy living.	• 2017 DC HSP • 2021 DC SUD NA Assessment
Evidence/Rationale: The 2017 HSP highlighted community stakeholder recommendations for patient navigator or community health worker programs that provide outreach, social service case management, and other supportive services to assist consumers to address barriers and promote engagement in care. The 2017 DC HSP includes strategies to integrate and reimburse community health educators/workers/promoters in health and community-based settings. The 2020 HCST found that some community members did not value primary care. Community health workers play a pivotal role as trusted bridges between individuals and communities and healthcare providers in efforts to educate and help patients navigate risk factors and link these patients to needed resources, potentially increasing the value that community members place on primary care. These team members communicate and provide outreach geared towards specific populations, many times in the communities they live. Patient navigators provide care coordination and culturally sensitive support by identifying barriers that limit care and guiding parents to ease access to health and social support systems. As noted by the Centers for Disease Control, effective health education teaches essential health knowledge, shapes personal values and beliefs that encourage healthy behaviors, develops group norms that value healthy behaviors, and develops important health skills.	

SHPDA Priority Area: Health System Strengthening

Recommendation	Supporting Documentation
Grow, sustain, and enhance equitable telehealth. [43, 44]	• 2017 DC HSP • 2020 ReOpen DC • 2020 DC HCST
Evidence/Rationale: Key informants from this project, the 2020 DC Mayor's Commission on Healthcare Systems Transformation (2020 DC HCST), and the 2020 Re-Open DC report identified telehealth implementation as an effective modality in strengthening health systems, promoting appropriate care intervention, and providing equitable access to care. In the process of increasing equitable care via telehealth, digital equity, culturally humble and patient-led care, and targeted reimbursements should be considered to ensure that this medium is reaching and serving all populations effectively. Telehealth may be a valuable tool in increasing access and engagement in primary and urgent care by surpassing difficulties in accessing specialty care and social determinant-related barriers, such as lack of transportation. The COVID-19 pandemic rapidly accelerated the use of telehealth as a means to maintain access to care while reducing transmission of Covid-19, and drove temporary changes to regulations and payment that had previously inhibited telehealth uptake.	

Recommendation	Supporting Documentation
Increase Training and Technical Assistance (TTA) to build organizational capacity, improve the quality of services, and enhance clinical and administrative operations.	• **2017 DC HSP** • **2019 DC HCST** • **2021 DC SUD NA**

Evidence/Rationale: Offering a broad range of TTA services in multiple formats, aimed at building organizational capacity, improving the quality of services, and enhancing clinical and administrative operations may help to strengthen the health system. The 2017 DC HSP recommends that DC primary care sites should continue to ensure that evidence-based strategies and protocols are implemented related to patient engagement, behavioral health integration, and chronic disease treatment and self-management support. Furthermore, the 2020 DC HCST pushed for increasing equitable care by establishing goals to create a healthcareers training consortium that will help to address and invest in workforce education, including topics such as implicit bias, expand early career education, recruit non-English speakers, and be responsive to community needs.

Recommendation	Supporting Documentation
Monitor efforts to increase engagement in care.	• **2017 DC HSP** • **2018 DC HER**

Evidence/Rationale: In the process of strengthening the health system and addressing goals and recommendations outlined in the 2021 HSP, 2017 DC HSP, the 2020 DC HCST, and other related reports, it will be important to continually monitor healthcare engagement and improve methodologies that will lead to a better health system. Key informants identified pervasive barriers that prevent District residents from engaging in primary and urgent care. These include lack of convenient transportation, limited hours of operation, linguistic barriers, lack of culturally responsive practices, perceptions of low-quality care, prioritization of basic needs such as food and shelter, and policies and practices that are not person-centered. Other reports have similar strategies — the 2020 DC HCST includes a goal to implement a healthcare workforce center that aims to collect and analyze data related to workforce supply, demand, and training needs that will inform policy and government-related recommendations. Additionally, the 2017 DC HSP report discussed the need to collect and analyze SDOH-related data, in order to further a more equitable health system. Finally, the 2017 HSP report ensured that it considered monitoring data to improve accountability and drive quality improvement measures in the process of considering the DC health system. There is an understanding that collecting and understanding data around the current health practices will help in improving the health system. There needs to be more systematic data collection to monitor these efforts in order to measure change over time, create accountability to remove barriers to care, and promote collaboration and capacity building among DC care systems.

SHPDA Priority Area: Social and Economic Factors (including Structural Racism) and the Physical Environment

Recommendation	Supporting Documentation
Support partnerships and coordination efforts through multisector collaboratives that address social determinants of health from screening to linkage to resources.	• **2017 DC HSP**

Evidence/Rationale: Addressing Social Determinants of Health (SDOH) may play a significant part in preventing many health issues within communities. Functioning at the crossroads of social and health needs, primary and urgent care organizations may play an integral role in addressing SDOH.

Key informants identified SDOH as a factor that has created barriers to access for many Medicaid patients. They believe that creating more opportunities for collaboration may bring in patients so they receive the care that they need, when they need it. The 2017 HSP report captures similar information, recommending that partnerships and multi-sector collaborations be used to not only address SDOH, but also to improve care coordination, reduce fragmentation of services, support patient/provider communication, and more. In their 2019 report, the DC Mayor's Commission on Healthcare Systems Transformation stated that addressing SDOH is integral to moving forward policy, program, and infrastructure considerations in the process of impacting DC residents' access to care. Additionally, the DC Healthy People 2020 Framework has set a goal to "Increase multi-sector public, private and non-profit partnerships to further population health improvement through a coordinated focus on social determinants of health and health equity." Finally, the 2017 DC HSP emphasizes the importance of partnership, collaboration, and place-based care to improve community health. Place-based care goals include advocating for financial incentive to increase health services that are local, convenient, and culturally competent; advocating for integrating and reimbursing community health workers into health and community settings, and providing local organizations with grants to improve health and address social determinants within their own communities.

Recommendation	Supporting Documentation
Support initiatives that increase access to housing, prevent housing instability, reduce food insecurity, promote economic security, promote transportation equity, and address other social factors.	• **2017 DC HSP** • **2021 DC SUD Assessment**

Evidence/Rationale: Along with addressing SDOH via partnership and collaboration, transportation equity emerged as an important topic during the data collection process and was specifically called out in the 2017 DC HSP, especially with regard to racism, health equity, and justice. Stakeholders agreed that transportation is a significant barrier to accessing healthcare and supportive services. Increasing access to transportation helps to increase quality of life, while addressing poverty, unemployment, and access to healthy foods, school, work, exercise, and other resources. The 2017 DC HSP named increasing transportation equity as a short- to mid-term goal in improving DC's health system and decreasing barriers to care for its residents.

SHPDA Priority Area: Health Education and Communication

Recommendation	Supporting Documentation
Coordinate a system-wide public awareness campaign promoting the importance of primary care and urgent care, available resources in the District, health prevention, risk and protective factors, including how to access medical services.	• **2017 DC HSP** • **2020 ReOpen DC** • **2020 DC HCST** • **2021 DC SUD NA**

Evidence/Rationale: There remains a need for a Districtwide educational and awareness campaign on the importance of appropriate engagement in primary-care. The 2017 HSP identified the need for such a campaign regarding major local health issues, risk factors for chronic disease and impediments to wellness, and engagement in primary care, among other issues. An educational and awareness campaign coincides with recommendations in the Mayor's Commission and Re-Open DC reports for increased health literacy programming in the District and is instrumental in reducing health disparities.

Key informants echoed the need for a coordinated public awareness campaign to promote use of the District's current primary care resources. COVID-19 has amplified the need for such an initiative due to the alarming rates of missed preventive care visits over the past year. A CDC study found that by June 2020, an estimated 41% of adults had delayed or avoided medical care, including urgent and emergency care (12%) and routine preventive care (32%). Since the start of the pandemic, 28% of families with young children missed a well-baby/well-child visit (3x increase to pre-pandemic rates) and preventive screenings for cervical, colon, and breast cancer declined from 94% to 86%. As the District emerges from the public health emergency, it is a critical time to engage or re-engage residents and promote the importance of primary care and urgent care.

C. COVID-19, POST PANDEMIC, AND EMERGENCY RESPONSE

Introduction

The COVID-19 pandemic has provided us with a rare and painful opportunity to examine our readiness to respond to health threats. While lessons learned will continue to be identified and addressed for years to come, there are early learnings emerging from the COVID-19 pandemic that can already influence action at the national, state and local levels.

First, the sheer scale of the COVID-19 pandemic has strained public health and healthcare resources and underscored the importance of strong partnerships and collaboration among governmental agencies and between the public and private sector. For example, COVID-19's toll on the long-term care facilities necessitated close collaboration between public health and healthcare licensing to assist these organizations to protect their residents in the face of shortages of personal protective equipment. Healthcare organizations such as community health centers, hospital systems, urgent care centers, home care agencies, and pharmacies, as well as community- and faith-based organizations, worked to augment the public health system's capacity to provide testing and vaccination services. These organizations have reengineered their roles to respond to the threat, providing testing, mass vaccination, and supporting alternate care sites. The District's "**Take the Shot – DC**" and "Faith in Vaccine" campaigns are fitting examples. The value and potential of these collaborations, a focus of the Assistant Secretary for Preparedness and Response's **2017–2021 Healthcare Preparedness and Response Capabilities**, has been made clearer during this pandemic.

In addition, the pandemic experience has laid bare the critical need for situational awareness and data sharing across these collaborations. For example, after New York City's spring 2020 crisis, a need to improve inter-hospital system reporting and resource sharing to balance patient loads was identified (Toner et al., 2021).

Additionally, weaknesses in public health information and data systems and protocols to support interoperability and data sharing within and between all levels of the response exist nationally as well as in the District of Columbia (Trust for America's Health, 2021).

Human behavior provides the fuel for pandemics, and COVID-19 was no different. This experience once again highlighted the essential need to provide clear, consistent, and culturally and linguistically appropriate information to the public, whether that information is addressing preventive behaviors, where to seek care, or the benefits of vaccination. As DC's COVID-19 messaging efforts have shown, message clarity, consistency and appropriateness, as well as the ability to counter misinformation, require relationships between healthcare, public health, community-based organizations and trusted community leaders (Zauzmer, 2021).

The final, most far-reaching reaffirmation from this pandemic is that health disparities, fueled by differential access, income inequality and structural racism are exacerbated in emergencies. Examples of extreme variations across socioeconomic fault lines in testing and vaccine availability, ability to take self-protective actions (e.g., quarantine, work from home), access to continuity of care for pre-existing conditions were commonplace (CDC, n.d.). In the District, for example, health disparities manifested themselves in large variations in access to SARS-CoV-2 vaccine as well as disproportionate COVID-19 morbidity and mortality in people of color (Johnson, 2021; Watson, 2021).

Key informants for this planning process, in reflecting on their COVID-19 experiences in DC, echoed these early lessons. Specifically, key informants identified four recommendations that are essential to improving emergency response and ensuring that DC leverages the lessons learned from COVID-19.

Recommendation 1:	Improve Emergency Response Coordination Through Role Clarification, Planning and Exercising
Recommendation 2:	Improve Access to Services for Frontline Workers and Disproportionately Impacted Populations In Emergencies
Recommendation 3:	Foster Equitable Access to Telehealth Services to Promote Resilience in Emergencies
Recommendation 4:	Improve Coordination of Health-related Communications to the Public in Emergencies

Recommendations 1 and 2 are directly linked to recommendations regarding Health Information Exchange and multisector collaboration in SHPDA's Health Systems Strengthening Priority, and support diverse multisector collaboratives in SHPDA's Social and Environmental Factors in the Physical Environment Priority.

Recommendations 3 and 4 are directly related to recommendations regarding expansion of telehealth services, frontline community partnerships and appropriate, coordinated messaging discussed in SHPDA's Service and Workforce Capacity and Health Systems Strengthening Priority, as well as the Racism Health Equity and Justice and Health Education and Messaging Priority Areas. These recommendations are also in line with the recommendations emerging from the Primary/Urgent Care Engagement Area of Inquiry in this report, which, when implemented, will enhance, health system and community resilience in public health emergencies. Finally, these key findings are echoed in DC Health's recent COVID-19 Pandemic Health and Healthcare Recovery Report (May 2021).

The following is a discussion of the rationale for the COVID-19, Post Pandemic and Emergency Response strategic area, emerging best practice, and specific recommendations that should be applied to improve emergency response in the future.

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Recommendation 1: Improve Emergency Response Coordination Through Role Clarification, Planning and Exercising

Rationale:

Interviewees expressed the need to more clearly define the roles of administrations within DC Health and external partners in emergency response, both as a way to improve efficiency and increase the effectiveness of all partners in achieving their missions. Additionally, DC Health's recent COVID-19 Pandemic Health and Healthcare Recovery Report identified wide variation in the technical assistance needs of healthcare partners, who sought technical assistance from multiple DC Health administrations related to infection control, staffing and Personal Protective Equipment (PPE) procurement and continuity of operations using telehealth strategies.

The COVID-19 experience was identified as an opportunity to understand and catalog emerging best practices for coordinating responses to pandemics and other emergencies that impact the public health and healthcare systems of the District.

Emerging best practices:

> *"SHPDA was very aggressive with giving waivers out....Kudos to them for being forward looking."*

The Federal Emergency Management Agency's (FEMA's) Comprehensive Preparedness Guide highlights the definition and assignment of organizational roles as a critical component of institutional and jurisdictional emergency response plans (FEMA, 2010). The Assistant Secretary for Preparedness and Response (ASPR), the Centers for Disease Control and Prevention (CDC) and FEMA subscribe to the Homeland Security Exercise Evaluation Program's, after action review, and improvement planning process to learn from past responses to improve future responses (ASPR, 2016; CDC, 2018; FEMA, 2020). Additionally, ASPR's Healthcare Preparedness and Response Capabilities describe a central role for healthcare coalitions in supporting collaborative planning, exercising and coordination of healthcare response (ASPR, 2016).

Upon reflection of the ongoing COVID-19 response in DC, interviewees identified four areas for improved role definition/institutionalization and coordination that could be explored via a post-response after action review process. Each of these areas was also highlighted in DC Health's COVID-19 Pandemic Health and Healthcare Recovery Report ("DC Health Recovery Report"):

- **Optimizing response activities of private sector healthcare partners based on the COVID-19 experience:** Interviewees reflected that the private sector has played an important role in the COVID-19 response in DC, and that the pandemic has brought into focus its important response role. They observed that private sector partners could have been engaged in the COVID-19 response at an earlier stage. The DC Health Recovery Report reflects the importance of private sector engagement in response, encouraging continued work by DC Health to provide technical assistance to healthcare partners on planning and coordination and incentivizing such planning via the Certificate of Need planning process. The Centers for Medicare and Medicaid Emergency Preparedness Rule may also encourage engagement of healthcare sector partners (CMS, 2021).
- **Coordinating data collection and reporting in both the preparedness and response phases:** Interviewees called for a more coordinated approach to data collection within DC Health, including defining a common set of needed data elements (e.g., bed capacity, discharge data needs), determining timing of requests and mechanisms for data collection. The DC Health Recovery Report calls for continuing efforts to streamline databases to reduce the number in use.

- **Facilitating information sharing across organizations in the healthcare response:** Linked to the above, interviewees underscored the importance of having access to real-time information during response, and noted that this access is variable depending on healthcare partner type and size. Along these lines, the DC Health Recovery Report called for improvements to information sharing platforms and agreements across organizations including labs, pharmacies, electronic health records and health departments.
- **Issuance of waivers for healthcare facilities:** Interviewees lauded SHPDA for its proactiveness and efficiency in issuing needed waivers to healthcare organizations to assist in response and manage surge. In describing the waivers issued to meet healthcare's staffing and bed capacity needs, the DC Health Recovery Report calls for additional work to establish interjurisdictional provider reciprocity agreements and inventory needed scope of practice changes identified via the pandemic experience.

Recommendations:

- Work via the DC Health and Medical Coalition to develop an After Action Report/Improvement Plan (AAR/IP) for the COVID-19 response that builds on DC Health's COVID-19 Pandemic Health and Healthcare Recovery Report. Include representatives of SHPDA, HRLA and other DC health administrations as well as responding health organizations to identify optimal roles of administrations within DC Health and of private sector partners.
    - » Document these roles the Organization and Assignment of Responsibilities sections of organizational and jurisdictional response plans; develop or update Standard Operating procedures to support these roles.
    - » Work via the DC Health and Medical Coalition to incorporate emergency exercises that include the objective of familiarizing all partners with these roles into ASPR's required Multi-Year Training and Exercise Plan (MYTEP).
    - » Coordinate monitoring of progress in AAR/IP implementation via SHPDA.
- As recommended in the DC Health Recovery Report, coordinate and standardize data collection and reporting and establish broad interagency data sharing infrastructure and agreements.
- Work via the DC Health and Medical Coalition to continue providing of emergency preparedness technical assistance to partners. Explore mechanisms to encourage preparedness and coordination among partners by:
    - » Providing technical assistance specific to CMS Emergency Preparedness Rule requirements;
    - » Working in collaboration with HRLA to consider extending its oversight of organizations such as Federally Qualified Health Centers (FQHC) and urgent care centers to increase preparedness;
    - » Consider establishing Emergency Preparedness plans as a "reasonable conditions" requirement in SHPDA's CON process.

References:

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Recommendation 2: Improve Access to Services for Frontline Workers and Disproportionately Impacted Populations in Emergencies

Rationale:

The pandemic, like all emergencies, exacted disproportionate impacts on historically marginalized groups due to racism, lower socioeconomic status, language, living arrangements, and employment circumstances; these factors also limited access to care and increased risk of exposure to SARS-COV-2 (Lopez, Hart, & Katz, 2021). In DC, reductions in health service availability due to COVID-19 contributed to increases in deaths from chronic diseases such as diabetes, chronic respiratory disease and heart disease (DC Health, 2021). Frontline workers such as healthcare workers report declining well-being, stress and burnout (DC Health, 2021). The ReOpen DC Report highlighted the importance of increasing access to primary and behavioral healthcare services beyond 9 a.m.–5 p.m. for frontline workers and others experiencing increases in stress and trauma (ReOpen DC Advisory Group, 2020).

Emerging Best Practices:

The DC Health Recovery Report describes the important work being undertaken to address health and healthcare access disparities in the District prior to the COVID- 19 pandemic, and the efforts by DC Health and community partners to maintain availability of non-COVID related healthcare services during the pandemic. The DC Health Recovery Report proposes utilizing regulatory and grantmaking authority to expand healthcare service hour availability. Key informants from this assessment noted that the Certificate of Need process has been successfully utilized to leverage resources to meet very specific needs (for example, the need for cancer navigation services and prevention education).

Expansions of service availability via this process would likely also foster access during public health and other emergencies.

Recommendations:

- In line with recommendations in the ReOpen DC Report, convene stakeholders (beneficiaries and service providers) to identify context-appropriate, evidence-based strategies for expanding care access for frontline workers and other populations that are historically disproportionately impacted by emergencies.
- Explore possibilities for utilizing regulatory and grantmaking authority to expand service availability (both in general, and in emergencies) as recommended by the DC Health Recovery Report.

References:

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Recommendation 3: Foster Equitable Access to Telehealth Services to Promote Resilience in Emergencies

Rationale:

Telehealth strategies are a key strategy for increasing access to populations that traditionally experience barriers to care. During the COVID-19 pandemic, telehealth evolved as a mechanism to reduce disease transmission and maintain continuity of operations and care.

In one CDC study of the four largest U.S. telehealth providers, the number of telehealth visits for non COVID-related issues in January–March 2020 was found to have increased by 50% over the same period in 2019 (with an 150% increase over the previous year in the last week of March 2020). COVID-19 related visits also increased three-fold in March 2020 (Koonin et al., 2020).

In DC, interviewees noted that the shift to telehealth for behavioral and health service delivery happened rapidly, with use for primary care visits following soon after. The DC Department of Healthcare Finance (DHCF) supported use of telehealth through implementation of policy changes that resulted in 36% of ever-enrolled beneficiaries using the service (DC Health, 2021). DHCF collaborated with the DC Primary Care Association to loan hardware and telehealth platform licenses to providers during the pandemic response (DC Health, 2021). DC Health staff provided technical assistance to support partner telehealth implementation (DC Health, 2021). Data from the DC Health Recovery Report illustrates the ability of telehealth to support continuity of healthcare operations. Due to availability, telemedicine, HIV and STI services provided by the DC Health and Wellness Center were able to rebound to pre-pandemic levels by October 2020 (DC Health, 2021).

> *"All FQHCs transitioned from in-person to telehealth relatively overnight after the COVID outbreak."*

In spite of this potential, the digital divide still presents a telehealth challenge. A study of primary healthcare utilization in a large San Francisco health system found that the proportion of visits for populations at risk of limited digital literacy (defined as patients ≥65 years old, non-English language preference, insured by Medicare or Medicaid) decreased significantly following the replacement of in-person visits with telemedicine visits due to COVID-19 (Nouri et al., 2020). Studies, including the ReOpen DC Report, have described numerous barriers to equitable access to telehealth, including non-inclusive platforms (that may limit access to people living with disabilities and people who speak languages other than English), geography (which may limit broadband access), socioeconomics (which may limit access to technology and privacy), cultural acceptability, and digital literacy. Interviewees and the Reopen DC Report outlined a need to increase access to broadband internet and devices with data plans in DC.

Emerging Best Practices:

Many communities and health systems have grappled with these challenges, and gained experience implementing telehealth services during the COVID-19 pandemic. In order to increase access to broadband internet, Washington State established 300 free, drive-in Wi-Fi hotspots in rural and under-resourced, low-income urban, and suburban communities. Boston also established low-cost hot spots, while other communities, such as Trenton, NJ, are working to establish telehealth Kiosks (CDC, 2020; Ortega et al., 2020). Municipalities and providers have inventoried free community hotspots or invited patients to access clinic Wi-Fi from the parking lot of healthcare facilities for telemedicine visits (Engel-Smith, 2020).

To counter the limited access to technical equipment, research and interviewees recommended that efforts be made to work collaboratively with community centers and public libraries to provide computer access, and to provide devices and data to those who would otherwise not have access (Ortega et al., 2020). In the interim, interviewees shared that FQHCs were able to provide audio-only telehealth services when needed and appropriate, which were found to be effective.

The ReOpen DC Report identifies ending the digital divide as a crosscutting enabler. The Report calls for 1) facilitating the use of telehealth through providing adequate support and equipment to providers and their patients by supporting establishment of telehealth services; 2) exploring options to provide targeted reimbursement for services including remote patient monitoring; and 3) classifying telehealth equipment as durable medical equipment (Reopen DC Advisory Group, 2020).

Finally, at the healthcare provider level, research suggests that providers should screen patients for potential obstacles to utilizing telehealth services (e.g., medical, technological, cultural and linguistic needs, and privacy barriers) prior to their first telehealth visit (CDC, 2020; Nouri et al., 2021). The DC Health Recovery Report recommends a role for Community Health Workers and Care Coordinators in making these assessments (DC Health, 2021).

Recommendations:

- In keeping with the recommendations in the Reopen DC Report, convene stakeholders (beneficiaries and service providers) to select context-appropriate, evidence-based strategies for expanding patient/client telehealth access in under-resourced District wards that can be supported by the Certificate of Need process.
- As described in the DC Health Recovery Report and ReOpen DC Report, continue efforts to expand provider- and community-based organizations' ability to provide telehealth services.

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Recommendation 4: Improve Coordination of Health-related Communications to the Public in Emergencies

> *At first [during the pandemic], people weren't using any PCP/ urgent care services because of fear.*
>
> *"Where is the campaign that says 'primary care right in your home?'"*
>
> *—Key informant interviewee*

Rationale:

The need for public education and coordinated messaging on accessing healthcare becomes exacerbated in an emergency such as the COVID-19 pandemic. Key informants shared that, particularly in the early stages of the pandemic, people were not accessing needed primary healthcare or urgent care.

While efforts were made to collaborate with Managed Care Organizations through print and other media forms, it was noted that there is a need to establish a more coordinated, health system-wide approach to communicating when, where, and why to get care, as well as to get the word out about the availability of telehealth services.

Emerging Best Practices:

In emergency situations, these established partnerships and frameworks provide the foundation for coordinated emergency public information and warning activities across the healthcare system. The ReOpen DC report highlighted a need for ongoing messaging to the public on mitigating COVID-19 risk that is "simple, multi-lingual, and informative", that works through multiple channels including trusted community partners and government programs, and that incentivizes people to "opt-in to ongoing communications" (ReOpen DC Advisory Group, 2020). The DC Health Recovery Report highlights social media feeds and website features such as live chats as ways to meet the public's information needs while reducing call volume (DC Health, 2021).

In emergencies, ASPR and CDC recommend coordinating messaging across jurisdictional partners to ensure information is accurate, consistent, linguistically and culturally appropriate, and disseminated to the community using one voice via a Joint Information System (JIS) (ASPR, 2016; CDC, 2018). In a JIS, public information professionals from multiple organizations work together to:

- Identify key information that needs to be publicly communicated;
- Craft messages that convey key information and are easily understood;
- Prioritize messages to ensure timely delivery of information without overwhelming the audience;
- Verify accuracy of information through appropriate channels, and
- Disseminate messages using the most effective means available (FEMA, n.d.; FEMA, 2016).

Recommendations:

- Work via the DC Health and Medical Coalition to develop/strengthen the health system JIS plan for emergency public information and warning, building off existing communications partnerships and incorporating lessons learned from the COVID-19 after action review process.
- Conduct emergency exercises to familiarize all partners with JIS functioning.

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APPENDIX A: SHPDA HEALTH SYSTEMS STRENGTHENING FRAMEWORK - RECOMMENDATIONS BY PRIORITY AREA

The recommendations below were drawn from the 2017 HSP as well as a series of other assessments, white-papers, and reports that have been conducted or developed since 2017. This compendium, organized by the four strategic priority areas that make up SHPDA's Health System Strengthening Framework, reflect the recommendations that are part of these documents and help to fulfill one of SHPDA's statutory charges to support the coordination of health policy and planning within the District. The Framework and the recommendations below provide a roadmap that SHPDA and the SHCC hope will guide the District's public agencies and service providers across the continuum to build system capacity and strengthen DC's health system.

SHPDA Priority Area: Service & Workforce Capacity

Service Capacity

Service Domain	Recommendations	Supporting Documentation
Primary and Urgent Care (Comprehensive)	Explore how to either enhance or expand existing **primary care capacity (including prenatal care) in targeted ways to address limited engagement and access barriers,** specifically in communities that have been historically marginalized (e.g., Black, Hispanic/LatinX).	2017 DC HSP 2020 DC HCST 2021 DC SUD NA
	Expand and promote the use of **telehealth**[1] to provide initial consultations, pre-arrival assessments, and follow-up care to promote appropriate care intervention in a timely fashion.	2017 DC HSP 2020 DC HCST
	Expand access to **urgent care** through stand-alone urgent care facilities and through existing primary care networks.	2017 DC HSP 2020 DC HCST
Primary and Urgent Care (Dental)	Expand comprehensive **dental service capacity** in targeted ways with special attention on the uninsured, those experiencing material poverty, and communities that have been historically marginalized (e.g., Black, Hispanic/LatinX, those with HIV or mental health or SUD conditions) (Including prenatal care).	2017 DC HSP
Primary and Urgent Care (Behavioral health)	Promote the bi-directional integration of medical and **behavioral health services** in outpatient settings through co-located and enhanced referral models.	2020 DC HCST 2017 DC HSP
Ambulatory Specialty Care (Medical)	Promote collaborations between DC's hospitals and safety net providers that address barriers and service gaps to **medical specialty care services.**	2017 DC HSP
	Support evidence-informed programs that enhance access to high-quality **medical specialty care services** for uninsured and Medicaid insured residents.	2017 DC HSP

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[1] Telehealth is defined as the use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Service Domain	Recommendations	Supporting Documentation
Behavioral Healthcare **(Crisis Stabilization)** **(Residential Services)** **(Outpatient Care)** **(Care Transitions)** **(Recovery Support)**	Expand access to evidence-based outreach and **crisis stabilization services** geared specifically to those with SUD.	2018 Live.Long.DC 2021 DC SUD NA
	Expand access to a range of person-centered **SUD transitional and supportive housing** service options.	2017 DC SUD 2018 Live.Long.DC 2021 DC SUD NA
	Expand access to a range of person-centered **SUD outpatient programs,** including MAT/medication management, comprehensive counseling, and intensive outpatient programs (IOPs).	2017 DC HSP 2018 Live.Long.DC 2021 DC SUD NA
	Ensure that the numerous policies and programs designed to encourage DC Medicaid providers in the District to furnish **care transition services** (e.g., My Health GPS, My DC Health Homes program, transition planning services) can be used by DBH certified SUD providers.	2017 DC HSP 2018 Live.Long.DC 2021 DC SUD NA
	Expand access to **recovery support services**, including peer support groups and multi-service community centers.	2017 DC HSP 2018 Live.Long.DC 2021 DC SUD NA
	Promote the development of **multi-service SUD service organizations** that provide multiple services along the ASAM continuum.	2018 Live.Long.DC 2021 DC SUD NA
	Expand access to **SUD sobering centers** as an alternative care site for intoxicated individuals who do not require acute medical attention.	2018 Live.Long.DC 2020 DC HCST 2021 DC SUD

Service Domain	Recommendations	Supporting Documentation
Hospital Care **(Emergency Services)**	Expand and enhance evidence-informed programs in hospital emergency department (ED) and primary care settings that **raise awareness and educate patients on appropriate use of ED services** and link patients to medical home (e.g., ED navigators, triage programs) and SUD services.	2017 DC HSP 2020 DC HCST 2021 DC SUD NA
	Expand and enhance evidence-informed **ED Triage practices** that help to direct individuals to the right level of care, and reduce overutilization of the hospital ED resources (e.g., SBIRT Programs, federal Emergency Triage, Treat, and Transport (ET3) Medicare model; community paramedicine responders; and community health workers).	2020 DC HSCT
	Implement **hospital surge management** protocols, during periods of overcrowding. (Per use of National Emergency Department Overcrowding Score (NEDOCS).	2020 DC HCST
Post-Acute Care **(Care Transition Services)**	Expand and enhance evidence-informed **care transitions programs** and policies that improve transitions from the hospital and other acute care settings to the home.	2017 DC HSP
Emergency Preparedness	Invest resources and plans that will ensure that “frontline organizations and workers”, particularly in communities that are disproportionately impacted during emergencies, are able to respond with expanded services and capacity in an appropriate and timely fashion.	2020 DC HCST

Workforce Capacity

Service Domain	Recommendations	Supporting Documentation
Primary and Urgent Care (Comprehensive)	**Expand primary care provider capacity** (including primary care providers, specialty care providers, and non-clinical service staff) by increasing loan repayment/incentives thus supporting recruit and retention efforts, particularly in Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs).	2020 DC HCST
	Explore programmatic investments to create a **DC-based Primary Care Residency Program** to replace the program that was operated at Howard University to provider workforce training opportunities that will support expansion of capacity in the District.	2017 DC HSP
	Expand the use of **community health workers, patient navigators, and/or community health educators** who can engage community members, address risk factors, support service navigation, promote healthy living, and provide emergency information.	2017 DC HSP 2021 DC SUD NA
Behavioral Health & Post-Acute Care (Care Transitions, Recovery Supports)	Expand access to **peer recovery coaches, recovery specialists, transition coaches, and specialized case managers** to support recovery for those with behavioral health or other chronic medical conditions.	2021 DC SUD NA
Hospital Care (Inpatient Care)	Expand workforce capacity with respect to specially trained **hospital discharge coaches** (e.g., "Coleman Coaches") to support the seamless, safe, timely transition of patients from the hospital inpatient setting to the post-acute setting or to home.	2017 DC HSP
Post-Acute Care **(Home Health Aids)**	Expand access to **home health aides, personal care attendants, and other certified and uncertified staff** to support home healthcare services.	2017 DC HSP

SHPDA Priority Area: Health System Strengthening

Recommendations	Supporting Documentation
Promote the development of evidence-based, person-centered standardized, guidelines, protocols, operating procedures, and tools across the service continuum (e.g., primary and urgent care, ambulatory specialty care, behavioral health, hospital care, and post-acute care) to promote outreach, screening, and identification, patient engagement, care coordination, service integration, and care transitions.	2017 DC HSP 2020 DC HCST 2021 DC SUD
Expand and enhance comprehensive case management programs that ensure that all participants in publicly-funded healthcare services have access to case management services to support navigation, referral management, and linkages to services.	2020 DC HCST 2021 DC SUD
Promote comprehensive assessment and transition planning to support seamless, safe, timely care transitions / step-down from one setting or level of care to another.	2017 DC HSP 2020 DC HCST
Enhance the power and influence of multisector collaboratives working collectively to promote partnership and develop collaborative responses geared to strengthening the health systems, improving health status, and promoting equity.	2017 DC HSP 2020 DC HCST
Invest in policy and program initiatives that promote the development of integrated provider networks (e.g., Accountable Care Organizations, Behavioral Health Integrated Care Networks, Clinically Integrated Networks) that facilitate collaboration, collective action, and health system integration, both within and cross-sectors.	2017 DC HSP 2020 DC HCST 2021 DC SUD
Continue to promote the use of value-based payment mechanisms that enhance payments for evidence-informed activities that are shown to improve outcomes.	2017 DC HSP 2020 DC HCST 2021 DC SUD
Expand equitable access to telehealth/telemedicine technology services and ensure it is covered by insurance. (Including ensuring access to broadband/internet, mobile phones with data access, etc.)	2020 Re-Open DC
Continue to invest in health information technology (HIT), electronic medical record (EMR) adoption and use, including targeted training/technical assistance activities, and policies, programs, and contracting efforts.	2021 DC SUD 2020 DC HCST
Continue to promote and expand health information exchange (HIE) capacity for clinical and non-clinical partners to promote information sharing, care coordination, and overall population health management, especially in behavioral health settings.	2017 DC HSP 2018 DC SMHP 2021 DC SUD
Continue to invest in and train organizations to implement robust quality and performance improvement, and accountability initiatives.	2017 DC HSP 2021 DC SUD 2020 DC HCST
Offer a broad range of training and technical assistance services, in multiple formats, aimed at building organizational capacity, improving the quality of services, and enhancing clinical and administrative operations, with special emphasis on the following areas of expertise and experience: outreach, identification, and screening; patient engagement; care coordination, care transitions; service integration, adoption / use of HIT/HIE; and network development and partnership.	2017 DC HSP 2018 DC SMHP 2020 DC HCST 2021 DC SUD

Recommendations	Supporting Documentation
Establish a healthcareers 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.	2020 DC HCST

SHPDA Priority Area: Social and Economic Factors (including structural racism) and the Physical Environment

Recommendations	Supporting Documentation
Social and Economic Factors and the Physical Environment	
Continue to support the development of a diverse **multi-sector collaborative** of residents, providers, and community organizations to address social determinants, guide community health improvement efforts, strengthen emergency plans and community resilience, and promote cross-sector collaboration.	2017 DC HSP
Continue to implement **social determinants of health screening, referral and engagement programs in community-based settings** (e.g., material poverty, housing, food insecurity, employment, education/training, and transportation).	2017 DC HSP 2021 DC SUD
Support existing initiatives that advocate for policy and program initiatives or investments in **safe, affordable housing, employment opportunities, education/training, food security, and transportation equity,** with an emphasis on those who are experiencing material poverty, being impacted by racism, or who are marginalized in other ways.	2017 DC HSP 2021 DC SUD
Support **health literacy** initiatives that improve consumer navigation and spoken/written communication between patients and providers.	2017 DC HSP 2020 Re-Open DC
Structural Racism and Health Equity	
Invest in broad, **comprehensive community efforts to reduce the impact of structural racism** and address the breadth of related structural inequities.	2021 DC SUD
Support initiatives that promote **transportation equity** and reduce transportation barriers.	2017 DC HSP
Support initiatives that **expand access and reduce barriers to care for frontline service organizations serving those disproportionately impacted populations in emergencies**.	2017 DC HSP
Ensure that **data is collected and reported by race and ethnicity**, to provide transparency and guide reforms.	2020 Re-Open DC
Explore innovative philanthropic partnerships to **provide health and economic support to communities in greatest need**, such as financial education and banking to enable cashless transactions.	2020 Re-Open DC
Ensure that all essential health-related **communications is simple, multi-lingual, and informative.**	2020 Re-Open DC
Launch a **'know your rights' campaign** for vulnerable populations during emergencies (e.g., COVID-19).	2020 Re-Open DC
Develop a **multifaceted Health-In-All-Policies approach**, in order to improve the health of all District residents, including achieving health equity.	2018 DC HER
Evaluate and disseminate information regarding the historical forces that have left a legacy of racism and segregation in the District, as well as the structural, institutional, and power-related factors that perpetuate persistent inequities.	2018 DC HER
Develop health equity goals and measure and monitor the impact of policies geared to address them to ensure goals and improved outcomes are being accomplished.	2018 DC HER

Recommendations	Supporting Documentation
Develop place-based models of care that provide culturally sensitive care focused on DC's most marginalized communities to address inequities and disparities in outcomes.	2017 DC HSP 2020 DC HCST
Implement cultural competence and implicit bias training for healthcare leaders and administrative/clinical staff at service organizations across the District.	2020 DC HCST

SHPDA Priority Area: Health Education and Communication

Recommendations	Supporting Documentation
Develop targeted community **health education and awareness campaigns** that promote awareness of the leading social determinants of health, health risk and protective factors, and other health prevention messaging.	2017 DC HSP 2020 Re-Open DC 2020 DC HCST 2021 DC SUD
Continue to invest in a **comprehensive, District-wide opioid education and awareness campaign** on the risks of opioid use disorders and effective prevention and treatment options.	2018 Live.Long.DC.
Develop a city-wide, multi-faceted campaign, geared to both residents and service providers, to promote **consumer care navigation and engagement** as well as facilitate **service provider referrals and care coordination.**	2017 DC HSP 2020 Re-Open DC 2020 DC HCST 2021 DC SUD
Ensure there is a single, easily accessible **District-wide healthcare advice line**, staffed by clinicians, to provide medical advice, healthcare system navigation, and appointment scheduling to all residents.	2017 DC HSP 2020 Re-Open DC 2020 DC HCST 2021 DC SUD
Invest in education, awareness, training, and technical assistance programs that **support expansion of evidence-informed harm reduction services** in the District (e.g., sobering centers, needle exchanges, wet shelters, etc.)	2018 Live.Long.DC. 2021 DC SUD
Support on-going investments to develop and maintain a **comprehensive, on-line resource inventory** with information on available services to address health-related needs across the service continuum, including emergency, clinical, social, public health, and other community-based services.	2017 DC HSP 2020 Re-Open DC 2020 DC HCST 2021 DC SUD
Develop and disseminate **health and safety information** that is accurate, accessible, and actionable.	2017 DC HSP 2020 DC HCST
Support and expand local efforts to provide **adult education, English language instruction**, and **culturally and linguistically appropriate health information services** in the community.	2017 DC HSP 2020 DC HCST

APPENDIX B: PRIMARY CARE AND URGENT CARE ENGAGEMENT - DATA TABLES

Appendix B1. Utilization by Gender and Age (2019)

		Medicaid Enrollees with Zero Primary Care Visits			Medicaid Enrollees with One or More Primary Care Visits			All Medicaid Enrollees	
Gender	**Age**	**Enrollees w/ Zero Visits**	**Percent Enrollees w/ Zero Visits (Row %)**	**Percent w/ Zero Visits (Col %)**	**Enrollees w/ 1+ Visits**	**Percent Enrollees w/ 1+ Visits (Row %)**	**Percent w/ 1+ Visits (Col %)**	**Total Enrollees**	**Percent of Total**
Female	0-4	2,861	26%	2%	8,240	74%	5%	11,101	4%
	5-14	9,280	25%	2%	16,957	75%	5%	11,500	4%
	15-34	20,343	38%	15%	33,016	62%	18%	53,359	17%
	35-44	8,850	62%	20%	14,069	38%	9%	42,332	13%
	45-54	5,515	39%	7%	10,321	61%	8%	22,919	7%
	55-64	5,591	63%	9%	12,143	37%	4%	18,727	6%
	65-74	3,938	35%	4%	7,368	65%	6%	15,836	5%
	75plus	4,439	53%	6%	4,194	47%	4%	14,888	5%
Male	0-4	2,932	35%	7%	8,568	65%	9%	26,237	8%
	5-14	9,692	35%	7%	17,780	65%	10%	27,472	9%
	15-34	26,291	32%	4%	16,041	68%	7%	17,734	6%
	35-44	11,884	44%	6%	6,843	56%	6%	18,245	6%
	45-54	7,936	35%	3%	6,952	65%	4%	11,306	4%
	55-64	8,031	45%	3%	10,214	55%	3%	9,863	3%
	65-74	4,419	51%	3%	5,444	49%	2%	8,633	3%
	75plus	2,352	55%	2%	1,897	45%	1%	4,249	1%
Total		**134,354**	**43%**	**100%**	**180,047**	**57%**	**100%**	**314,401**	**100%**

Appendix B2. Utilization by Gender and Age and Enrollment Length (2019)

	Full-Year Enrollment							
	Medicaid Enrollees with Zero Primary Care Visits			Medicaid Enrollees with One or More Primary Care Visits			All Medicaid Enrollees with Full-Year Enrollment	
Age	Enrollees w/ Zero Visits	Percent Enrollees w/ Zero Visits (Row %)	Percent w/ Zero Visits (Col %)	Enrollees w/ 1+ Visits	Percent Enrollees w/ 1+ Visits (Row %)	Percent w/ 1+ Visits (Col %)	Total Enrollees	Percent of Total
0-4	3,284	21%	3%	12,160	79%	8%	15,444	6%
5-14	14,988	32%	15%	32,461	68%	21%	47,449	18%
15-34	34,795	45%	35%	43,394	55%	27%	78,189	30%
35-44	15,477	46%	16%	18,309	54%	12%	33,786	13%
45-54	10,073	40%	10%	15,364	60%	10%	25,437	10%
55-64	10,372	34%	10%	20,172	66%	13%	30,544	12%
65-74	5,544	33%	6%	11,112	67%	7%	16,656	6%
75plus	4,694	47%	5%	5,315	53%	3%	10,009	4%
Total	**99,227**	**35%**	**100%**	**158,287**	**65%**	**100%**	**257,514**	**100%**

	Partial-Year Enrollment							
	Medicaid Enrollees with Zero Primary Care Visits			Medicaid Enrollees with One or More Primary Care Visits			All Medicaid Enrollees with Partial-Year Enrollment	
Age	Enrollees w/ Zero Visits	Percent Enrollees w/ Zero Visits (Row %)	Percent w/ Zero Visits (Col %)	Enrollees w/ 1+ Visits	Percent Enrollees w/ 1+ Visits (Row %)	Percent w/ 1+ Visits (Col %)	Total Enrollees	Percent of Total
0-4	2,509	35%	7%	4,648	65%	21%	7,157	13%
5-14	3,984	64%	11%	2,276	32%	10%	6,260	11%
15-34	11,839	68%	34%	5,663	79%	26%	17,502	31%
35-44	5,257	67%	15%	2,603	36%	12%	7,860	14%
45-54	3,378	64%	10%	1,909	27%	9%	5,287	9%
55-64	3,250	60%	9%	2,185	31%	10%	5,435	10%
65-74	2,813	62%	8%	1,700	24%	8%	4,513	8%
75plus	2,097	73%	6%	776	11%	4%	2,873	5%
Total	**35,127**	**43%**	**100%**	**21,760**	**2516%**	**100%**	**56,887**	**100%**

APPENDIX C: GLOSSARY OF TERMS AND DEFINITIONS

Accountable care organization: A network of doctors and hospitals who share financial and medical responsibility for providing care to their patients.

Ambulatory care: Refers to medical services performed on an outpatient basis, without admission to a hospital or other facility. It is provided in settings such as offices of physicians and other healthcare professionals, hospital outpatient departments, ambulatory surgical centers, specialty clinics or centers (e.g., dialysis or infusion), and urgent care clinics.

Behavioral healthcare: Mental health, psychiatric, counseling and addictions treatment, including services provided by social workers, counselors, psychiatrists, neurologists and physicians. Behavioral health also includes both mental health and substance use, encompassing a continuum of prevention, intervention, treatment and recovery support services.

BIPOC: Black, Indigenous, and People of Color

Care coordination: Deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

Care transitions: The movement patients make between healthcare practitioners and settings as their condition and care needs change. These transitions can occur when care is transferred from one member of a care team to another, between departments, wards, or clinics within a single facility, or between organizations as one transitions or steps up or down from one care setting to another.

Case management: A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.

Certificate of Need (CON): Allows healthcare providers to establish new facilities or services, make certain capital expenditures, or take certain other actions as specified in DC Official Code 44 – 401 et. seq. of the Health Services Planning Program Reestablishment Act of 1996, as amended, and the Certificate of Need (CON) Regulations (Title 22B, DC Municipal Regulations, Sec. 4000, et seq.)

Clinically integrated network: A selective partnership of physicians collaborating with hospitals to deliver evidence-based care, improve quality, efficiency, and coordination of care, and demonstrate value to the market.

Crisis stabilization services: Direct mental healthcare to non-hospitalized individuals experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or rehospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Cultural competency: The ability to understand, appreciate and interact with people from cultures or belief systems different from one's own.

Electronic Medical Records (EMR): Digital versions of the paper charts in clinician offices, clinics, and hospitals, which contain notes and information collected by and for the clinicians in that office, clinic, or hospital and are mostly used by providers for diagnosis and treatment.

Emergency department triage: The methods used to assess a patient's severity of injury or illness within a short time after their arrival, assign priorities, and transfer the patient to the appropriate place for treatment.

Emergency Medical Sevices (EMS): A service providing out-of-hospital acute care and transport to definitive care, to patients with illnesses and injuries which the patient believes constitute a medical emergency.

Emergency Triage, Treat, and Transport (ET3): A voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency healthcare needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call.

Harm reduction: Policies, programs, and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies, and drug laws.

Health Equity: The attainment of the highest level of health for all people. That requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

Health in all policies (HiAP): A collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people and recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities.

Health information exchange (HIE): The movement of health information electronically across multiple organizations.

Health information technology (HIT): The programs, services, technologies, and concepts that store, share, and analyze health information in order to improve care.

Health literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Health Professional Shortage Areas (HPSAs): Geographic areas, populations, or facilities. These areas have a shortage of primary, dental or mental healthcare providers.

Health Systems Plan (HSP): A roadmap for how to leverage DC's high-quality medical services and facilities.

Home health aide: A worker, usually trained and state-certified, who provides care for elderly, sick, or disabled people in their own homes.

Hospital surge: Describes the ability of a hospital to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of healthcare organizations to survive a hazard impact and maintain or rapidly recover operations that were compromised.

Intensive outpatient programs (IOPs): Treatment programs used to address addictions, depression, eating disorders, or other dependencies that do not require detoxification or round-the-clock supervision. They enable patients to continue with their normal, day-to-day lives in a way that residential treatment programs do not. Whereas residential treatment requires that clients reside on-site, clients in intensive outpatient programs live at home.

Implicit bias: A bias or prejudice that is present but not consciously held or recognized.

Medication-Assisted Treatment (MAT): The use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient's needs.

Medical home: A model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Medically underserved areas (MUAs): Areas or populations designated by Health Resources and Services Administration (HRSA) as having too few primary care providers, high infant mortality, high poverty, or a high elderly population.

Medical transport: Transportation services offered to patients and healthcare consumers who face extraordinary barriers getting to their medical appointments.

Multisector Collaborative: The partnership that results when government, non-profit, private, and public organizations, community groups, and individual community members come together to solve problems that affect the whole community.

National Emergency Department Overcrowding Score (NEDOCS): Estimates severity of overcrowding in emergency departments.

Peer recovery: A process through which people who share common experiences or face similar challenges come together as equals to give and receive help based on the knowledge that comes through shared experience.

Personal care attendant: Professionals that help people living with physical or mental disabilities perform day-to-day activities and lead normal lives.

Post-acute care: A range of medical care services that support the individual's continued recovery from illness or management of a chronic illness or disability. Post-acute care includes rehabilitation or palliative services that beneficiaries receive after or in some cases instead of, a stay in an acute care hospital. Depending on the intensity of care the patient requires, treatment may include a stay in a facility, ongoing outpatient therapy, or care provided at home.

Primary care: A patient's main source for regular medical care, ideally providing continuity and integration of healthcare services. All family physicians, and many pediatricians and internists, practice primary care. The aims of primary care are to provide the patient with a broad spectrum of preventive and curative care over a period of time and to coordinate all the care that the patient receives.

Primary care engagement: Combines patient activation with interventions designed to increase activation and promote positive patient behavior.

Quality improvement: The framework used to systematically improve the ways care is delivered to patients. Processes have characteristics that can be measured, analyzed, improved, and controlled.

Racism: The marginalization and/or oppression of people of color based on a socially constructed racial hierarchy that privileges white people.

SBIRT: Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders.

Sobering centers: Facilities that provide a safe, supportive, environment for mostly uninsured, homeless or marginally housed publicly intoxicated individuals to become sober.

Social determinants of health: Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.

Structural racism: The macro-level systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups.

Telehealth: The use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Transitional housing: Supportive – yet temporary – type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, support (for addictions and mental health, for instance), life skills, and in some cases, education and training.

Transportation equity: Accessible and affordable transportation for everyone in the community resulting in fair distribution of transportation resources, benefits, costs, programs and services based upon differences in income, ability, and other factors affecting transportation choice and impact.

Urgent care: A walk-in clinic focused on the delivery of medical care for minor illnesses and injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department.

Value-based payment: A concept by which purchasers of healthcare (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care.

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STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

2021 ANNUAL IMPLEMENTATION PLAN FINAL REPORT