Human Services, Social Services, and Health Committee Recommendations to the ReOpen DC Advisory Group Steering Committee

May 21, 2020

For more information, and to see the ReOpen DC Advisory Group Steering Committee's full recommendations, please visit https://coronavirus.dc.gov/.

COMMITTEE MISSION & FOCUS

More than 6,500 DC residents have been infected by COVID-19, and more than 350 have died. Eighty percent of people who have succumbed to COVID-19 in DC are African American, and about a quarter of them are in a vulnerable population, including those living in senior facilities, group homes, detention centers, and homeless shelters. On the other hand, the highest incidence rates for COVID-19 illness are in Wards 4, 5, 7 and 8 where many essential workers live. The District invests heavily in our residents, with health and human services expenditures making up approximately $5 billion of our $15.5 billion annual budget. The District also boasts one of the highest levels of insured individuals in the nation, but our health outcomes do not mirror these investments.

The committee focused on ensuring that our investments in the COVID-19 recovery continue to make the District's healthcare and social services delivery systems more accessible to all residents, and that vulnerable children, families and communities, in particular, have access to services they need, including testing; primary, specialty, behavioral health, and hospital care; and social supports such as shelter, permanent housing, food, income replacement services, and protections to prevent child abuse and neglect. The committee evaluated, among other things, the financial toll that the crisis has taken on providers, how crisis standards of care can be safely stepped down, the impact of elective procedures at area hospitals and psychiatric facilities, how to safely perform essential dental procedures and fully begin primary care services on site, and how to make our systems better prepared in terms of a local supply distribution system. In addition, the committee studied how to ensure that vulnerable residents, including those experiencing homelessness, those with behavioral health needs, and young people in our child welfare system, can continue to safely access benefits, as well as be healthy and protected.

The committee's recommendations – for Phase 1 of reopening – are based on six guiding principles, around which specific actions were identified. These six guiding principles are (1) provide guidance for essential care; (2) ensure access to PPE, testing, contact tracing, equipment, supplies, and other safety measures; (3) accelerate the use of telehealth, technology, and connectivity; (4) stabilize the workforce; (5) employ effective communication strategies; and (6) focus on the District's most vulnerable residents.

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OVERVIEW & STATUS

CURRENT STATUS

The human services, social services, and health sectors have largely continued to function during the COVID-19 public health emergency, as they provide services that are critical to ensuring the health and well-being of District residents. However, all sectors have had to modify their operations to some degree.

The impacts of this emergency can be felt by the institutions themselves, their workforce, and those they serve. Many healthcare providers are experiencing a substantial decrease in patient visits, which is negatively impacting revenue. At the same time, both healthcare and social service providers are scrambling to purchase personal protective equipment (PPE) and confronting increased staff overtime due to decreased staff availability for a host of reasons. In addition to exposure to the COVID-19 virus, front-line workers are impacted by the Stay-at-Home Order, which has resulted in the closure of childcare facilities and schools and the reduction of transportation options. At the same time, they are dealing with the increased physical and mental stress associated with their daily work responsibilities.

To illustrate some of these challenges, the homeless services system has struggled to provide socially distant shelter, routine testing, and other protections, which have contributed to high rates of virus transmission within the system. The risks of the virus have also disrupted the lives of children and youth in foster care, creating additional hurdles to safe placement, family visitation, and permanency efforts. Simultaneously, preliminary data suggest that consumers' fear of seeking medical care in hospitals and emergency departments may be contributing to a

worsening of health conditions, further exacerbating health access disparities and health inequities and placing some children and youth at risk. The committee fears that medical care is being avoided during the Stay-at-Home Order, resulting in worsening health conditions for those impacted. For example, people are not getting appropriate cancer therapy; critical clinical preventive medicine such as control of high blood pressure, control of diabetes, pediatric vaccines, and access to mammography is limited; and there is reason to believe that some people with life threatening conditions like angina are not receiving care at all.

ASSESSING RISK BY SECTOR

The Human Services, Social Services, and Health Committee apportioned its work into five sectors: (1) hospitals; (2) doctors, dentists, maternal care, dialysis facilities, and nonemergency medical; (3) heath centers, skilled nursing facilities, long-term acute care facilities, home health care agencies, and assisted living facilities; (4) mental health; and (5) homeless services, public benefits, and child welfare. The matrix below (Figure 1) provides a risk assessment for each sector by examining contact intensity, number of contacts, and the degree to which activities can be modified.[1]

Figure 1. Risk Matrix by Sector

Sectors	Contact Intensity	# of Contacts	Modification Potential
Hospitals	High	High	Low/Medium
Doctors, Dentists, Maternal Care, Dialysis Facilities, and Nonemergency Medical	-	-	-
Doctors	High	Low	Low/Medium
Dentists	High	Low	Low/Medium
Maternal Care	High	Low	Low/Medium
Dialysis Facilities	High	Low	Low/Medium
Nonemergency Medical	High	Low	Low/Medium

[1] Adapted from: Public Health Principles for a Phased Reopening During COVID-19: Guidance for Governors. See page X for further description of risk assessment.

Health Centers, Skilled Nursing Facilities, Long-Term Acute Care Facilities, Home Health Care Agencies, Assisted Living Facilities	-	-	-
Health Centers	High	Low	Low/Medium
Skilled Nursing Facilities	High	High	Low/Medium
Long-Term Acute Care Facilities	High	High	Low/Medium
Home Health Care Agencies	High	High	Low
Assisted Living Facilities	High/Medium	Low	Low
Mental Health	High	High	Medium
Homeless Services, Public Benefits, Child Welfare	-	-	-
Homeless Services	High	High	Low
Public Benefits	Medium	Medium	Medium
Child Welfare	High/Medium	High/Medium	Medium

Hospitals

Acute- care hospitals have continued to operate 24 hours, 7 days a week during the public health emergency and represent the cornerstone of essential medical surge readiness in responding to COVID-19. In order to prepare for the possibility of a significant medical surge of COVID-19 cases, all District hospitals voluntarily suspended non-essential or elective surgeries and procedures. While the District has experienced a number of residents contracting COVID-19, social distancing and other mitigation steps have resulted in a gradual rise in cases, rather than the steep rise anticipated. Thankfully, hospitals have been able to respond to the demand placed on their services. On average, less than 25% of the District's staffed hospital beds are currently being utilized for suspected or confirmed COVID-positive patients.[2] On May 15, 2020,

[2] Data Source: DC Hospital Association COVID-19 Surge Capacity Tracker

hospitals will finalized medical surge capacity bed targets, and will be prepared to add another 1,632 surge beds to their current operating capacity of 2,530, for a total of 4,162 beds.

While hospital workers are critical to maintaining continuity of operations, the Stay-at-Home Order, inclusive of closures of schools and childcare services and reductions in transportation operations, has directly impacted the availability of essential personnel, at all levels, to meet workforce demands. Of even greater concern, many staff have been unable to work due to COVID-19-related self-quarantining or infection.

The financial impact of COVID-19 on hospitals is immense. DC hospitals have experienced revenue losses that exceed $150 million through the end of March, and these losses continue to mount. These losses are largely due to reductions in hospital admissions and the suspension of elective procedures. At the same time, immediate COVID-19 investments, associated with medical surge planning, exceed $35 million.

As discussed earlier, the data suggest that patients have not been seeking non-COVID-19 related health care, which promises to exacerbate longstanding health disparities in the District. As we move toward reopening, it is essential that patients feel safe coming to hospitals to receive treatment.

Hospital operations require a high number of intense contacts, in order to treat their patients. Due to the nature of these interactions, modification opportunities beyond protective equipment and actions to maximize social distancing around hospital entrances and waiting areas are minimal.

Doctors, Dentists, Maternal Care, Dialysis Facilities, and Nonemergency Medical

While the professional practices of doctors, dentists, maternal care, and other nonemergency medical care continue to some degree, current operations are being conducted in a vastly different fashion than business as usual. Outpatient health services are now being conducted overwhelmingly by phone or by telehealth. Naturally, not every person or condition can be properly evaluated via telehealth or telephonic care. The inability to have in-person patient visits is directly affecting the financial viability of many providers in the District, as well as the health of their patients. This situation is made worse by the fact that many patients are reluctant to seek in-person care because of the perceived risk of exposure to COVID-19, especially in the context of spread by people with minimal symptoms.

In most instances, physicians and dentists are limiting their patient visits to emergencies and are otherwise hesitant to treat patients in their offices. In the case of dentists, dental emergencies are being accommodated, but not by all providers.

Fortunately, dialysis services have continued during the public health emergency, albeit with substantial adjustments to protect the patient. These necessary, but costly, requirements strain resources for personnel, PPE, and space within facilities. In addition, patients requiring dialysis services must have safe transportation to dialysis centers, which can be difficult to arrange.

Providers in this sector frequently have close contact with their patients for a prolonged period of time, and while they can limit the number of patients in their offices at any one time, there are limited options for mitigation beyond proper protective equipment. Unlike hospitals, physician and dentist offices have little to no access to testing, yet may perform procedures that generate droplets. In particular, dental procedures often generate aerosols that are difficult to contain. Increasingly, however, dental centers are considering the use of existing teledental technology, such as handheld x-ray systems, to assess and diagnose patients.

Health Centers, Skilled Nursing Facilities, Long-Term Acute Care Facilities, Home Health Care Agencies, Assisted Living Facilities

Like other nonemergency medical services, health centers have been forced to make substantial changes to their operations in the face of COVID-19. They have seen a dramatic decrease in in-person visits, which has taken a heavy toll on them financially. To be sure, recent emergency regulations by the Department of Health Care Finance (DHCF) brought direct relief by permitting health centers to expand telehealth services to fee-for-service beneficiaries, allowing the patient's home to serve as a site of care, and permitting telephonic-only visits. In addition, Health Centers have at their disposal inexpensive software to address issues of personal data confidentiality.

Residential facilities such as skilled nursing facilities (SNFs), long-term acute care facilities, and assisted living facilities, as well as services provided in patients' residences through home health care agencies have continued to operate, but have made a number of changes to ensure that patients and providers are safe. These residential facilities have taken aggressive infection control measures, including restricting visitors, implementing screening procedures, and employing isolation when needed. Despite these measures, incident cases are still being identified.

Importantly, patients served by these provider groups continue to need care even when they have tested positive for COVID-19 or have been exposed and must self-quarantine. Across all of these providers, the ability to access PPE has been vital in ensuring that staff and patients remain safe. While providers are following the guidance provided by DC Health regarding proper use of PPE, some have had difficulty obtaining sufficient supplies.

While risk varies across this sector, these providers typically have intense and frequent contacts with their patients. This situation is made more perilous given the heightened risk of COVID-19

complications among this sector's patients, due to their age and preexisting conditions. Providers within this sector are implementing the modifications that are available to them, but these are largely limited given the nature of the care provided.

Mental Health

Behavioral health providers have continued to provide direct care to residents in need of mental health and substance use services. In particular, the public behavioral health network has continued to provide services, with approximately 63% of providers delivering services on a modified schedule and 37% operating on a regular schedule. Both face-to-face services and services via telephone or video applications are being conducted, but special efforts are being made to offer face-to-face services to those consumers enrolled in Assertive Community Treatment (ACT), Wraparound and Community-Based Interventions (CBI), and other intensive evidence-based practices.

Behavioral health providers are following the guidance provided by DC Health regarding proper use of PPE, but many have had difficulty obtaining sufficient supplies. The Department of Behavioral Health (DBH) has supplied providers with infrared thermometers to support their screening efforts to assist in ensuring that providers and patients are safe. Still, providers are reporting that their staff are apprehensive of the District's opening. As the transition from crisis standards of care is being contemplated, staff would like certain assurances, namely that they will have proper PPE, structural changes will be made within their facilities to ensure that the workplace environment is safe, social distancing strategies will continue to be followed to reduce transmission of the disease, and access to universal testing for the virus will be available. Providers have also expressed the need for financial support to offset recent increases in operating costs, such as from hiring contract staff and paying overtime wages. The average financial loss to date, among mental health and substance use providers, is 17% and 28%, respectively.

Many individuals who are diagnosed with mental health and/or substance use disorders are also experiencing homelessness, making identification and treatment more challenging. Further, the Stay-at-Home Order is more difficult to manage for residents who are experiencing homelessness, and the variety of settings in which services may be offered are more limited. Shortages of outreach workers may also impact the provisions of services to those who are experiencing homelessness.

At the same time, the Stay-at-Home Order and public health emergency have also increased the need for prevention-focused behavioral health supports throughout the broader District population, as well as front-line staff. DBH has undertaken a number of measures aimed at addressing these needs, including making their 24/7 Mental Health Help Line, which is staffed by licensed mental health clinicians, available to all DC residents experiencing anxiety,

depression, or behavioral health issues. In addition, information on strategies for addressing anxiety and depression are posted on the DBH website. Finally, DBH, in partnership with the Department of Human Services and the Office of the Chief Medical Examiner, is providing support to families grieving the death of a loved one due to COVID-19. These efforts include connecting families to burial assistance, food, rental assistance, and mental health services and support.

Services provided within the behavioral health system vary greatly, as do the number and type of contacts a provider might have. For example, some providers have both high intensity and frequent contacts. In these cases, the modification potential is low.

Homeless Services, Public Benefits, Child Welfare

Homeless services, public benefits, and the child welfare system have continued to serve their clients during the public health emergency, albeit with certain modifications. The homeless services system has implemented a number of changes to ensure the safety of individuals experiencing homelessness, including keeping shelters open 24 hours a day, 7 days a week; establishing isolation and quarantine sites; and standing up sites for older residents and those who are medically vulnerable. Semi-congregate settings have limited access to common spaces, and screening is happening at entry at all sites. Services available through the use of technology, such as telehealth and on-line opportunities, have been limited for individuals and families in shelter as access to computers or other devices are limited.

Opportunities to move people into permanent housing and Rapid Rehousing are constrained by resources and made worse due to the limited stock of affordable housing in the District. Importantly, legislative efforts have postponed the initiation of eviction proceedings for the duration of the public health emergency. Still, once the emergency is lifted, it is foreseeable that a surge in need will arise.

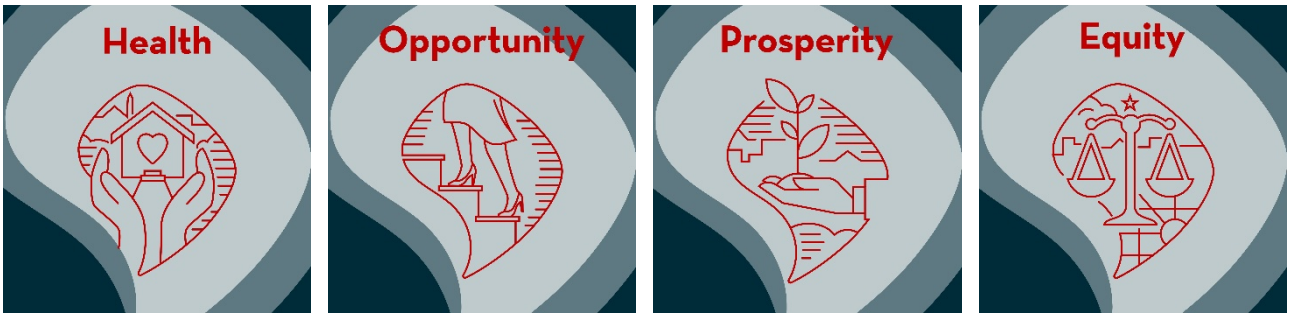
Within the homeless services system, both the intensity and number of contacts are high, contributing to the high number of positive COVID-19 cases in shelters. The Department of Human Services has implemented a number of changes to try to minimize exposures, but opportunities for modifications, including socially distant housing, are low, particularly in congregate settings.

Access to public benefits has been essential, as we see many people experiencing financial instability during the Stay-at-Home Order. Fortunately, flexibility has been built into the system to allow people to continue receiving existing benefits, as well as easily apply for new benefits. However, some of these changes, such as flexibility regarding recertification requirements, are only permitted by the federal government for a limited time period. The number and intensity

of contacts within this system are moderate, but there are some changes that can be made to ensure people are safe, while still accessing the benefits they need.

While the child welfare system has continued to function to ensure the immediate safety and welfare of children, there has been a significant decrease in the number of reports. As children are leaving the home less frequently, there are fewer opportunities for those who normally notice warning signs and report cases of suspected child abuse and neglect. In addition, for children in foster care, necessary opportunities for them to spend face-to-face time with their families and work toward successful reunification have been modified to ensure the safety of children, their families, and the workforce. Due to the necessary interactions that those working within the child welfare system must have with children and families to ensure that they are safe, the number and intensity of contacts is medium to high, but there are also some opportunities for modification.

MOVING TOWARD OUR VALUES



COMMITTEE APPROACH AND ENGAGEMENT

The Human Services, Social Services, and Health Committee created five subcommittees based on the five sectors outlined above, with work plans structured around the critical anchor of the District's HOPE values. For each subcommittee, community and government leaders used their expertise and the advice of colleagues in the District to analyze important information relating to their sector. The subcommittees reviewed matters such as current operating status, risk-mitigation options, lessons learned, and challenges and opportunities as we move forward. Each subcommittee met separately to discuss their priorities and consulted with sector experts. The entire committee held three general meetings with presentations focused on making sure that the committee's recommendations were equitable and prioritized the health and safety of District residents.

The committee leadership then reviewed the subcommittees' recommendations and developed a comprehensive report for the Human Services, Social Services, and Health Committee that aligns with public expectations, while emphasizing the need to improve the

quality –of life of all District residents. This report will provide guidance and support to DC's health and human services providers, their employees and the residents whom they serve.

Throughout this process, the members of the Committee considered their recommendations in the context of feedback from stakeholders and residents across all eight wards through focus groups, interviews, the ReOpen DC Survey, and Mayor Bowser's Virtual Town Hall. These community engagement methods were designed to ensure that residents and stakeholders had a seat at the table during this process and could share their thoughts and perspective. This resulted in high-quality public interactions with insightful recommendations and critiques for the Committee's consideration. All stakeholders that were engaged in this process are listed in Appendix A.

ReOpen DC Survey

The District's ReOpen DC Survey included responses from over 15,000 District residents, workers, and business owners who provided their thoughts on the challenges the District will face in reopening, and offered ideas and suggestions for the reopening process. Two areas under the purview of the Human Services, Social Services, and Health Committee, vulnerable populations and personal and family health, were among those that respondents were most concerned about. 83% of respondents expressed concern for vulnerable communities, with 44% of respondents reporting that concern for vulnerable communities "keeps them up at night." Respondents noted that shelter residents are particularly vulnerable and asked that all shelter residents be provided testing and more PPE, and that shelter capacities be reduced to allow for additional social distancing by moving more residents into hotels or other temporary shelters. In addition, 64% of respondents expressed concern for their own or their family's health with 29% of respondents reporting that concern about their personal or family health "keeps them up at night." Many respondents suggested that additional testing is needed across the District.

Several respondents also provided ideas and suggestions for the committee's consideration. Suggestions included increasing opportunities for telehealth and maintaining this option beyond the current pandemic; waiving licensure requirements for social workers and allowing new graduates with a masters degree in social work to practice immediately; allowing nursing home residents some time outside to improve their mental health; providing and encouraging the use of free washable masks for all DC residents; quickly reopening elective and other non-COVID medical procedures to avoid a rush on these services once they are available; providing better access to PPE; ensuring clear guidelines are in place regarding allowable medical procedures; and waiving application fees for and providing free medical marijuana for all low-income residents.

Stakeholder Focus Groups

The Committee conducted three focus groups to gather ideas and input for reopening and learn more about stakeholders' experiences during the Stayat-Home Order. These groups consisted of social services providers and advocates, long-term care and home health providers, and individuals with lived experience of homelessness. Across all sectors, several unifying issues emerged including requests for the District to provide devices and internet connectivity to residents to enable them engage in virtual care and education; ensuring workers and clients have access to testing and PPE; maintaining certain flexibilities that were in place during the Stay-at-Home Order as the District reopens; and preparing for the increased service needs that may come when the District reopens.

Within the social services sector, providers noted that the Stay-at-Home Order created several challenges for their workforce and clients, including reduced transportation options, fewer available resources, limited options for meeting benefit work requirements, and mental health challenges. As the District reopens, providers were concerned about the increased need for social services and the impact of budget cuts on critical services, and requested that changes that were made during the Stay-at-Home Order such as online applications, leniency in recertifications for public benefit programs, and emergency relief measures continue after the District reopens. Participants also noted new opportunities for the District Government during reopening such as creating local food grants, flexing capacity between virtual and face-to-face services, and developing reskilling programs for people whose jobs may not immediately return. With regard to communication and outreach, participants noted that reliable and accurate information regarding COVID-19 has not been available across all areas of DC, and suggested that the District provide households with communication kits upon reopening to encourage safe practices when re-engaging. Further, they said that the DC Government needs to find ways to communicate with undocumented residents who may not want to be known to government systems.

Among individuals with lived experience with homelessness, there was concern about the potential vilification of people experiencing homelessness, greater incidence of COVID-19 among people experiencing homelessness, and the need for enough PPE and cleaning supplies to practice recommended social distancing and sanitization procedures in shelters. They emphasized that word of mouth can be a strong method of communication and that the District should consider prioritizing communications outreach near government offices and Metro stations, as well as through community partners who provide in-person outreach. Participants noted that housing is the primary issue for individuals experiencing homelessness and suggested that the District use reopening as an opportunity to create more options for safe shelter and permanent housing. These suggestions included converting empty office buildings into temporary wellness centers, using empty apartment or hospitality units as shelters, and using vacant apartment buildings as housing units for individuals experiencing homelessness.

Other issues of concern to participants as the District reopens include childcare availability and the capacity of District agencies to handle any backlog of cases related to the pandemic.

Long-term care and home health providers both identified the availability of both PPE and staff as continued challenges. Staff exposure to the virus has reduced availability, and some staff have declined to take cases, opting to file for unemployment instead of providing care to COVID-positive patients. As the District reopens, providers stated that rapid testing will be critical and expressed concerns about bringing families back into nursing homes. They shared that a public awareness campaign and literature for nursing homes on how people can safely visit and what procedures need to be followed would be beneficial. Participants also suggested that individuals who are recently unemployed can be recruited to work in these fields, but training opportunities are needed to do so. Finally, hazard pay and home-delivered meals were noted as helpful initiatives during the Stay-at-Home Order that providers would like to see continue once that is lifted.

Council of the District of Columbia

Councilmembers Brianne Nadeau, Chair of the Committee on Human Services, and Vincent Gray, Chair of the Committee on Health, joined the first Committee meeting to present key issues relating to COVID-19's effect on the District, and to highlight ideas and opportunities regarding the ReOpen DC initiative. Councilmember Nadeau stressed the importance of ensuring safety and availability of shelters, while also highlighting the need to reduce shelter density. Additionally, she emphasized the need for counseling and support for those working in all healthcare settings. Councilmember Gray spoke on the disproportionately high percentage of African Americans in the District suffering from COVID-19, and the need to build an improved healthcare system in Wards 7 and 8, as well as expressing a need to invest in grocery stores and early childhood education East of the River.

OPPORTUNITIES

Technology Platforms

The Stay-at-Home Order created a favorable environment for the use of technology platforms for healthcare visits, behavioral health consultation and treatment, crisis services, and child welfare worker and family visits. In many cases, technology was the only way to provide needed services and care for residents. Technology can be beneficial to providers and those they serve for a number of reasons, particularly in an environment where there are still risks to in-person interactions.

At the outset of the public health emergency, the Department of Health Care Finance promulgated emergency regulations that provided additional opportunities for Medicaid beneficiaries to use telehealth, including allowing a beneficiary's home to serve as an originating site for care; allowing reimbursement for telehealth services for all Medicaid

beneficiaries, including fee-for-service; and providing flexibility for telephonic-only visits. These actions created opportunities for patients to receive care in new ways and helped ensure they were able to get needed treatment during the Stay-at-Home Order.

As the District begins to reopen, many patient-clinician and client-provider interactions may still be most appropriately conducted via technology such as telehealth or other alternative modes of delivery. For example, telehealth is effective and efficient in closely monitoring patients with chronic diseases. Providers should continue to consider technology that will enhance care, including teledental and telebehavioral health services. Appropriate reimbursement to support these services is paramount and continued reimbursement will be needed to support its use.

As we move forward, additional support is needed for both providers and residents regarding the use of technology, and access to devices and the internet. We need to continue to evaluate the broad application of telehealth, across conditions and populations, to monitor its effectiveness and the safety of data exchange. Healthcare providers need training to ensure that they have the resources and expertise needed to perform telehealth successfully. These resources include general knowledge about how to implement various telehealth services, including provider workflows, equipment, and proper and safe usage. Healthcare and human services providers and residents also need to have adequate hardware, software, and bandwidth to have appropriate clinical and service-related interactions. This need is particularly critical from the lens of equity, as all residents do not have equitable access to smartphones and internet access.

Workforce Sustainability and Development

The public health emergency has placed additional stressors on front-line workers. While these needs have become more acute during this crisis, we have the opportunity to build long-term supports for the health and human services workforce. As we prepare for the impact of anticipated COVID-19 post-traumatic stress, we must build resiliency models to support the front-line workforce, including an expanded supply of mental health services for workers. In addition, we can increase training and education to ensure readiness of all health and human service workers for emergency preparedness and response protocols. Simultaneously, we need to prepare additional surge capacity within District hospitals, as well as ensure that the broader health and human services system has the staffing capacity needed to meet increased demands. Certain regulatory changes may help ensure that the District can accomplish these objectives, including recognizing professional licenses from out of state providers, such as doctors, nurses, social workers, and other professions. Finally, as the District reopens, there will likely be an increased need for services related to mental health, child welfare, and housing. It will be critical that the District ensure our workforce has the capacity to meet these demands.

Care Coordination

Throughout the public health emergency, we have seen the need to accelerate the creation and implementation of care coordination models. Both technological and non-technological solutions can assist providers in transitioning patients between healthcare settings or to allow them to remain in existing settings. For example, the use of technology to assist in treating individuals in skilled nursing facilities (SNFs), such as with remote patient monitoring, as well as allowing the on-site SNF staff to connect with other providers, can result in better medical outcomes and decreased risks associated with transport to an acute care facility. Federally-qualified health centers, community health centers, and SNFs can enhance their coordination by using telemedicine, teledental, and telebehavioral health to treat individuals, including providing support to individuals as they are transitioning back into the community. Behavioral health providers can utilize technology platforms and in-person services to increase coordination between in-patient and residential facilities and community providers as people in care move between levels of care. Care coordination is vital for stabilizing families and individuals experiencing or on the brink of homelessness, as providers work to ensure they have the resources they need. Further, in order to prevent unnecessary entry into foster care and to support family reunification and other forms of permanency, care coordination between the child welfare, the health and behavioral health systems, public benefits, and the family court must be maintained.

These services are essential to ensuring that residents are appropriately connected and retained in care. These types of care coordination models will maximize the opportunities to continue progress toward a value-based care environment, as well as serve as an indispensable conduit for advancing health equities.

LESSONS LEARNED FROM THE STAY-AT-HOME ORDER

Sector Coordination

Increased coordination across a number of areas would have permitted a more robust response to this crisis. Foremost, an uncoordinated supply chain management model forced hospitals and other providers to compete against each other, state governments, and large corporations for product, creating a seller's market that favored sales for PPE and lab supplies based on size and ability to order supplies in large quantities. Understanding where and how PPE can be easily obtained in the future will help ensure that services can be appropriately provided in future crises. Relatedly, access to testing was uneven and remains an important consideration for resuming business as usual across the various committee sectors. Moreover, the challenges associated with executing a coordinated testing scheme diminished our ability to leverage and coordinate important data to provide real time situational awareness and disease surveillance, which could have permitted a more unified response to the emergency across the District and region. Finally, concerns related to acute care surge capacity – both staffing and facilities – require immediate attention and resolution.

Impact on Necessary Services

As discussed earlier, paring down hospital services to a COVID-19-only operation contributed to an environment in which consumers avoided seeking needed healthcare services. We also learned the extent of how underdeveloped our telehealth infrastructure is and the disparities between various health sectors and populations in utilizing these technologies. There is an urgent need to get internet throughout the entire city, potentially through the use of a public-private partnership, and to ensure that residents have access to telecommunication devices. This lack of infrastructure not only has negative repercussions for patient health, as many sick patients, older adults, and those with behavioral health needs could not connect to care via telemedicine, but has also contributed to the financial instability of hospitals and other health care providers. Early communications regarding the ability of the healthcare system to treat non-COVID-19 patients might have mitigated this fear and helped ensure that patients were still seeking care for other conditions.

Similar impacts can also be seen in the social service sector. Reports to the Child Abuse and Neglect Hotline were significantly down, with less than half the calls received from March 16 to April 18, 2020, compared the same time period the year before. Importantly, while residents were able to delay recertification for public benefits during the Stay-at-Home Order, particular attention will need to be paid to ensuring residents recertify once that flexibility is lifted.

Emergency Preparedness Education

Throughout the continuum of care, there is a need for emergency preparedness education and training to ensure consistency in protocols and standards for both providers and patients. While some sectors of the health care system may have been prepared for the current public health emergency, others had not. For example, ambulatory care facilities, dialysis facilities, and other providers were not prepared for this pandemic or related major disasters; neither the layout of the facilities nor the ventilation systems are engineered to protect the occupants from the spread of respiratory-borne pathogens. Moving forward, healthcare facilities should be specifically designed to be safer for healthcare workers and patients alike.

CHALLENGES

Financial Stability and Resiliency

Many providers are facing serious financial challenges, both from a lack of revenue and increased costs related to supplies, overtime, staffing, facility modification, and childcare as a result of the COVID-19 emergency. These impacts are even more acute for certain segments of the healthcare system: clinics that serve Wards 7 and 8, for example, have been disproportionately impacted by this crisis. In addition, smaller providers, federally ualified health centers (FQHCs), and community health centers are especially dependent on timely reimbursement from insurance companies, which may become less certain in this unpredictable time. In the case of FQHCs, care models are based on looking at the whole

person; FQHCs are not just providing health or mental health services but are also assessing for food insecurity, housing insecurity, and risks for child abuse or neglect and domestic violence, among other conditions. The need for these services is growing and will continue to increase even after the District flattens the curve. Meanwhile, government services and grant opportunities are expected to diminish. Further complicating matters is the fear that patients will avoid seeking necessary medical care, due to lingering concerns about the COVID-19 virus. This reality, coupled with changes in the payor mix due to job losses, creates a potentially devastating financial outlook for nearly all health providers, payors, and the District. Under the circumstances, it is foreseeable that both small practices and larger multi-physician practices will need financial support; otherwise, the District may be at risk of losing a significant proportion of its healthcare access capacity.

Supply Chain and PPE Needs

A lack of sufficient access to and transparency regarding national stockpiles, when needed, created significant challenges across the health and human services sectors. In a context in which many who are transmitting COVID-19 have minimal symptoms and shortages of testing supplies, the availability of PPE has been paramount to protecting essential worker and especially front-line healthcare workers. Nearly all providers – hospitals, clinics, long-term care facilities, child welfare workers, group home providers, and homeless service providers, among others – lacked adequate access to PPE during this crisis. This was further exacerbated by the lack of coordination discussed earlier, which created inequitable access and distribution of PPE across the supply chain. Smaller providers, especially safety net providers, often lack the funds necessary to purchase and stockpile emergency supplies, even when PPE is available. In times of emergency, immediate financial assistance is essential. Going forward, equity should ensure that these providers are afforded the resources needed to treat and serve their communities, not just during the reopening period, but also within the "new normal" environment. Otherwise, the District will continue to see higher rates of COVID-19 cases among its essential workers including those in the health sector.

Funding Limitations

While the District has worked to put in place waivers regarding funding from the Center for Medicare and Medicaid Services, restrictions still remain regarding both federal and local funding that create challenges for providers. For example, while the CARES Act provides additional federal funding to health and human services organizations, much of this emergency funding is designated for a specific purpose or program impacted by COVID-19, and cannot be easily reallocated to individual organizations' most pressing needs beyond payroll. For those organizations with existing federal grants, there is additional complexity to integrate CARES Act funding with ongoing federal awards. This poses mid-term risk of leaving federal funds on the table as individual organizations navigate grants management, audit, and compliance matters related to these federal awards. Similarly, additional local funding has been made available, but

may not fully account for capital improvements that may be needed to allow for social distancing, additional costs when foster children are home from school, or additional protections that may be needed by workers and clients.

Public confidence

Without widespread, coordinated testing within the metropolitan area, the public is unlikely to be comfortable resuming normal activities related to health and social services. Many may postpone nonessential, but necessary, procedures or services rather than put themselves in a situation that they perceive as risky. It is essential that regularly scheduled communication be continued to keep the community informed and address questions and concerns. This includes the continuation of regularly scheduled Mayoral press conferences, virtual town hall meetings held by public officials, and public service announcements.

Social Determinants of Health

Individuals with lower incomes across the District, but especially in Wards 7 and 8, often have less access to healthy food choices, fewer employment opportunities, reduced transportation options, and other challenges that contribute to health inequities. These problems have been exacerbated during the Stay-at-Home Order and may become more acute as we move toward reopening. Lower income individuals typically have little to no savings and are not in a position to weather losses to their income. Even modest reductions in income impact their ability to meet basic necessities, including food, medicine and rent. Without question, this situation compounds the mental health stresses already associated with the challenges of having less income. Focused attention on this community and their needs is critical.

REOPENING GUIDANCE AND PREPARATION

PRIORITIZATION AND PHASING OF SECTORS

The human services, social services, and health sectors have remained open, at least to some extent, during the Stay-at-Home Order. With this in mind, the committee focused its efforts on improving service delivery, as we move to the "new normal," as well as considering how to reopen those services that have been put on hold. As the District attempts to prioritize those services in need of reopening, ranking should be based on the services that are most critical to residents' health in the mid-term, including cancer screening, diagnosis, and treatment; management of chronic conditions; childhood immunizations, developmental assessment, and preventative care; pregnancy and postpartum care; behavioral health treatment; and dentistry. Similarly, within the human services sector, the District should prioritize the reopening and improvement of services that are required to protect the well-being and safety of residents, with consideration given to federal flexibilities that are only in place for a limited timeframe.

The committee drafted its recommendations with certain underlying objectives: (1) continue to prioritize the safety and well-being of all workers, patients, clients, children and youth, and the community at large; (2) pursue strategies leading to the economic recovery of the District and region, with a particular focus on the sectors included herein; and (3) create innovative high-quality service delivery models, with an emphasis on technology and care coordination, for the present and future of health and social services — in the District, the region, and nation.

For Phase 1, the committee recommends certain principles that apply to all of sectors in the human services, social services, and health fields. These initiatives include

1. **Provide Guidance for Essential Care:** Position hospital, healthcare, and social service industries to progressively resume full offerings of services and business operations in a safe and efficient way.
2. **Ensure Access to PPE, Equipment, Testing, Supplies, and Other Safety Measures:** Create more equitable access, availability, and distribution across the supply chain for personal protective equipment, testing, and other supplies, as well as opportunities to ensure social distancing.
3. **Accelerate the Use of Telehealth, Technology, and Connectivity:** Leverage acceptance of telehealth and other new and innovative models of service delivery to accelerate and sustain positive changes in treatment and behaviors. At the same time, promote care coordination services, as a means to connect residents to physical and behavioral health services, as well as to retain clients in prevention and treatment services.
4. **Stabilize the Workforce:** Build resiliency models to support and expand the workforce.
5. **Employ Effective Communication Strategies:** Promote communication and outreach strategies to mitigate fear and promote the importance of seeking essential services in a timely fashion and, doing so in the most appropriate setting.
6. **Focus on the District's Most Vulnerable Residents:** Prioritize reopening strategies that ensure the District's most vulnerable residents have access to the care and resources they need.

Proposed prioritization and phasing of the reopening of each sector are described in Figure 2, below.

Figure 2. Proposed Prioritization and Phasing

Initial Round	Second Round
Hospitals • Continue efforts to preserve inpatient capacity. • Perform outpatient and some short-stay surgeries and procedures that have a low impact on resources. • Special attention should be given to those conditions and procedures that contribute to an increase in patient mortality and morbidity by further delaying treatment. • Significant consideration should be given to the need for inpatient hospital utilization, need for PPE, and blood product utilization before proceeding with these procedures. • All surgeries and procedures should be prioritized and performed if delay results in: (1) threat to the patient's life; (2) threat of permanent dysfunction of an extremity or organ system; (3) risk of cancer metastasis or progression; or (4) risk of development of severe symptoms.	**Hospitals** • If adequate inpatient capacity exists, perform all other surgeries and procedures making case-by-case, clinical determinations that such surgeries and procedures can be performed safely from clinical and environmental perspectives. • Restarting such surgeries and procedures should continue to be predicated on minimizing adverse patient outcomes associated with delayed care, minimizing surgical risk to patients, minimizing community and iatrogenic transmission, and preserving PPE. • Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate.
Doctors, Dentists, Maternal Care, Dialysis Facilities, and Nonemergency Medical • Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate. • Prioritize opening elective medical and dental care that is essential, based on the time urgency for care and the necessity of face-to-face medical care. • Address essential pediatric and maternal care, by working with providers to identify the safest possible ways to provide preventative care.	**Doctors, Dentists, Maternal Care, Dialysis Facilities, and Nonemergency Medical** • Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate. • Continue to open elective medical and dental care, focusing on minimizing adverse patient outcomes associated with delayed care, minimizing risk to patients, minimizing transmission, and preserving PPE.
Health Centers, Skilled Nursing Facilities, Long-Term Acute Care Facilities, Home Health Care Agencies, Assisted Living Facilities • Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate. • Prioritize opening elective care that is	**Health Centers, Skilled Nursing Facilities, Long-Term Acute Care Facilities, Home Health Care Agencies, Assisted Living Facilities** • Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate. • Continue to open elective care, focusing on minimizing adverse patient outcomes

becoming essential, based on the time urgency for care and the necessity of face to face medical care. • Visitors to senior living facilities should continue to be prohibited unless medically necessary.	associated with delayed care, minimizing risk to patients, minimizing transmission, and preserving PPE. • If proper protocols regarding hygiene, screening, and social distancing can be established, visits to senior care facilities can resume.
Mental Health • Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate. • Expand services to address increased domestic violence, child sexual abuse and exploitation and domestic violence that is the result of the Stay-at-Home requirement, as well as collective community trauma resulting from the impacts of the virus. • Prioritize opening care that requires face-to-face care, such as intensive evidence-based practices.	**Mental Health** • Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate. • Continue to expand services that will address increased needs as a result of the virus and the public health emergency. • Continue opening face-to-face services, prioritizing those most needed to help stabilize patients, while minimizing the risk to patients, minimizing transmission, and preserving PPE.
Homeless Services, Public Benefits, and Child Welfare • Maintain and expand hotel capacity both for vulnerable clients and those who have tested positive for COVID-19, as well as for those needing respite care. • Continue offering expanded shelter and food access, including keeping shelters open 24 hours per day, 7 days per week. • Continue to conduct eligibility for homeless services for families remotely. When in-person visits are needed, utilize a staggered schedule for staff. • Maintain emergency housing protections, including eviction delays. • Continue to use the online submission portal to allow individuals to apply for benefits remotely. • Plan for the safe resumption of in-person visits for system-involved families on a staggered timeline based upon safety and permanency planning timeline. As in-person case work resumes, prioritize high-risk cases for in-person meetings first, while assuring safety to the extent	**Homeless Services, Public Benefits, and Child Welfare** • Maintain hotel capacity both for vulnerable clients and those who have tested positive for COVID-19, as well as for those needing respite care. • Begin resuming normal shelter hours and procedures, evaluating options to continue to keep residents safe. • As eviction delays and other housing protections are rolled back, prepare for an increase in housing instability by increasing shelter capacity, and facilitating transitions to permanent housing to ensure social distancing can be maintained. • Begin reopening in-person service centers for public benefits, using modified schedules and other mitigation procedures to keep staff and clients safe. • Continue to resume in-person case management across the social services sector, prioritizing cases based on risk and assuring safety to the extent possible. • Continue to prepare for increases in hotline calls as the District continues to

possible. • Continue to connect with children, families, and foster caregivers remotely, when possible. • Prepare for a surge in hotline calls regarding child welfare when the District re-opens by ensuring adequate capacity in hotline and investigation divisions. • Reach out to all older youth about to exit foster care to ensure they know they can remain in care longer and be supported for finding housing and employment.	reopen and all students return to school. • Increase access to judicial hearings when needed to promote permanency and comply with permanency timelines. • Enhance capacity for connectivity for people in shelter and other congregate facilities to support sheltering in place and remote service provision.

To support the proposed phased reopening, as discussed above, the committee has developed several recommendations that apply to all sectors under the committee's purview. These recommendations are listed below, in Figure 3. In addition, other sector-specific recommendations are included in Appendix B.

Figure 3. Proposed Recommendations for Reopening – All Sectors

All Sectors
Provide Guidance for Essential Care • Provide clear and explicit guidance regarding workflow, patient, staff, and visitor safety that are fully implementable by the entity to whom the guidance applies. Provide tools (e.g., PPE) and capabilities (e.g., testing) for those entities that lack the resources or expertise to fully adhere to the guidance on their own. • Align guidance and efforts to reopen with our geographic partners in Maryland and Northern Virginia to ensure the reopening strategy supports equitable revitalization of providers. • Include flexibility in policies governing the resumption of services to ensure adjustments can be made in response to any changes in public health conditions or surge in COVID-19 cases. At the same time, recognize the risk-risk tradeoffs, including the consequence associated with delaying routine preventative health care. • Maintain some temporary administrative and reimbursement waivers that have supported new models of healthcare delivery, along with a few targeted expansions. • Ensure compliance with the mandates of the Language Access Act of 2004 across all agencies and sectors. **Ensure Access to PPE, Equipment, Testing, Supplies, and Other Safety Measures** • Take steps to ensure the health and well-being of health and human service workers and their patients and clients via District-wide support for increased COVID-19 testing and contact tracing and management, as well as consistent and reliable access to PPE and other supplies, as appropriate. • Consider new funding and supply chain models, including supply chain management models and a designated funding pool for the need-based purchase of PPE for front-line workers within these sectors. • Offer universal, ongoing testing, particularly among vulnerable populations, with a focus on outreach and access for individuals experiencing homelessness or housing

instability, and those in the child welfare system.

Accelerate the Use of Telehealth, Technology, and Connectivity

- Utilize telehealth and other technology for services that have been offered successfully via such mechanisms during the Stay-at-Home Order, and expand the reimbursement for and use of technology for other services.
- Provide assistance to providers and residents to enable them to use telehealth and other technology solutions, with a focus on ensuring equitable access. This includes ensuring that residents have access to devices and internet connectivity, and providing technical assistance and other resources to providers.

Stabilize the Workforce

- Address trauma and fatigue among front-line staff, including anticipated COVID-19-related post-traumatic stress, by expanding the supply and capacity of mental health services for front-line workers and encouraging support for Employee Assistance Programs.
- Institute strategies to increase the available professional workforce, including reciprocity and other licensure strategies.

Employ Effective Communication Strategies

- Invest in a communications strategy related to "seeking medical care" that fully engages health and behavioral health care providers, public/private partnerships, and other key stakeholders, and focuses on mitigating fear and myths in the wake of COVID-19. Such strategies should promote health equity and improve health literacy for all DC residents, as well as leverage acceptance of new models of care delivery to sustain positive changes in behaviors.
- Promote recruitment and engagement of trusted community leaders, including community health workers and other grassroots constituencies, to serve as "messaging" ambassadors for positive communications on the appropriate use of healthcare services (right care, right time and right place).

Focus on the District's Most Vulnerable Residents

- Address social determinants of health, including the need for rental assistance and the associated vouchers, supported employment opportunities and food availability.
- Increase access to care and services through 24/7 availability of services, integrated healthcare models, reimbursement to support "in-reach" and "outreach," and expanded services for residents who may have been harmed during the Stay-at-Home Order, such as victims of domestic violence and child abuse.
- Develop additional capacity for services to prevent trauma, address behavioral health needs, and help families manage through the pandemic.
- Maintain the District's commitment to health insurance coverage for all residents by preserving robust levels of Medicaid and Alliance coverage and upholding the District's individual health insurance requirement.

Potential Metrics

Metrics that focus on capacity, PPE availability, and testing and contact tracing capabilities will help the District and providers ensure that the health and human services systems are meeting, and can continue to meet, the needs of District residents. These include, but are not limited to:

- Changes in the number of COVID-19 infections and associated deaths;
- Hospital admissions and ICU bed usage;

- Utilization measures to monitor non-emergency services;
- Days-on-hand of PPE and other appropriate supplies;
- Testing and contact tracing capabilities;
- Adverse changes in morbidity and mortality that may be attributable to reduced access to healthcare and clinical prevention;
- Incidence of new COVID-19 infections among providers in the health and human services sectors;
- Availability and accessibility of mental health and substance use service providers in each ward;
- Number of individuals who receive an initial behavioral health service who are retained in care as indicated by their treatment plans;
- Number of individuals who contact the Mental Health Support Line for anxiety or depression related to the pandemic and are connected to care;
- Number of individuals moved from PEP-V and ISAQ sites to permanent housing;
- New infections and deaths of people experiencing homelessness;
- Incidence of child abuse and neglect;
- Foster care placement stability; and
- Number of people without gaps in coverage when they are scheduled to recertify.

MITIGATION AND GUIDELINES FOR REOPENING

Consistent and reliable access to PPE, testing, and other supplies and equipment will be of the utmost importance to ensuring that health and human service workers and patients can remain safe and healthy as we reopen. The District must ensure there is a commitment to protecting patients and workers as it moves into a new phase of health care delivery. This will require our collective efforts in continuing to flatten the curve of new COVID-19 infections. As such, community adherence to safety measures to slow the spread of COVID-19 remains a top priority.

Hospitals and other healthcare providers must be positioned to progressively resume their full offerings of services in a safe and efficient way. As we move toward reopening, the District's providers will need clear and consistent guidance to keep their workforce and patients safe. The Department of Health (DC Health) should develop general guidance on the ethical allocation of scarce resources among patients, occupational health priorities, facility cleaning and environmental protocols, and facility plant recommendations. At the same time, DC Health should consider developing sector-specific guidance, particularly related to the dentistry and dialysis sectors, as well as best practices for maximizing physical distancing in social services and ambulatory office spaces, especially in waiting rooms and behind registration desks.

Finally, providers in these sectors should embrace the well-known "hierarchy of controls":

- **Physical Distancing:** Wherever possible, providers should have their staff work from home. This should include restructuring responsibilities to minimize the number of

workers that need to be physically present. As we begin fully opening all of the sectors under the committee's jurisdiction, and until there is a vaccine, physical distancing should be practiced to the maximum extent possible. While opportunities may be limited, some facilities may be able to modify their physical layouts to create more physical distancing. For example, if there is more than one door, offices can have a separate entrance and exit for people who are most vulnerable. Offices also can eliminate crowding in waiting areas by using smartphones to call people in.

- **Engineering controls:** While creating physical barriers between people is less preferable, these controls can be effective in reducing coronavirus spread. For examples, providers may consider creating separate air handling areas to prevent spread of aerosols from patient to patient in ambulatory settings. Engineering controls could be particularly important in the case of dentistry, which generates a lot of aerosols that are not well contained or removed, creating the risk of patient-to-patient spread with procedures.
- **Administrative controls:** Though less desirable than engineering controls, providers should consider redistributing responsibilities to reduce contact between individuals and use technology to facilitate communication. Administrative controls are already widely being applied today in the form of telehealth and other means of providing care to avoid contact. However, there are additional administrative measures that can be taken such as alternative locations for delivering immunizations (for example in schools and pharmacies), or providing other preventive measures in alternative facilities where it is easier to assure a greater level of physical distancing between clients.
- **PPE:** Though it is the least preferable control measure, PPE is still extremely important given the inability to fully implement physical distancing, engineering controls and administrative controls in existing facilities.

Figure 4. Proposed Phase 1 Mitigation and Guidelines by Sector

Sector	Mitigation Guidelines
Hospitals	• **Physical Distancing:** To the extent possible, hospital administrative staff should consider continuing to telework. Hospitals should consider opportunities to limit patient interactions, including in entrances and exits, and waiting rooms. • **Engineering Controls:** Where possible, healthcare providers should consider creating physical barriers to reduce patient exposure. • **Administrative Controls:** Telehealth should continue to be used to the extent that care provided is adequate. Forging telehealth relationships with other providers can reduce the need for emergency department (ED) visits and in-patient hospitalizations. For example, increased remote patient monitoring of SNF patients may prove helpful in preserving acute care capacity. For some COVID-19 patients, remote patient monitoring can allow them to remain at home, until hospitalization is needed, thus potentially preserving space during a true surge. • **PPE Requirements:** Hospital staff will require a full array of PPE to care

	for patients.
Doctors, Dentists, Maternal Care, Dialysis Facilities, and Nonemergency Medical	• **Physical Distancing:** To the extent possible, any staff that can telework should continue to do so. Providers should consider opportunities to limit patient interactions, including in entrances and exits, and waiting rooms. • **Engineering Controls:** Where possible, providers should create physical barriers to reduce patient exposure. • **Administrative Controls:** Telehealth should continue to be used to the extent that care provided is adequate. Remote patient monitoring could be very helpful in the field of maternal care, reducing the number of in-person visits and the associated risks. • **PPE Requirements:** Nonemergency staff will require a full array of PPE to care for patients, depending on the procedures that will be performed.
Health Centers, Skilled Nursing Facilities, Long-Term Acute Care Facilities, Home Health Care Agencies, Assisted Living Facilities	• **Physical Distancing:** Long-term care facilities should consider continuing to limit visitors and screen any visitors that are allowed. Patient interactions should continue to be limited. • **Engineering Controls:** Where possible, providers should create physical barriers to reduce patient exposure. • **Administrative Controls:** Telehealth should continue to be used to the extent that care provided is adequate. Additional remote patient monitoring could assist health centers in treating their patients with multiple chronic illnesses, and directly reduce ED utilization and hospitalization. • **PPE Requirements:** Long-term care and home health staff will require a full array of PPE to care for patients.
Mental Health	• **Physical Distancing:** To the extent possible, any staff that can telework should continue to do so. Providers should consider opportunities to limit patient interactions, including in entrances and exits, and waiting rooms, and ensure that social distancing is maintained during face-to-face interactions. • **Engineering Controls:** Where possible, providers should create physical barriers to reduce patient exposure. • **Administrative Controls:** Telehealth should continue to be used for both individual and group visits, to the extent that care provided is adequate. • **PPE Requirements:** Mental health staff will need PPE available, depending on the type of contacts they have with patients.
Homeless Services, Public Benefits, and Child Welfare	• **Physical Distancing**: Business should be conducted from home to the extent possible without jeopardizing client needs. Consideration should be given to how to create greater social distancing in congregate shelters, particularly as additional capacity is needed. • **Engineering Controls:** Where possible, providers should create physical barriers to reduce client exposures. In the homeless services space, this may require continuing to operate hotels and other hypothermia sites and keeping share spaces closed until a vaccine is

	developed. • **Administrative Controls:** Remote technology should continue to be used to the extent possible, including for the assessment of the safety and well-being of children, parent-child visits, and court hearings. • **PPE Requirements:** Social services staff need access to PPE for interactions with clients and other staff. PPE will be particularly important for staff entering family and foster parent homes, group care facilities, and shelters.

Compliance Recommendations

While guidelines are vastly preferable to rules, any rulemaking to ensure compliance should consider resource limitations and the conditions of work in these sectors.

EQUITY CONSIDERATIONS FOR REOPENING

According to the World Health Organization, equity is the absence of avoidable differences among groups of people, whether those groups are defined socially, economically, or demographically. In order to achieve equity in DC, one must overcome inequalities that compromise fairness and human rights norms. The lack of political, social and economic power is a common thread of marginalized communities in the District; therefore, if interventions are going to be effective and sustainable, they must go beyond the provision of healthcare and address the social determinants of health (SDOH). These essential human rights, including housing, food, education and job security, have proven to have a direct correlation to positive health outcomes. These SDOH are often intertwined. An equitable and robust educational system will maximize lifetime economic security, providing sustainable wages, health insurance and a peaceful and comfortable community to live in. These livelihood amenities build economic, social and political power, which in turn expedite systemic changes that are often the most powerful and effective interventions for cost-effective health outcomes.

If families and individuals can earn a living income, then access to quality affordable housing, nutritious food, and safe, socially distanced transportation is possible. Accordingly, they will be better protected today and in the future from crises like COVID-19, recessions and other environmental emergencies that disproportionally harm low-resource individuals and people of color.

The District should coordinate access to healthcare across the region, with our partners in Maryland and Northern Virginia, in order to overcome concerns about where patients live, and instead prioritize their access to quality healthcare. Creating reciprocity agreements between jurisdictions will ensure that reimbursements can take place for any provider that provides care, regardless of the jurisdiction in which they are based.

In order to create a more equitable healthcare system, we should think about the District we envision decades from now – beyond reopening DC, or what will happen in three, six, or twelve months. This means we need to address the socioeconomic inequities that make African Americans, immigrants, and low-income individuals extremely vulnerable to a pandemic like COVID-19.

Figure 5. Equity Considerations for the Proposed Round 1 Mitigation and Guidelines

Vulnerable Population	Equity Considerations
Healthcare workers, first responders, and other essential workers in contact with the public	• Continue to abide by social distancing guidelines for all residents. • Provide readily available PPE to all residents and workers. For those who show up unprotected, they should be provided PPE, including at clinics, on the bus, and in the grocery stores. • Engage workers to assess their needs and what they believe is important to giving them a sense of safety in the work environment. While we may not be able to meet their requests, it is the right thing to do and we can strive to fulfill their needs. • Offer telework options for first responders, if they are unable to or uncomfortable returning to work.
Non-essential workers in high-contact jobs	• Consider every worker essential as to avoid making choices about the type and the quantity of PPE and other protection measures available to them.
Older adults living in nursing homes	• Make sure all workers and residents complete temperature checks every morning. • Create safe ways for families to visit, including universal guidelines and practices (e.g., temperature checks). • Address the added behavioral health needs resulting from the new practices of distancing that will have to be implemented long term.
Racial and ethnic minorities (including the minority LGBTQ community)	• Provide easy access to testing in the community, connected to a primary care setting. • Offer culturally safe and accommodating spaces to obtain care. • Use testing encounters to offer additional services (e.g., screen for housing, economic insurance needs), recognizing past, present and future economic hardships. • Consider contact tracing administered by trusted entities.
Immigrant and refugee populations	• Provide protection that does not compromise individuals' identity or status. • Invest in capacity to serve these populations with cultural and language competence. • Create spaces to allow for grievances and complaints about work and other conditions that are unfair and/or illegal. • Provide recommendations in all of the common languages spoken in DC. • Utilize and remunerate the lay people who already are bilingual and bicultural in their communities as ambassadors of education

	on reopening, contact tracing, and distribution of government equipment, food, etc.
Justice-involved populations	• Reduce or eliminate barriers for returning citizens living in public housing or with relatives. • Use technology for check-ins and managing parole status to help keep these individuals out of crowded spaces. • Prioritize this population for testing and contact tracing.
People experiencing homelessness	• Incentivize landlords to relax their screening criteria to allow individuals and families with barriers to have a second chance. • Encourage private developers to create safe and quality housing stock for all people experiencing homeless. Ultimately, this will reduce expenses in many government-funded spaces, including hospitals and shelters. • Increase access to technology and internet connectivity. • Engage people with lived experience in the planning processes. • Monitor data to ensure that exits to housing are equitable and returns to homelessness are not racially disproportionate.
Low-income households	• Ask affected people how to best assist them. • Address the digital divide experienced by people living on low income by pursuing citywide internet access.
Residents with a multitude of chronic medical conditions	• Subsidize and/or provide free transportation in taxis and rideshares. • Provide delivery of medications. • Expand access to telemedicine for mental healthcare, including the tools needed to do so, such as better broadband access. • Experiment with more home visits for non-COVID-19-related care, where appropriate.
People with disabilities and living in state institutions, group homes, and other congregate settings, as well as those living independently	• Ensure that everyone conducts a temperature check every morning. • Increase the number of people who are able to live in their community or their own home for longer time periods. • Set new, higher standards of care expected by these institutions. • Address the impact of wearing face masks on the communications ability of individuals who are deaf or hard of hearing.
Small businesses and non-profits that primarily support underserved communities	• Provide easier access to loans and grants for minority business owners to enable them to make structural changes to address safe distancing and compensate for loss of revenue due to less capacity. • Expand access to PPE, free of charge. • Equip businesses with hand sanitizers and other infectious disease prevention features.

PREPARATION AND RESOURCES NEEDED FOR REOPENING

Testing, PPE, and Other Supply Recommendations

The District should demonstrate a commitment to protecting health care workers, social service providers, and their patients and clients as the District moves into a new phase of service delivery. Testing, PPE, and other supplies are essential to ensuring that health and human services can be delivered safely and effectively. To this end, we must work to create more equitable access, availability and distribution across the supply chain for personal protective equipment, as well as testing supplies. New funding and supply chain models should be considered, including supply chain management models and a designated funding pool for the purchase of PPE for front-line workers within these sectors. Consideration should be given to modest grants for underresourced providers.

Transportation Recommendations

During the Stay-at-Home Order, the workforce in these sectors has been impacted by the reduction of transportation options. At the same time, there have been transportation challenges faced by patients and clients seeking services. These issues will increase as the District seeks to gradually reopen services. It is worth noting that medically fragile patients confront particular risks when as they access public transportation to travel to healthcare facilities. Any contact with a driver or a fellow passenger in a bus or on a Metro train is a potential risk and generates stress when appropriate social distance cannot be maintained. Transportation issues also contribute to inequitable access to healthcare, as disparate service disproportionately impacts lower-income residents, especially in Wards 7 and 8. Alternatives are often out of reach for patients and other front-line healthcare workers, as the cost of ridesharing services is often prohibitive.

The District should work to support the city's front-line workers as they return to work, as well as the patients who are seeking medically necessary care. Ideally, these transportation needs should be coordinated with our regional partners in Maryland and Virginia.

Legislative, Regulatory and Policy Recommendations

Technology Platforms

The use of technology was a common thread among all the sectors in this committee, as it has been effectively utilized for telehealth, child welfare, case management and education during the Stay-at-Home Order. However, there are disparities related to access to devices and internet connectivity. To address these, the District should take steps to address equity issues and ensure there is equitable access to this equipment and these services. Among other things, the District might explore the expansion of free WiFi networks throughout the city, keeping in

mind the security needed to protect patient information and prioritizing neighborhoods with the most children receiving public benefits. Further, by ensuring all public school students have access to a device, the District can help ensure that people can utilize health and social services, in addition to virtual learning opportunities.

In addition to addressing access issues around technology, the District would be well-served by continuing the recent changes in telehealth reimbursements, including allowing an individual's home to serve as an originating site for purposes of receiving care and telephonic visits, as well as implementing new regulations for remote patient monitoring and classifying telehealth equipment as "durable medical equipment" for purposes of Medicaid reimbursement. The District should also example other regulatory changes that create efficiencies in services, including the use of telecourt as a permanent option for involuntary admissions (FD-12).

Care Coordination

The committee believes that there are a number of opportunities in the District to explore expanded care coordination models, particularly around discharge planning, acute care support for SNFs and home health agencies, assistance for residents with behavioral health needs moving between levels of care, and additional support for individuals experiencing homelessness. Data and measurements should be implemented to validate new services delivery models, including performance measures for addressing health disparities.

Child Welfare

Within the child welfare system, there are several services that the Child and Family Services Agency (CFSA) should consider providing utilizing technology to perform. First, CFSA should develop the opportunity for foster parents to apply online and complete as much of the approval process virtually as possible. They should also continue the process of allowing government and non-profit partners that are applying for Child Protection Register clearances to do so electronically, thereby reducing the need for in-person visits to CFSA. In addition, in order to ensure the process for exit to permanence can be done as safely as possible, for cases where there is an agreement between CFSA and parents on the termination of parental rights, CFSA should consider establishing a process with the courts that can be done remotely. CFSA should collaborate with Family Court to increase the number and type of family court cases that are heard remotely, while ensuring that families have the technology to enable them to participate.

Given the financial instability many individuals are facing as a result of COVID-19, CFSA should allow young people age 21 and over who elect to remain in care to continue to receive support from CFSA for longer periods of time (for at least 12 months post-COVID) and should allow young people who have aged out to be allowed to reengage for support and services through the age of 23.

Homeless Services

Within the homeless services system, there are great risks for the transmission of COVID-19, and as reopening occurs, we expect to see large increases in the demand for services. Testing should be prioritized in shelter and other congregate care settings to allow for isolation of those persons who test positive. This will help prevent the further transmission of the virus among the vulnerable population of shelter residents. Following CDC guidelines, a coordinating body should be put in place to assure protocols are refined with experience, information is flowing between programs, and that public health professionals are available as needed.

As reopening occurs, it will be important to prevent as many residents as possible from becoming homeless, as well as quickly move families and individuals out of shelter, and into a space of their own. Thus, programs and policies that facilitate these goals, such as Rapid Rehousing, eviction delays, and rental assistance, will be invaluable. Opportunities for employment will also help stabilize residents experiencing homelessness. Hiring individuals experiencing homelessness, including young adults, as contact tracers and community ambassadors will help create opportunities for pathways out of homelessness.

Even as shelter-in-place guidelines are lifted, shelter residents continue to need increased access to technology and connectivity to allow them to participate in mitigation measures. Enhancing access to mental health services among individuals experiencing homelessness, including through remote access and telehealth, is critical.

Promote Health Equity and Improve Health Literacy

The District should leverage the acceptance of telehealth and other new models of care delivery to accelerate and sustain positive changes in health seeking behaviors. Using communication and outreach strategies, the District can work to mitigate fear of the health care environment and emphasize the importance of seeking necessary care at the right time and in the right place.

Workforce Changes and Needs

The health and human services sectors are facing workforce shortages as a result of this crisis. There are a number of actions that regulatory agencies can take to help alleviate these challenges, including allowing practitioners to practice in DC if they have a license in another state while they go through the credentialing process; implementing interstate licensure compacts to additional professions; and developing and implementing requirements that allow graduates of professional school (i.e., MDs, LICSWs, nurses, psychologists, etc.) who have completed training to practice under the supervision of a fully licensed clinician while preparing for, taking and passing their exams. In addition, providers should work with the Department of Employment Services to establish and implement a process for gathering data to identify District-wide needs for behavioral health professionals.

In the next phase of reopening, health provider and social service front-line worker burnout is likely to continue to be an issue. The stress this emergency has placed on front-line personnel could have a negative impact on the quality of care delivered for patients, especially those with chronic medical conditions who have not been seeking treatment. Potential solutions for providers to explore include extended and weekend hours for delivery of care to allow for adequate rest and recovery of personnel.

Figure 6. Necessary Preparation and Resources by Sector

Sector	Preparation and Resources
Health Sectors	• Address disparities related to technology, including access to devices and internet connectivity. • Continue telehealth reimbursement for home as an originating site and telephonic visits. • Implement new regulations for remote patient monitoring. • Classify telehealth equipment as "durable medical equipment" for purposes of Medicaid reimbursement. • Enhance the flexibility of care coordination models. • Implement data and measurements to support new services delivery models, including performance measures for addressing health disparities. • Allow practitioners to practice in DC if they have a license in another state while they go through the credentialing process. • Implement interstate licensure compacts to expand the pool of professions and providers. • Develop and implement requirements that allow graduates of professional school (i.e., MDs, LICSWs, nurses, psychologists, etc.) who have completed training to practice under the supervision of a fully licensed clinician while preparing for, taking and passing their exams. • Work with the Department of Employment Services to establish and implement a process for gathering data to identify District-wide needs for behavioral health professionals. • Explore extended and weekend hours for delivery of care to allow for adequate rest and recovery of personnel.
Homeless Services, Public Benefits, and Child Welfare Sectors	• Address disparities related to technology, including access to devices and internet connectivity. • Prioritize testing in shelter and other congregate care settings to allow for isolation of those persons who test positive. • Establish a coordinating body to assure protocols are refined with experience, information is flowing between programs, and that public health professionals are available as needed. • Implement and enhance programs and policies that prevent homelessness and quickly move residents out of shelters, including Rapid Rehousing, eviction delays and rental assistance. • Hire individuals experiencing homelessness, including young adults,

	as contact tracers and community ambassadors. • Enhance access to mental health services among individuals experiencing homelessness, including through remote access and telehealth. • Develop the opportunity for foster parents to apply online and complete as much of the approval process virtually as possible. • Continue to allow government and non-profit partners that are applying for Child Protection Register clearances to do so electronically. • Collaborate with Family Court to increase the number and type of family court cases that are heard remotely and ensure that families have the technology to enable them to participate. • Allow young people age 21 and over to elect to remain in care and to continue receiving support from CFSA for longer periods of time (for at least 12 months post-COVID). • Allow young people who have aged out to be allowed to reengage for support and services through the age of 23.

COMMUNICATION AND SIGNAGE

As we move to reopen, a coordinated communication strategy is needed to proactively address fear and concerns of health care consumers, health care workers, and general public. The District should invest in a communications strategy focused on "seeking medical care" that fully engages health care providers, public/private partnerships and other key stakeholders. The strategy should:

- Develop a citywide campaign to thank Health Care Heroes and other front-line workers;
- Help to mitigate fear and myths in the wake of COVID-19;
- Promote health equity and improved health literacy for all DC residents;
- Leverage the acceptance of new models of care delivery, including telehealth, and to sustain positive changes in health-seeking behaviors;
- Stress the importance of reporting suspected cases of child abuse and neglect and domestic violence; and
- Promote the recruitment and engagement of trusted community leaders including community health workers, youth in the Summer Youth Employment Program, and other grassroots constituencies to serve as "messaging" ambassadors for positive communications on the appropriate use of healthcare services.

Communication tools for this campaign may include:

- Social media and digital platforms;
- Earned and paid media;
- Celebrity, media and sports personalities;
- Radio and TV public service announcements; and

- Distribution of information flyers at public transportation sites, hospitals, other medical facilities, churches etc.

ISSUES FOR FUTURE PHASES

CONSIDERATIONS FOR FUTURE ROUNDS OF REOPENING

The committee believes that Phase 2 initiatives should focus on opportunities to assess and improve on the existing system, by building on opportunities, challenges and lessons learned from the public health emergency:

1. **Institutional Integration:** Better integrate and engage across health and human service providers to improve care transitions, including discharge planning. Ensure resources are available for SNFs and home health to support post-acute services. Improve integration of health and human services to best serve our populations, with a particular focus on vulnerable populations.
2. **Improve on Telehealth:** Evaluate existing telehealth regulations and other models to determine their effectiveness in supporting providers and residents.
3. **Data and Performance:** Implement data and measurements to support transitions to new service delivery models. This should include performance measures for addressing disparities, as well as tracking whether the use of technology can improve outcomes through the remote patient monitoring of chronic patients, synchronous telehealth for increased appointment adherence for mental health services, and whether greater connectivity to care leads to better outcomes and reduced health disparities.
4. **Reimbursement:** Consider establishing new forms of reimbursement to support innovative payment models and new care paradigms.
5. **Safety:** Make ambulatory care facilities safer by considering new rules and guidelines regarding construction and licensing of new facilities to reduce the spread of infectious diseases.

CONSIDERATIONS FOR RECOVERY

The Committee believes that it is critical that the District align its actions, where possible, with those of our geographic partners in Maryland and Northern Virginia.

RESEARCH, RESOURCES, AND REFERENCES

RESEARCH AND RESOURCES

Hospitals

- The outbreak of COVID-19 has highlighted the great need for effective emergency planning and preparedness. A critical component of the ability to respond to large-scale emergencies involves creating a strategic plan for the rapid expansion of existing hospital inpatient space.
    - Chicago's Rush University Medical Center is specifically designed for infectious disease outbreak.
    - The Robert McCormick Foundation Center for Advanced Emergency Response, which encompasses their emergency department, is intended for large-scale emergencies.

Health Centers

- Health centers help increase access to timely primary care and preventive care services by reducing barriers such as cost, lack of insurance and distance.
    - The U.S. Department of Health and Human Services is providing support through the Provider Relief Fund in support of the national response to COVID-19. Given the number of financially insecure residents, particularly as the number increases due to COVID-19, we must ensure the economic viability of health centers.
    - In addition to providing primary and preventive care, community health centers are critical to the COVID-19 response. Health centers can help to divert those seeking nonemergency care from going to the emergency rooms, educate the surrounding community about COVID-19, and provide alternative processes for care.

Nursing Homes

- With hospitals needing to free up beds to accommodate more critically ill patients, nursing homes may be alarmed at the prospect of admitting patients who may have a COVID-19 diagnosis or exposure.
    - Nursing homes in Maryland are required to conduct COVID-19 testing of all residents and staff regardless of symptoms. Facilities are also required to create staffing surge plans to ensure continuity of care in the event of an outbreak.

Long-Term Acute Care Facilities

- Patients with chronic illnesses frequently need extended hospital-level care. During the COVID-19 crisis, long-term acute care facilities can provide care for non-COVID-19 patients and provide overflow space for patients who test positive.
    - In an effort to reduce burden on area hospitals, Bethesda Rehabilitation Hospital in St. Paul, Minnesota, converted their facility into a 90-bed COVID-19 crisis hospital. By outfitting the rehab facility with intensive care and negative air pressure rooms, health officials have been able to safely utilize a cohorting strategy.

Mental Health

- SAMHSA has awarded grants for expanding community-based behavioral health services to strengthen coronavirus response.
    - With social distancing comes the need to address the weakened or otherwise strained social networks. Additional phases of reopening should provide considerations for public information campaigns to address potentially fragile emotional states.
    - In the same way that DC Health and other District Government agencies were able to identify and share information about symptoms for COVID-19, information and resources about symptoms of depression, substance use, burnout, and other mental health needs should be provided to residents.

Homelessness

- People experiencing homelessness are at risk of infection, especially with ongoing, widespread community transmission. Various cities in California have taken steps to provide a safe place for high-risk, unsheltered residents to self-isolate including Oakland's Operation HomeBase and Los Angeles' Project Roomkey.
    - Oakland's Operation HomeBase is a COVID-19 isolation trailer program. Operation HomeBase will use 67 trailers as a public health-driven intervention; the other 24 trailers were provided to the cities of Alameda, Berkeley, and Hayward, which requested them for their unsheltered residents. The primary

goal is to provide a safe place for high-risk people to self-isolate and maintain their safety and health.

- Los Angeles' Project Roomkey is a partnership between the state, county, and the Los Angeles Homeless Services Authority to secure hotel and motel rooms for vulnerable people experiencing homelessness. Hotel rooms will provide temporary housing for people experiencing homelessness who are not COVID-19 positive or symptomatic, but are vulnerable to complications should they become infected with COVID-19.

Further Resources

- Guidance and Resources for Hospitals
  - Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (CDC)
  - Comprehensive Hospital Preparedness Checklist for Coronavirus Disease 2019 (COVID-19) (CDC)
  - Updates and Resources on Coronavirus (COVID-19) (American Hospital Association)
  - Guidance for Universal Masking and Healthcare Personnel Monitoring, Restriction and Return to Work (DC Health)
  - COVID-19 Guidance for Conserving the Supply of Personal Protective Equipment in DC (DC Health)
- Guidance and Resources for Doctors, Dentists, Maternal Care, Dialysis Facilities, and Nonemergency Medical
  - Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response (CDC)
  - Interim Guidance on Breastfeeding and Breast Milk Feeds in the Context of COVID-19 (CDC)
  - Interim Additional Guidance for Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Outpatient Hemodialysis Facilities (CDC)
  - Outpatient and Ambulatory Care Settings: Responding to Community Transmission of COVID-19 in the United States (CDC)
  - Guidance for Universal Masking and Healthcare Personnel Monitoring, Restriction and Return to Work (DC Health)
  - Notice for District of Columbia Pharmacy Staff Coronavirus Disease (COVID-19) (DC Health)
  - Interim Guidance for Outpatient Pediatric Providers in the District of Columbia (DC Health)

    - COVID-19 Guidance for Conserving the Supply of Personal Protective Equipment in DC (DC Health)
- Guidance and Resources for Health Centers, Skilled Nursing Facilities, Long-Term Acute Care Facilities, Home Health Care Agencies, and Assisted Living Facilities
    - Outpatient and Ambulatory Care Settings: Responding to Community Transmission of COVID-19 in the United States (CDC)
    - Guidance for Universal Masking and Healthcare Personnel Monitoring, Restriction and Return to Work (DC Health)
    - Interim Guidance for Outpatient Pediatric Providers in the District of Columbia (DC Health)
    - COVID-19 Guidance for Conserving the Supply of Personal Protective Equipment in DC (DC Health)
    - Considerations When Preparing for COVID-19 in Assisted Living Facilities (CDC)
    - Preparing for COVID-19: Long-term Care Facilities, Nursing Homes (CDC)
    - Infection Control Recommendations for Preparedness & Management of COVID-19 in Skilled Nursing Facilities (DC Health)
    - Universal masking and use of face coverings for residents, HCWs, staff and visitors in LTCFs (DC Health)
- Guidance and Resources for Mental Health
    - Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic (SAMHSA)
    - Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic (SAMHSA)
    - COVID-19: Interim Considerations for State Psychiatric Hospitals (SAMHSA)
    - Guidance for Universal Masking and Healthcare Personnel Monitoring, Restriction and Return to Work (DC Health)
    - COVID-19 Guidance for Conserving the Supply of Personal Protective Equipment in DC (DC Health)
- Guidance and Resources for Homeless Services, Public Benefits, and Child Welfare
    - Interim Guidance for Homeless Service Providers (CDC)
    - Coronavirus Disease 2019: Homeless Population (CDC)
    - Coronavirus (COVID-19) Information for Homeless Shelters and Homeless Service Providers (National Health Care for the Homeless Council)
    - Coronavirus 2019 (COVID-19): Guidance for Essential (Non-Healthcare Workers on How to Stay Safe in the Workplace) (DC Health)
    - Additional Personal Protective Equipment Guidance: Case Examples for Usage (DC Health)
    - COVID-19 Guidance and Information for Human Services Programs (U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation)

- COVID-19 Guidance and Information for Human Services Programs (National Conference of State Legislatures)
- A Framework for COVID-19 Homelessness Response - Responding to the Intersecting Crises Of Homelessness and COVID-19 (National Alliance to End Homelessness)
- Children's Bureau Letter on Title IV-E Flexibility (U.S. Department of Health and Human Services, Administration for Children and Families)
- Children's Bureau COVID-19 Resources (U.S. Department of Health and Human Services, Administration for Children and Families)
- Children's Bureau Letter - COVID-19 and Child, Legal, and Judicial Letter (U.S. Department of Health and Human Services, Administration for Children and Families)
- ACF Information Memoranda 20-06 – Foster Care as a Support to Families (U.S. Department of Health and Human Services, Administration for Children and Families)
- Stafford Act Flexibility for Criminal Background Checks and Monthly Casework Visits in Childs Residence (U.S. Department of Health and Human Services, Administration for Children and Families)

APPENDIX A: STAKEHOLDERS

The committee received feedback from the following stakeholders and residents on their challenges, risks, needs, and questions:

- Waldon Adams, Interagency Council on Homelessness Consumer Engagement Group
- Amilia Alcema, Deanwood Rehabilitation and Wellness Center
- Ijeoma Arungwa, DC Home Health Association
- Mae Best, East River Family Strengthening Collaborative
- Reginald Black, Interagency Council on Homelessness Consumer Engagement Group
- Dionne Bussey Reeder, Far Southeast Family Strengthening Collaborative
- Cherie Craft, Smart from the Start
- Veronica Damesyn-Sharpe, DC Health Care Association
- Karen Feinstein, Georgia Avenue Family Support Collaborative
- Kim R. Ford, Martha's Table
- Sue Hargreaves, Lisner-Louise-Dickson-Hurt Home
- Kimberly Harris, Department of Human Services Customer Advisory Group
- Menyonga Igwacho, Meiger Health
- Amy Javaid, A Wider Circle
- Gail Jernigan, Transitional Care Center
- Shonta Jones, Department of Human Services Customer Advisory Group
- Dirk Keaton, So Others Might Eat
- Jacqueline Kosloski, Fedcap
- Mark LeVota, DC Behavioral Health Association
- Judith Levy, IONA Senior Services
- Erin Loubier, Whitman-Walker Health
- Elizabeth Mohler, Latin American Youth Center
- Marie Morilus-Black, MBI Health Services, LLC
- Amy Nelson, Whitman-Walker
- Sheila Pannell, AARP
- Donnell Potts, Sasha Bruce
- Samirra Robinson, Department of Human Services Customer Advisory Group
- Calvin Smith, BridgePoint Healthcare
- Kelly Sweeney McShane, Community of Hope
- Robert Warren, Interagency Council on Homelessness Consumer Engagement Group
- Beverly Wheeler, DC Hunger Solutions
- Sally White, IONA Senior Services
- Eric Wolcott, DC Home Health Association
- Ilana Xuman, Leading Age DC

Human Services, Social Services, and Health Committee submission to the Steering Committee for its recommendations to the Mayor

APPENDIX B: ADDITIONAL RECOMMENDATIONS FOR REOPENING, BY SECTOR

Figure 7: Proposed Recommendations for Reopening – Hospitals

Hospitals

Provide Guidance for Essential Care

- Retain regulatory flexibility to support readiness for a second wave, if needed.

Accelerate the Use of Telehealth, Technology, and Connectivity

- Make telecourt a permanent option for involuntary admissions and guardian determination.
- Promote connectivity with skilled nursing facilities, health centers, and individual patients.

Stabilize the Workforce

- Increase training and education to ensure readiness for emergency preparedness and response protocols for all healthcare workers throughout the continuum of care. This includes continued drilling and preparedness efforts to socialize staff regarding the emergency plans and decision-making processes.

Employ Effective Communication Strategies

- Proactively address fear and concerns for healthcare consumers, healthcare workers, and the public through a coordinated communications strategy.

Focus on the District's Most Vulnerable Residents

- Responsibly resume medically necessary surgeries and procedures through phases. Prioritize the growing number of non-COVID patients who have medically urgent needs and have delayed treatment. All organizations choosing to resume elective procedures should have an established plan in place to safely phase-in surgeries based on sound clinical judgment.

Figure 8: Proposed Recommendations for Reopening – Doctors, Dentists, Maternal Care, Dialysis Facilities, and Nonemergency Medical

Doctors, Dentists, Maternal Care, Dialysis Facilities, and Nonemergency Medical

Provide Guidance for Essential Care

- Create training protocols, checklists, and other means to assist providers and offices with promoting physical distancing based on CDC guidance.

Ensure Access to PPE, Equipment, Testing, Supplies, and Other Safety Measures

- Consider mechanisms like small business loans to incentivize upgrades to existing facilities, with specific attention for dental facilities, which may need to be completely redesigned and engineered to operate safely.

Focus on the District's Most Vulnerable Residents

- Prioritize opening essential elective medical and dental care.
- Providers should follow the guidance of local and national associations and experts, regarding the type of care that should be considered essential.
- Address essential pediatric care, by recognizing the importance of early childhood health monitoring and prevention. This District must work with pediatric providers to identify the safest possible ways to provide preventative care, as well as monitor growth and development, iron and lead status, and immunizations. These efforts should also include work to determine the safest possible ways to diagnose and treat childhood febrile illnesses. Efforts to reopen these services should include use of telehealth, symptom and fever screening, patient spacing, testing, PPE for children, and delivery of care outside of doctors' offices or where COVID-19 treatment is occurring.
- Address essential maternal care to prevent maternal mortality and adverse birth outcomes by working with OB/GYN providers, midwives, nurses, lactation consultants to identify the most critical preventative services and the safest possible ways to deliver those services. This should include care delivery at sites apart from where COVID-19 screening and treatment are occurring.

Figure 9: Proposed Recommendations for Reopening – Health Centers, Skilled Nursing Facilities, Long-Term Acute Care Facilities, Home Health Care Agencies, Assisted Living Facilities

Health Centers, Skilled Nursing Facilities, Long-Term Acute Care Facilities, Home Health Care Agencies, Assisted Living Facilities

Provide Guidance for Essential Care

- Create training protocols, checklists, and other means to assist providers and offices with promoting physical distancing based on CDC guidance.
- Update provider guidance from DC Government to health care providers in this sector.
- Develop specific guidance on occupational health priorities, facility cleaning, environmental, and facility plant considerations to enhance social distancing, and criteria for scarce resource allocation among patients.

Ensure Access to PPE, Equipment, Testing, Supplies, and Other Safety Measures

- Expand community health centers' role in COVID-19 testing, contact tracing, and surveillance through partnerships between DC Health and FQHCs' other community-based ambulatory care groups. Consider building specific disease investigation and surveillance elements on existing health centers' community health worker, care navigation, and testing capacities.
- Establish a designated funding pool for the purchase of PPE for health care providers in this sector. Consider a group purchasing or cooperative buying model to secure the best price and volume via a DC Government agency or major vendor.

Accelerate the Use of Telehealth, Technology, and Connectivity

- Allow Medicaid reimbursement for health care providers for remote patient monitoring (RPM).
- Permanently adopt telemedicine to tackle ongoing health disparities, increase connectivity with patients, and enhance provider-to-provide coordination. Invest additional funds and implementation resources, such as medical workflows, patient education, technology, and privacy.

Stabilize the Workforce

- Expand DC healthcare provider capacity through regulatory changes such as accelerating DC's administrative process for participation in the Interstate Medical Licensure Compact, and expanding DC regulatory requirements to offer licensure reciprocity for physician assistants, advance nurse practitioners, nurses, and other key healthcare professionals.

Employ Effective Communication Strategies

- Initiate a community-wide public health messaging campaign with cultural influencers whose voices resonate across all communities in DC. Consumers and patients should be engaged to provide input and feedback on messaging, branding, and other cultural matters.

Focus on the District's Most Vulnerable Populations

- Expand community health centers' care navigation network to address health disparities and reduce unnecessary and/or avoidable ER and inpatient utilization. This work should focus on the most at-risk DC residents who live with chronic conditions. In addition, this initiative can be combined with the permanent adoption of telemedicine and remote patient monitoring to accelerate DC Medicaid's efforts around value-based payment reform.

Figure 10: Proposed Recommendations for Reopening – Mental Health

Mental Health

Ensure Access to PPE, Equipment, Testing, Supplies, and Other Safety Measures

- Support infrastructure changes to make buildings safe (air circulation/quality, installing Plexiglas barriers, social distancing strategies).
- Expand non-emergency transportation for individuals to get to appointments.
- Ensure that workplaces are safe for staff and those receiving care on-site or in congregate setting such as Saint Elizabeths Hospital, community residential facilities (CRFs), and residential and community provider facilities by providing access to a consistent supply of PPE and providing funding to support the modification of physical spaces for social distancing.

Accelerate the Use of Telehealth, Technology, and Connectivity

- Use virtual telehealth applications to provide trauma and grief support and therapeutic interventions to staff.

Stabilize the Workforce

- Stabilize the provider network by establishing updated reimbursement rates for behavioral health services. This should also include rate setting for innovative and new services that are not currently reimbursable, and opportunities for increased coverage of behavioral health services.
- Increase access to care to address community trauma and the behavioral health needs of front-line staff, individuals receiving services through the public behavioral health system, and community residents by retaining existing telehealth capabilities, including reimbursement for telephonic communication, providing licensure and credentialing reciprocity with other states, and requiring 24/7 access to care.

Employ Effective Communication Strategies

- Provide educational information and materials to all residents at community sites and via social media and websites regarding how they can access behavioral health services through the Access Helpline and providers.
- Inform the public of the signs and symptoms and strategies for reducing the impact of trauma and grief using telecommunications, social media, written materials, and in-person and virtual presentations.

Focus on the District's Most Vulnerable Populations

- Mitigate collective community trauma through virtual support groups, connection to services, educational information via community sites and social media, and enlisting the support of the faith community.

Figure 11: Proposed Recommendations for Reopening – Homeless Services, Public Benefits, and Child Welfare

Homeless Services, Public Benefits, and Child Welfare

Provide Guidance for Essential Care

- Develop procedures to safely house children in the child welfare system until COVID-19 test results are known.

Ensure Access to PPE, Equipment, Testing, Supplies, and Other Safety Measures

- Review existing programs and fund capital projects to support physical distancing.
- Ensure that testing and adequate screening is in place to enhance the safety of people who are unsheltered or are staying in congregate, semi-congregate, and non-congregate shelter.
- Ensure that any public-facing staff have sufficient workspace for social distancing and PPE to maintain safety.
- Develop capacity in the child welfare system to complete preplacement COVID-19 testing of children at their preplacement physical location or prior to a change in placements, as well for foster families and congregate care programs.
- Explore the role of contact tracers in verifying the well-being of young people in exposed households.

Accelerate the Use of Telehealth, Technology, and Connectivity

- Address equity issues around access to technology and internet connectivity, so that students in families experiencing housing instability have the ability to continue distance learning like their peers. Enhance capacity to provide access to devices for clients in congregate settings to manage their time productively and to help mitigate the negative effects of social isolation.
- Develop the capacity for potential foster parents to apply online and complete as much of the approval process virtually as possible.
- Expand the capacity for virtual mobile crisis stabilization services.
- Continue to connect with families remotely when possible. To facilitate this, provide equipment and/or resources to families, such as money for phones, minutes, and data.
- Continue process of allowing government and non-profit partners applying for CPR clearances to do so electronically.
- Collaborate with Family Court to increase the number and type of family court cases that are heard remotely and ensure that families have the technology to enable them to participate. Continue to conduct eligibility for homeless services for families remotely. This should include an examination of in-person requirements to determine if they are necessary, and a staggered schedule for staff when in-person visits are needed.
- Continue to use the online submission portal to allow individuals to apply for benefits remotely, continue the development of a mobile application to allow individuals to apply from a phone, and consider completing face-to-face requirements via video chat.
- Expand the availability of grocery delivery for SNAP beneficiaries by encouraging big box stores, local DC retailers, and Farmer's Markets to participate.

Stabilize the Workforce

- Consider hiring individuals who have recently become unemployed and/or homeless during due to COVID-19 to cover shifts in emergency shelters and at hotels and for contact tracing work and as Community Ambassadors, when possible.
- Focus employment vendors on connecting clients to job opportunities in industries that have grown during COVID-19.

- Prepare for a surge in hotline calls regarding child welfare when the District reopens by ensuring adequate capacity in hotline and investigation divisions.
- Consider allowing CFSA employees to continue using personal vehicles to conduct government business to reduce the number of in-person trips to CFSA and the use of shared vehicles.

Employ Effective Communication Strategies

- Prepare an aggressive outreach plan to identify and support individuals to meet recertification requirements for public benefits when the federal government reinstates these requirements.
- Until the District reopens, continue public messaging and outreach to schools about reporting alleged child abuse and neglect.
- Ensure that individuals and families know how to access District benefits, including TANF, SNAP, and emergency rental assistance.

Focus on the District's Most Vulnerable Populations

- Establish a Strike Force or coordinating body for homeless services through the Interagency Council on Homelessness to ensure protocols are working and that there is input from public health professionals when needed, as well as good coordination between systems.
- Prepare for the likelihood that housing instability will increase as reopening occurs. Invest in prevention and diversion to mitigate this likelihood, including assistance with rent and eviction avoidance, and Rapid Rehousing to quickly move people from shelter to private housing. Analyze the potential for including private sources for the Emergency Rental Assistance Program (ERAP) and the Homeless Prevention Program, and examine the need to expand eligibility criteria to ensure that the needs of individuals and families who are impacted by COVID-19 can be addressed.
- Maintain and expand hotel capacity both for vulnerable clients and those who have tested positive for COVID-19, as well as for those needing respite care. When housing subsidies are available, move vulnerable individuals directly from PEP-V sites or respite care to housing, in partnership with the Coordinated Entry and Housing Placement system.
- Consider continuing to operate hypothermia shelter sites, which would typically close, until there is a plan for safe housing for individuals at those sites.
- Enhance the provision of mental health services to people in the homeless services system through remote means and/or safe social distancing.
- Continue to support individuals and families experiencing homelessness by helping them transition to permanent and/or appropriate housing. Appropriately fund programs that provide short to medium-term assistance and help families quickly exit shelters.
- Plan for the safe resumption of in-person visits for system-involved families on a staggered timeline, based upon safety and permanency planning timeline. As in-person case work resumes, prioritize high-risk cases for in-person meetings first.
- Allow young people age 21 and over who elect to remain in care to continue to receive support and assistance from CFSA for longer periods of time (for at least 12 months post-COVID), and allow young people who have aged out to reengage for support and services through age 23.