Testimony Before the Committee on Health and The Committee on Business and Economic Development
Council of the District of Columbia
B23-0777, "New Hospital at St. Elizabeths Act of 2020"

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Thank you for the opportunity to testify on the "New Hospital at St. Elizabeths Act." We are faculty associated with the George Washington University's School of Medicine and Health Sciences and the Milken Institute School of Public Health. Through our work at the university and through the Redstone Center and Rodham Institute, we are all committed to promoting health equity, eliminating structural and environmental barriers to health that are rooted in a legacy of racism and white supremacy, and focusing on preventing and ameliorating diet-related chronic diseases that disproportionately impact communities of color in the District. Our testimony reflects our own views and does not necessarily reflect the views of the George Washington University.

Construction of a new, state of the art hospital east of the Anacostia is long overdue. The Mayor, the Council (particularly Council Member Gray), and the many residents and advocates who have pushed for many years should be commended for the progress that today's hearing and the proposed agreement before the Council represents. We fully support construction of a new hospital at the St. Elizabeth's site. However, a new hospital alone will not address the deep health disparities in Wards 7 and 8. What is needed is creation of a "health hub" that can both meet the acute health needs of residents in Wards 7 and 8 as well as address the underlying determinants of health that drive most health outcomes, such as access to healthy food and physical activity, economic opportunity, and safe housing. The proposed

agreement to build and operate a hospital at St. Elizabeths is the District's opportunity to ensure the new hospital will truly drive health equity and not simply deliver clinical services.

We support the proposed legislation and related proposed agreements with amendments that would more directly address health equity and non-medical determinants of health. Below we lay out where we think the agreement can be strengthened.

Social and Environmental Factors Drive Health Outcomes

Social and environmental determinants of health including health-related behaviors, socioeconomic factors, and environmental factors, account for 80 to 90 percent of modifiable contributors to the health of a population, while medical care accounts for 10 to 20 percent.[1] Social and environmental determinants are driving a public health crisis in the District. Nearly 50% of District residents have diabetes or pre-diabetes,[2] and more residents die each year from complications related to obesity than from AIDS, cancer, and homicides combined.[3] Residents of Wards 7 and 8 suffer from high rates of poverty, earn lower incomes, and experience higher rates of unemployment than residents of other parts of the District. Life expectancy also differs significantly based on which side of the Anacostia River you reside. Residents in Ward 8 are expected to live 69.8 years, versus 85.1 years in Ward 3.[4] The median household income in Wards 7 and 8 is half that of the District of Columbia as a whole. The rates of unemployment east of the river are 2 to 2.5 times higher and education levels are also lower, with most residents having some college and less compared to overall D.C., where more than 50% of adults have a bachelor's degree or higher. The poverty rates are 1.5 - 2 times higher than overall D.C.

Ward 7 and 8 residents are served by only three full-service grocery stores, compared to dozens in other parts of the District. Lack of access to healthy food as

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[1] Magnan, S. (2017). Social determinants of health 101 for health care: Five plus five - national academy of medicine. Retrieved from https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

[2] American Diabetes Association, The Burden of Diabetes in the District of Columbia (2015). http://main.diabetes.org/dorg/PDFs/Advocacy/burden-ofdiabetes/district-of-columbia.pdf

[3] District of Columbia Department of Health, Chronic Disease Prevention State Plan for the District of Columbia, 2014-2019, at 4 (2014). https://dchealth.dc.gov/sites/default/files/dc/sites/doh/Chronic%20Disease%20State%20Plan%20v%2008%2026%2014%20%28Final%29.pdf

[4] District of Columbia Department of Health (2018). Health Equity Report District of Columbia: The Social and Structural Determinants of Health. Accessed from https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw.

well as more limited options for physical activity due to a lack of amenities or community violence are major contributors to higher rates of chronic disease.

Improving access to care for residents of Wards 7 and 8 is essential. The new hospital facility as currently designed can provide that care, but access to care will not begin to close the existing health disparities and address factors contributing to health disparities such as HIV, cancer, obesity, diabetes, and poor birth outcomes. The design of the new hospital at St. Elizabeths must take social and environmental determinants into account by incorporating into the facility resources that can prevent the development of chronic diseases in addition to treating chronic diseases after they emerge. With such high rates of chronic disease and associated health care costs in Wards 7 and 8, it is prudent to make investments in prevention and incorporate them into the plan for the new hospital. Rebalancing the mix of acute services at the new St. Elizabeth's hospital facility with adequate investments in prevention and job creation could improve the rates of disease in Wards 7 and 8, thereby improving the ability of those residents to achieve health and their ability to be educated, employed and economically stable.

The recommendations below focus on improvements to Article 3 Operations Covenants and Article 8 Community Investments in the proposed Hospital Operations Agreement.

<u>Amend Article 3.5 ("Community Engagement") to Ensure Authentic and Robust Community Engagement</u>

We commend the proposal for recognizing the need for community engagement and partnership with community organizations. However, as currently drafted, this article lacks the specificity to assure a community engagement process that is inclusive, strategic and authentic. This article should lay out a deliberate and specific strategy for engaging community members. Absent such a strategy, the engagement process may not truly account for the view of the community and may not reach residents who are not already associated with community organizations. This effort is essential to assure that the plans for the hospital align with the community's expectations.

We recommend including specific deliverables for community engagement. These might include utilization of representative focus groups, development and deployment of survey instruments, and use of a health impact assessment (HIA) process. This type of authentic engagement requires resources, but would provide invaluable insight worthy of support as part of this article.

<u>Amend Article 3.6 to Incorporate Population Health Principals More Broadly Into the Agreement Focusing on Service Delivery to Improve Population Health</u>

The type of research outlined in this article is essential, but we recommend changes to ensure the research is actionable and more directly aimed at identifying unmet community needs and mechanisms to address them via the new hospital complex.

For example, if population health research points towards continued high rates of diabetes, research methods such as system dynamics modeling or community based participatory research could point toward solutions instead of simply identifying long-standing problems.

In addition, we recommend that this section focus not only on research but on service delivery. Research activities could include the baseline health assessment recommended earlier in our comments. It should also include a robust service delivery component that incorporates preventive services such as cradle to grave screening including EPSDT, developmental assessments, wellness, routine screenings such as mammography and colonoscopy and for other chronic conditions know to be common in residents of Wards 7 and 8. A full array of services should be targeted at early detection, primary prevention and secondary prevention (prevention targeted at preventing diseases from becoming worse after they have been detected). Preventive interventions would be complemented with a hub within the physical plant that could house organizations and agencies whose services directly address social determinants such as housing, employment and community safety. These organizations would work alongside service providers who work with people who have preexisting chronic diseases e.g. as diabetes education and HIV counselors. For services not available within the hospital facility, a patient navigation service that could inform residents and refer and link them to outside services is critical to health promotion. We recommend establishing a transportation service that can ensure that patients reach facilities for ambulatory appointments and that can transport them to outside agencies for health-related services not available at this facility. Lastly, communication with Medicaid managed care is important for care coordination. There should be robust information systems that communicate with managed care when their members are seen and receive services and/or referrals.

<u>Amend Article 3.7 to Ensure Community Benefit Spending Addresses Social and Environmental Determinants of Health</u>

We commend the agreement for specifically including community benefits. The community benefits structure can be one of the primary means for the new hospital to invest in non-clinical supports to improve health outcomes by addressing the social and environmental determinants of health and underlying community inequities. Robust community benefits can invest in items such as safe housing, economic opportunities, access to healthy foods, and child care and family supports. We are concerned that as currently drafted, the community benefits language may have minimal impact.

Although the 3% set-aside may represent a substantial amount of resources, including uncompensated care in the calculation could result in few resources going toward other community benefits. Uncompensated care as a percent of hospital operating budgets averages around 3% nationwide (based on 2015 data) and 1.3% in the District, 3.1% in Maryland, and 4.8% in Virginia. While the District's rate is

lower, the new hospital's proximity to other jurisdictions and patient mix could mean a higher than average amount of uncompensated care. If close to 3%, the uncompensated care portion could push out other crucial community benefits investments.

To alleviate this concern, Article 3.7 should be amended to include a higher percentage for community benefit and uncompensated care or to include a specific set-aside (we'd recommend at least 2%) for community benefits outside of uncompensated care. In addition, we recommend that this article outline specific areas on which to focus community benefits spending, including food access and nutrition, workforce development, bridging the digital divide for Ward 7 and 8 residents, and other areas that might be identified through the community engagement progress.

We are also concerned that this article specifically mentions that failure to meet the standards laid out would not constitute a material breach. Given the substantial investment the District is making in this project, we recommend not including such an exemption for these essential provisions. At the very least, the agreement should build in other provisions for accountability, such as annual reporting on the scope and impact of community benefits projects.

<u>Articles 8.2, 8.3, and 8.4 can be strengthened by further incorporating community voice and a more deliberate strategy to support workforce development</u>
We support the inclusion of a workforce development strategy as part of the agreement and agree that the development and operation of the hospital can improve community outcomes by providing economic opportunity for District residents, particularly in Wards 7 and 8. An intentional and deliberate strategy can ensure not only that immediate job opportunities go to District residents, but also that partnerships and programs are in place to build the pipeline for the future workforce through supports for training and education.

A recent brief analyzed the direct services workforce in the District and Maryland. Among other findings, the study found that the workforce is overwhelmingly (88%) comprised of women of color. It also found that much of the workforce lacks formal education in their field. These findings point to the need to examine necessary supports for these workers. For instance, given the demographic makeup, focusing on family supports, such as child care supports, is critical. We recommend that the current workforce development provisions be amended to specifically include these elements.

<u>Conclusion</u>
We commend the District Government and UHS for their progress in the process of building and operating a new hospital at St. Elizabeths. The District has a unique and important opportunity to shape this agreement in ways that will advance health equity, invest in the residents of Wards 7 and 8 and move us toward a future where

health is not determined by race or address. We stand ready to work with you and your staff to improve this agreement and move it forward.

Additional References Utilized

1. District of Columbia Department of Health. (2014). The Burden of Cancer in the District of Columbia. Accessed from https://dchealth.dc.gov/sites/default/files/dc/sites/doh/DOH_BurdenOfCancer_V5.pdf
2. District of Columbia Department of Health (2018). Perinatal Health and Infant Mortality Report. Accessed from https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/Perinatal%20Health%20Report%202018_FINAL.pdf
3. District of Columbia Department of Health (2018). Annual Epidemiology and Surveillance Report. Accessed from https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/HAHSTA%202018%20Annual%20Report%20FINAL.PDF
4. District of Columbia. Office of the Mayor. (2018). Mayor Bowser announces major milestone in partnership with George Washington University for New Hospital and Health Services. Accessed from https://mayor.dc.gov/release/mayor-bowser-announces-major-milestone-partnership-george-washington-university-hospital-new.
5. Dcist (author Natalie Delgadillo). DC Will Partner with George Washington University on the New Hospital at St Elizabeths. (2018)Accessed from https://dcist.com/story/18/08/10/dc-will-partner-with-george-washing/ dcist.
6. Heller, Jonathan; Malekalafzali, Shireen; Todman, Lynn C.; and Wier, Megan. (2013). Promoting Equity through the Practice of Health Impact Assessment.
7. Human Impact Partners. (2011). A Health Impact Assessment Toolkit; A Handbook to Conducting HIA, 3rd Edition.
8. John R. Kemm, Jayne Parry, and Stephen Palmer (eds). (2004). *Health Impact Assessment: Concepts, Theory, Techniques and Applications*. Oxford University Press. (ISBN13: 9780198526292).
9. The Urban Institute (2019). What would it Take to Reduce Inequities in Healthy Life Expectancy. Accessed from https://next50.urban.org/sites/default/files/2019-09/Next50%20Health%20Catalyst%20Brief_0.pdf