GOVERNMENT OF THE DISTRICT OF COLUMBIA

Public Hearing on Bill 23-777
"New Hospital at St. Elizabeths Act of 2020"

Testimony of
Rashad Young
City Administrator

Before the
Committee on Health
Councilmember Vincent C. Gray, Chairperson
and the
Committee on Business and Economic Development
Councilmember Kenyan R. McDuffie, Chairperson

June 30, 2020, 9:00 a.m.
(Virtual Hearing via Webex)

Introduction

Good afternoon Chairman Gray, Chairman McDuffie, and members of the committees. My name is Rashad Young and I am the City Administrator for the District of Columbia. On behalf of Mayor Muriel Bowser, it is my honor to testify before you today on Bill 23-777, the New Hospital at St. Elizabeths Act of 2020.

Since 2017, the Office of the City Administrator has coordinated the District's effort to establish a new hospital and fully integrated network of care east of the Anacostia River to serve all District residents and in particular the residents of Wards 7 and 8. Before I begin, I want to thank the Mayor for her continued leadership and recognize the entire project team including, the Office of the Deputy Mayor for Health and Human Services, the Department of Health Care Finance, DC Health, the Department of General Services, the Deputy Mayor for Planning and Economic Development, and the Office of the Senior Advisor, all of whom made it possible to get to this point. I want to specifically recognize the longtime efforts of Deputy Mayor Wayne Turnage, who has worked tirelessly across Administrations to bring a new hospital agreement forward for the Council's consideration, while at the same time ensuring that United Medical Center (UMC) remains open and available to residents.

I want to affirm that the Bowser Administration expects UMC to remain open until the new hospital is completed and we recognize the work and care that UMC staff has and continues to provide to District residents during the current pandemic.

Understanding our History

As many convened here today are aware, operating a hospital east of the Anacostia River has challenged the District for over two decades. Over those twenty years, the hospital has at times lost its license and accreditation, been required to close critical services and has required a massive infusion of District funds to ensure its continued operations.

Over this time, the Greater Southeast Community Hospital, and its ultimate successor, UMC, have encountered significant financial and operational challenges that have been documented across numerous studies and assessments, the most recently completed by Huron Consulting Group in March of 2018. They include: the privatization of public hospitals, significant contractions in the hospital industry that have led to the majority of hospitals becoming part of larger regional or national systems, a paradigm shift in care delivery that emphasizes outpatient care over large inpatient facilities, obsolete and ineffective electronic health record and medical billing systems, the failure to develop and successfully implement clinical integration strategies in the community, the continued flight of patients to other hospitals, the burden of an inefficient and obsolete operating and physical structure, staff flight and talent drain, inflated costs, mismanagement and significant turnover in hospital leadership.

Combined, these challenges have had two results. First, they that have left the residents of Wards 7 an 8 with a struggling acute care hospital that has seen a significant decline in patient volume, limited services and no meaningful nexus to community health centers and critically important specialty care centers. Second, these challenges have essentially starved the hospital of critical revenues and since FY2016, UMC has been functionally bankrupt, surviving only through public subsidy.

The Mayor's Challenge

To address these unacceptable results, Mayor Bowser challenged us with the herculean, but necessary task of establishing a long-term, financially stable solution for providing all District residents with high quality care in their community. Her vision included the following components.

- Establish a full-service hospital and new network of care east of the Anacostia River.
- Allow mothers to give birth and receive maternal health services near their homes.
- Ensure seniors can receive the services they need to help them age in place.
- Provide treatment and services for those with chronic conditions to include education and prevention.
- Continue the long-standing and successful partnership with Children's National Hospital for pediatric care.
- Establish a trauma center that can treat nearly 90% of residents who are severely injured by accidents, falls and acts of violence.
- Integrate care with the existing clinics and primary care physicians who have served the residents of Wards 7 and 8 for many years.
- Support and create jobs through the $375 million investment in new construction.
- Provide opportunities for current residents to receive training so that they can enter and consider careers in the healthcare workforce.
- And finally, negotiate an agreement that aligns with the District's values and protects its interests.

In addition to the vision above, last fall Mayor Bowser established the Mayor's Commission on Healthcare Systems Transformation. The purpose of the Commission was to make recommendations to the Mayor on the strategies and investments necessary to transform health care delivery in the District of Columbia. Comprised of healthcare leaders from across the District, the Commission issued its final report and recommendations last December. In regards to inpatient care east of the Anacostia River, the Commission recommended that the District, "Develop a work plan for the success of a new hospital at St. Elizabeths, which should include

the establishment of an integrated health system for all Washingtonians, with an emphasis on the East End" of the District.

The Need

For far too long residents seeking health and hospital care east of the Anacostia River have been voting with their feet – we know that nearly 9 of 10 residents who live near UMC currently choose to receive care elsewhere in the District. The many reasons for this decision have been identified and analyzed, but all are valid — trust, perception of quality, reputation and brand, aging facilities and equipment, confidence in physicians and staff, and a lack of services and connectivity.

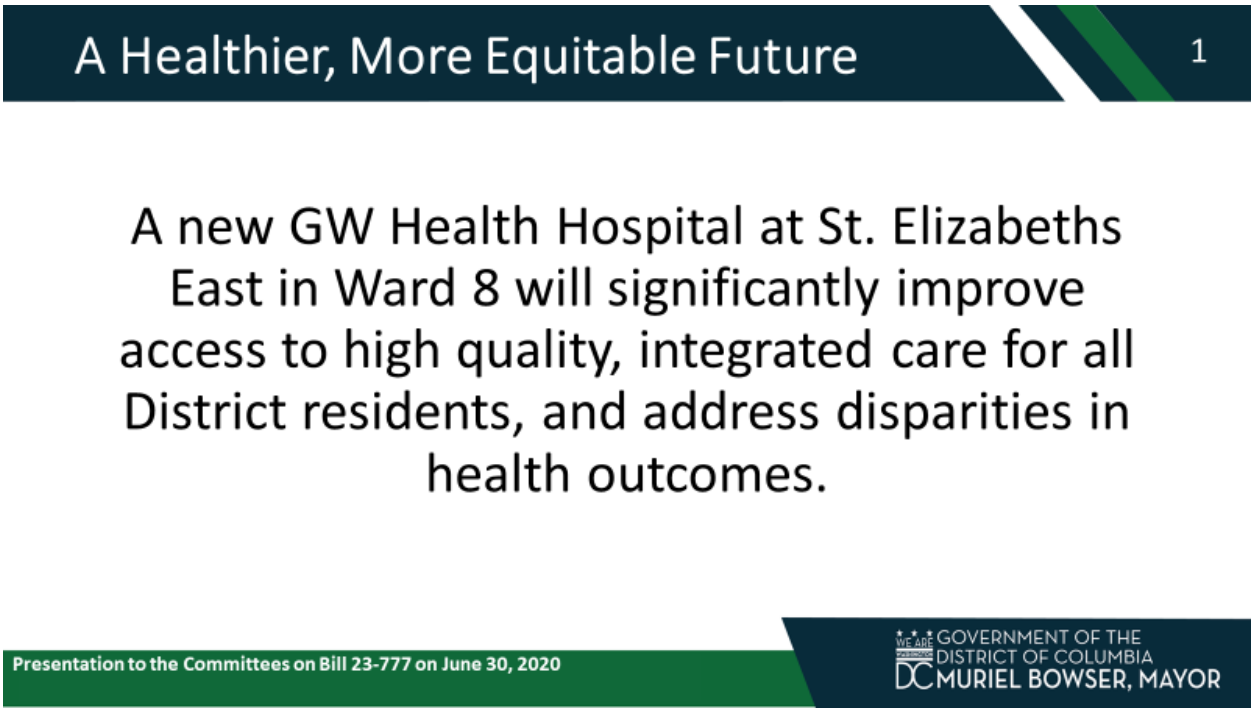
The legislation and agreements before you today propose a fresh start. They are grounded in what we know about why residents are not using UMC and what they have said they want to see when seeking care at a new facility. I'd now like to provide an overview of the legislation and agreements through the following PowerPoint presentation.

How the Legislation and Agreements Work Together

The legislation approves the development agreement as a contract in excess of $1 million, approves the operations agreement as a contract in excess of $1 million and as a multiyear contract, and approves the disposition of the hospital and underlying land to UHS for a period not to exceed 99 years, pursuant to the lease agreement. In addition, the legislation would enact two statutory provisions necessary to implement the agreements: the creation of the hospital startup reserve fund and the establishment of an updated uncompensated care requirement for the new hospital.

The Proposed Agreement for a New GW Health Hospital at St. Elizabeths

*****Presentation starts on the next page.*****



A new GW Health Hospital at St. Elizabeths East in Ward 8 will improve access to high quality, integrated care for all District residents, and address disparities in health outcomes.

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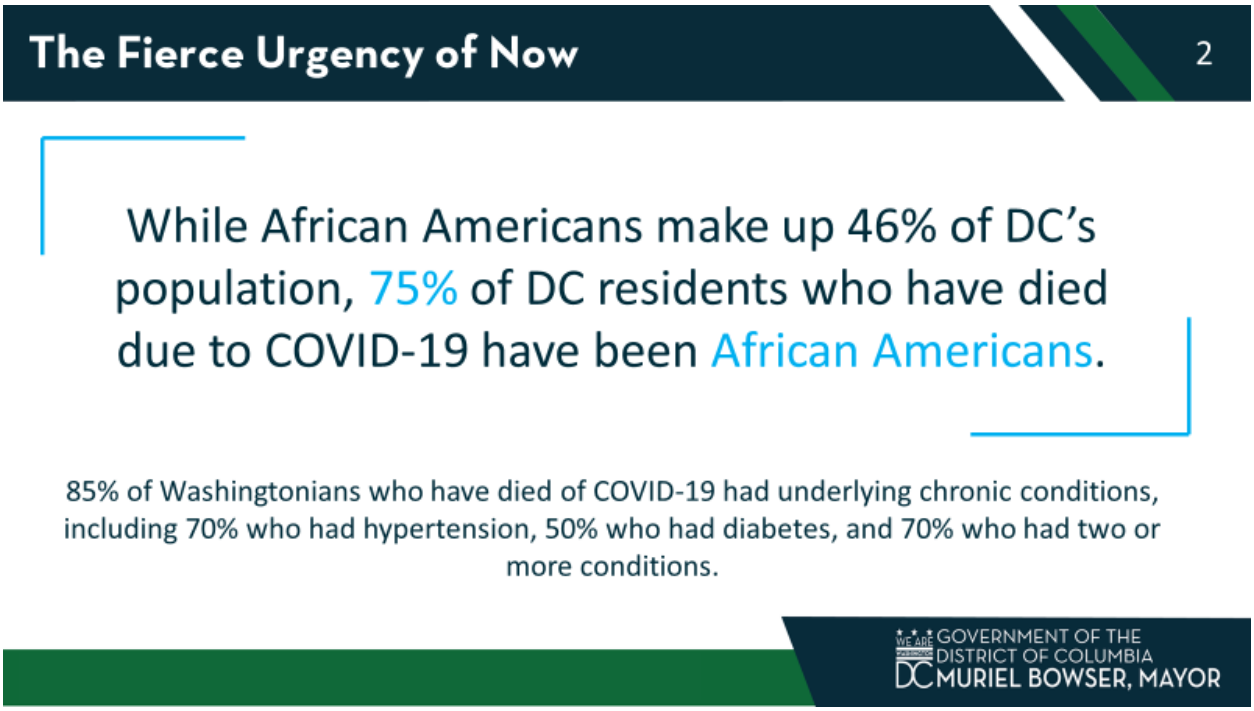

The current and ongoing COVID-19 pandemic has exposed and significantly exacerbated the unacceptable health disparities that have long existed in our black, brown and low-income communities for generations.

Specifically, we know that African Americans make up 46% of the District's population, but that 73% of District residents who have died due to COVID-19 have been African Americans.

We also know that 85% of Washingtonians who have died of COVID-19 have had underlying chronic conditions, including 70% who had hypertension, 50% who had diabetes, and 70% who had two or more conditions.

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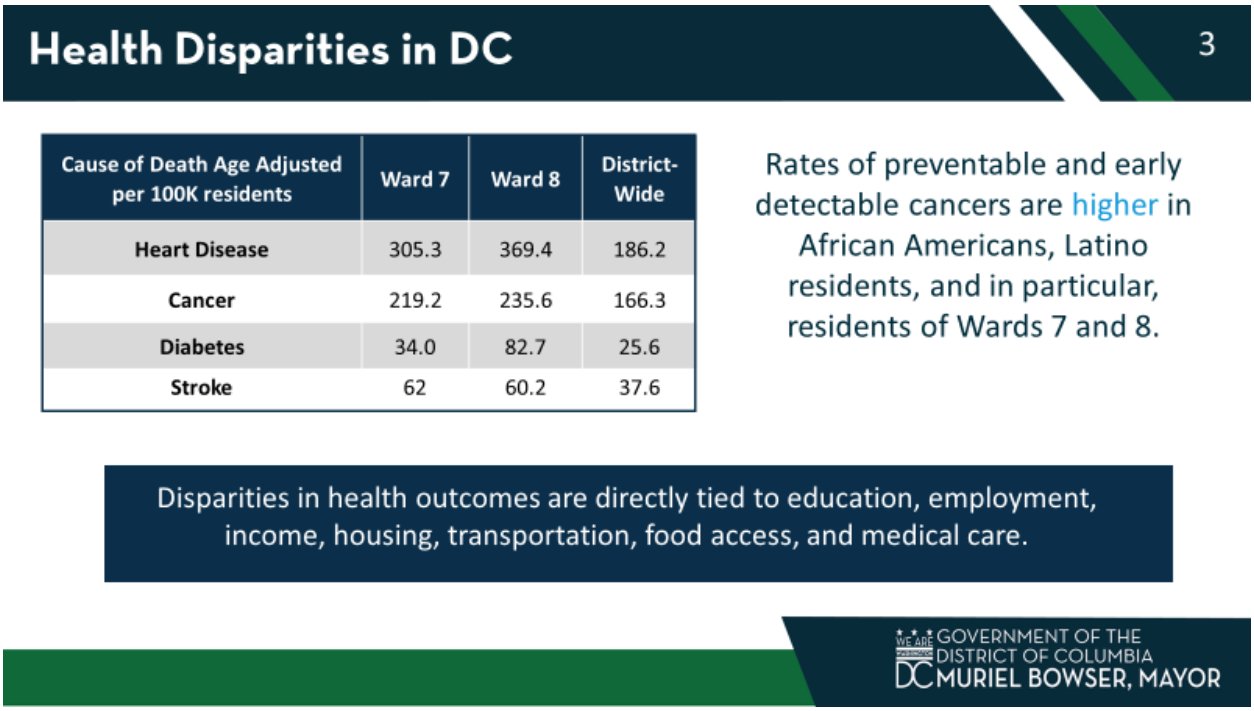

Before the current pandemic, residents of Wards 7 and 8 were — and still are —facing an epidemic of their own, with rates of chronic disease and death that are 2 to 3 times higher than the rest of the District.

While we know that a new hospital and integrated system of care are critical to reducing these disparities, we also know that they are only part of the larger puzzle that must be combined to improve residents' lives. These critical social determinants of health include education, housing, transportation, food access, safe neighborhoods and stable employment.

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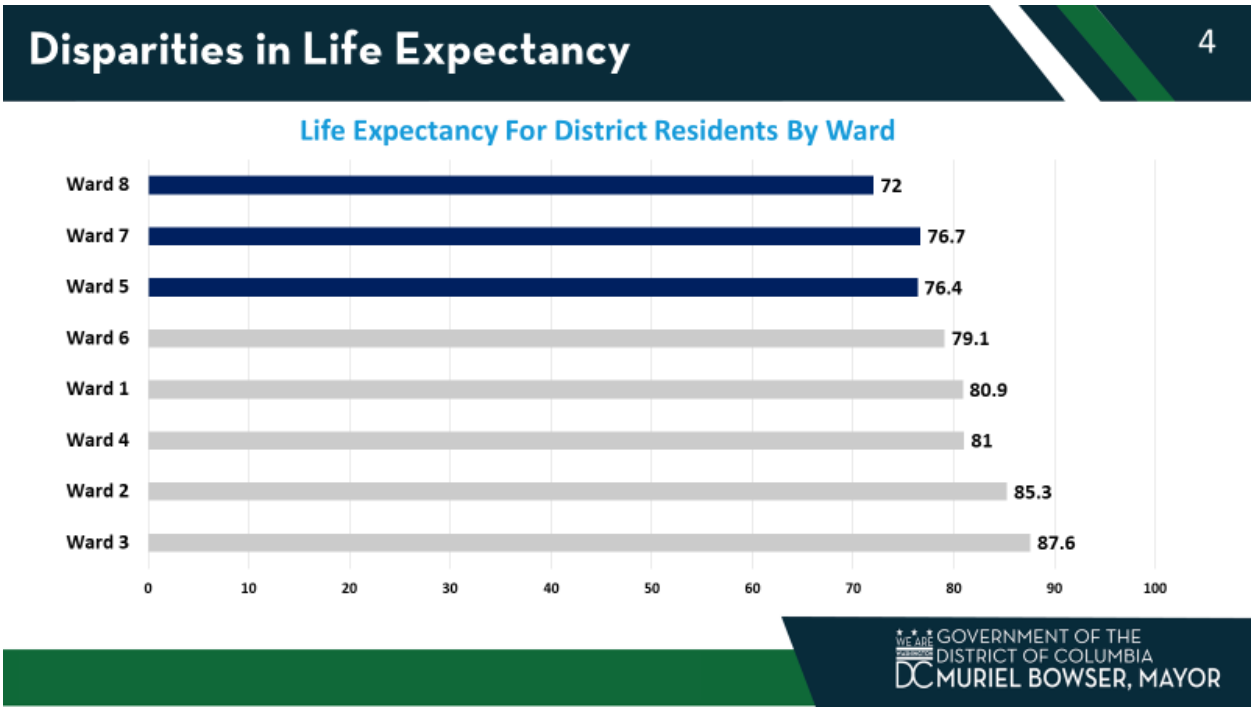

The results of these health outcomes and disparities are undeniable and unacceptable. Residents living in Wards 5, 7 and 8, die 11 to 15 years before residents living in other parts of the District.

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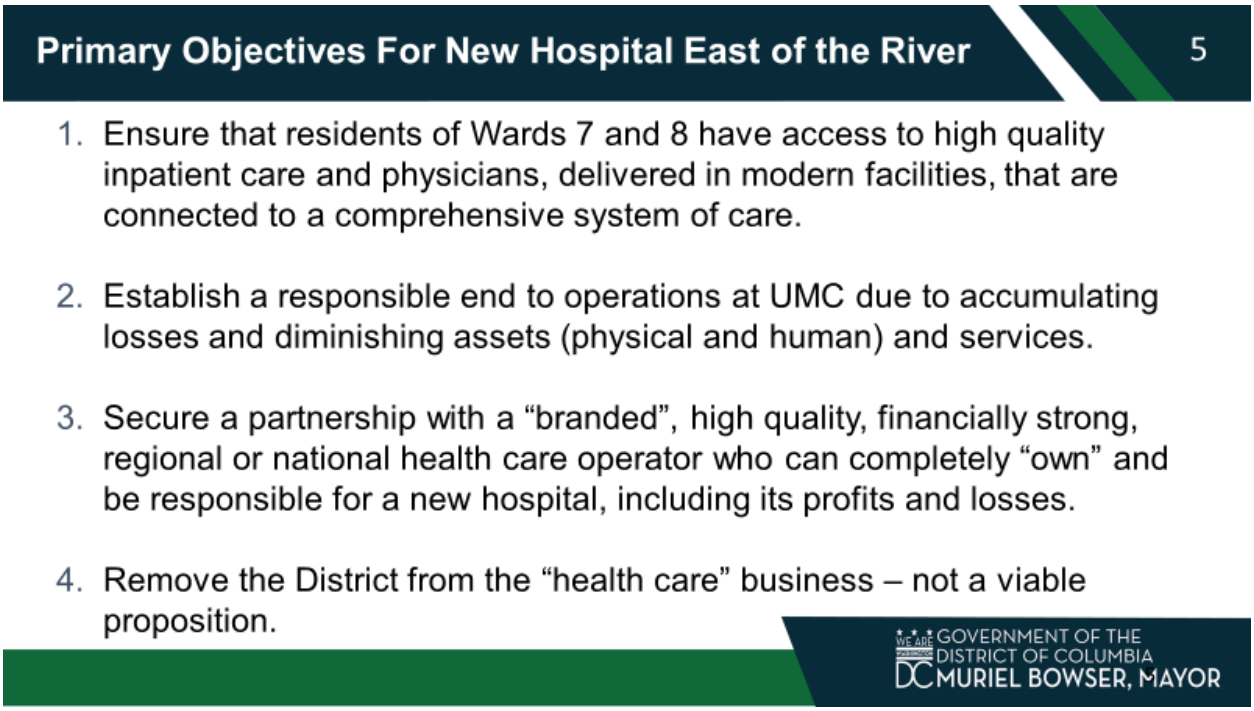

To turn the tide, the Mayor challenged us to establish an agreement that would build a FULL SERVICE, financially stable community hospital that would also establish a system of care for all District residents and in particular the residents of Wards 7 and 8. To achieve that goal, the District established four objectives for a new hospital east of the river, they are listed on the current slide.

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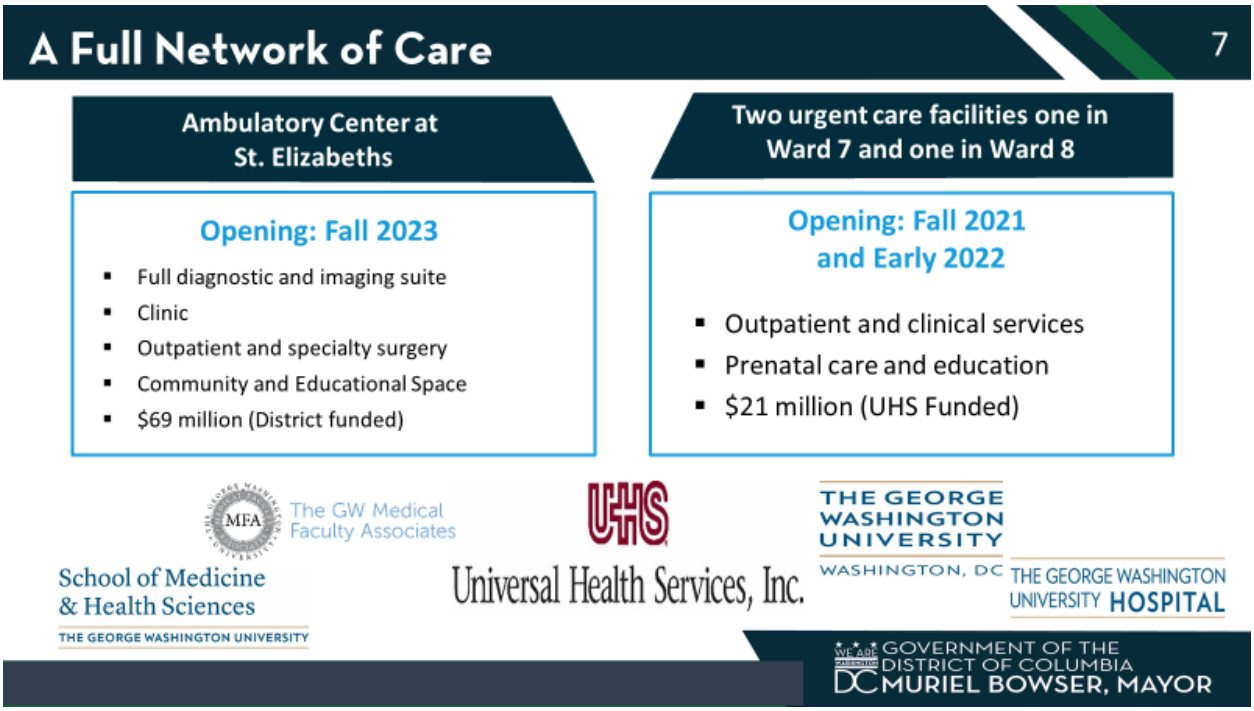
The proposed legislation and corresponding agreements before you today between the District and Universal Health Services, propose a new FULL-SERVICE community hospital with a verified trauma center, that looks, feels and functions like Johns Hopkins Sibley Memorial Hospital in Ward 3. The new hospital would open in the Fall of 2024 with 136 beds, 16 of which will be for behavioral and mental health and can be expanded in the future to 196 beds.

Specifically, the hospital includes:

- A Verified Trauma Center
- Intensive Care Unit, Surgery and Operating Rooms
- Newborn Delivery and Women's Services
- Level II Neonatal Intensive Care Unit
- Adult and a Pediatric Emergency Department operated by Children's National
- Physicians, medical students and research in partnership with the George Washington University School of Medicine and GW Medical Faculty Associates
- Parking and Transportation to the Congress Heights Metrorail Station

The hospital will cost $293 million and the garage will cost $13 million for a total cost of $306 million.



In addition to the hospital, the agreements propose building with District funds, a $69 million ambulatory care center next to the new hospital that can provide outpatient and specialty services, physician offices, surgical care and community and educational spaces. This facility would open in the fall of 2023.

To expand access to care throughout the community, Universal Health Services will spend $21 million to open two new urgent care facilities, one in Ward 7 and one in Ward 8. These facilities would open in the Fall of 2021 and Early 2022. The urgent care facilities will serve as clinics and critical nodes for the overall system of care.

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The slide above lists some of the core traditional and specialty services we will be available at St. Elizabeths. I want to reiterate that this will be a full-service hospital. Critically, the new hospital is required to provide maternal health, newborn deliveries and a level two NICU, which will allow for the vast majority of mothers in Wards 7 and 8 to deliver their babies near home.

The new facilities will also provide general surgery, mental health and rehabilitation services and a full range of specialty services designed to meet the needs of the community. These include many chronic conditions such as diabetes, cardiac and hypertension, cancer and urology.

This list is not intended to be exhaustive and final. As Dr. Nesbitt continuously reminded me during our negotiations, the health care landscape changes all the time - through national policy like the Affordable Care Act and/or local market changes such as the recent closure of Providence, or the unexpected, such as today's pandemic. The agreements before you today account for change by ensuring that there is a continued dialogue between the parties and the community over the next four years and when the hospital opens such that new services can be considered and established as needed.

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District's Current and Future Community Hospitals

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	GW Health St. Es	Sibley	UMC
Constructed	2024	1961 (Updated 2016)	1966
Verified Trauma Center with 24/7 General and Orthopedic Surgery	Yes	--	--
Newborn Deliveries, Level 2 NICU, Maternal Health	Yes	Yes	--
Full Range of Specialty Services (Cancer, Kidney, Diabetes, Orthopedic)	Yes	Yes	--
Integrated Care with Community Based Ambulatory & Urgent Care Facilities	Yes	Yes	--
Modern Facility with State of the Art Equipment and Technology	Yes	Yes	--
Physicians with an Academic Affiliation*	Yes	Yes	--
Partnership with Children's Hospital*	Yes	Yes (Cancer)	Yes

*Established via MOAs.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

This slide illustrates some of the key services and assets of the District's existing community hospitals and the proposed GW Health Hospital at St. Elizabeths. As you can see, the new hospital will be very similar to Sibley Memorial Hospital, except that the new hospital will include a verified trauma center, which I will describe in more detail later in my remarks.

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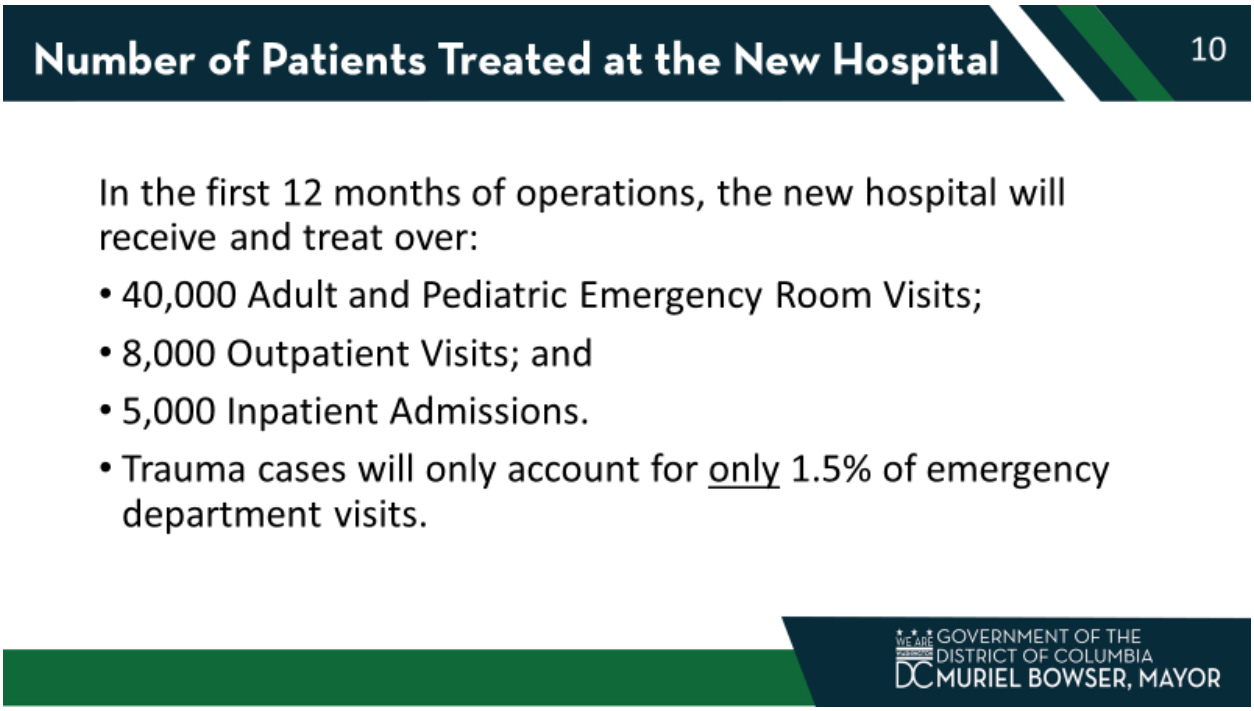

We expect the new hospital and ambulatory center will see tens of thousands of patients in its first year of operations. Specifically, over the first 12 months the new hospital is expected to receive over:

- 40,000 adult and pediatric emergency room visits;
- 8,000 outpatient visits;
- 5,000 inpatient admissions; and
- Fewer than 700 trauma cases, which will account for only 1.5% of emergency department visits.

As a full-service hospital, patients can receive a full range of critical health services for example:

- A 52-year-old patient can be admitted due to progressive shortness of breath with extensive smoking history and some weight loss over the last month. The patient would receive a CT scan of the chest, a colonoscopy, and cancer bio marker. Based on the results, the patient would be diagnosed and staged for lung cancer. The hospitalist would facilitate a telemedicine consultation with the oncologist to plan for the patient's cancer treatment regimen.
- A 36-year-old with a headache that has been unresolved by Tylenol or Advil. His family's history reveals a history of uncontrolled hypertension. The patient's blood pressure is taken, and he is treated and educated on the risk of uncontrolled hypertension. Due to the severity of his blood pressure he is admitted to the intensive

care unit and placed on multiple blood pressure medications. After a 30 hour stay in the ICU, he is successfully discharged with a normal blood pressure and appropriate outpatient blood pressure medications.

- An 81-year-old is transferred from a local nursing home with uncontrolled diabetes. The patient is noted to have blood sugars in the 800's despite having started an insulin regimen at the nursing home. She also has multiple chronic foot ulcers for which the wound care service is consulted. The patient is admitted through the emergency department into the ICU to bring the extremely high blood sugar down with insulin and then spends a few more days at the hospital to have her blood sugar regimen adjusted prior to being transferred back to the nursing home.

- An 87-year-old resident who lives alone is brought to their primary care physician's office by concerned family members who say he has been losing weight and has fallen two nights ago. Concerned about his home safety and health, the primary care physician arranges for a direct admission to the hospital. The hospitalist service cares for the patient along with the nutritionist, and physical therapy. The team also consults via telemedicine a gerontologist as well as a social worker on site to determine along with the primary care physician and the patient's family the best and safest plan for the patient to include physical improvements to the patient's home through programs such as the Department of Aging and Community Living's Safe at Home program.

- A 27-year-old female who presents at 38-weeks of pregnancy in active labor to the Labor and Delivery Unit. Through established relationships between the hospital and the prenatal care providers in the community, the patient's health records are available at the hospital upon arrival. The patient delivers a healthy 7 lbs. 3 oz. baby boy 6 hours later. Both mom and baby go home after two days.

- And a 23-year-old female who calls EMS complaining of abdominal pain and vaginal bleeding, being 39.5 weeks pregnant. The patient is brought by FEMS to the Labor and Delivery unit. Upon assessment of the patient, fetal distress is noted by the obstetrician. A high-resolution ultrasound shows a significant hemorrhage. An immediate caesarean section is called by the obstetrician. The time from calling the c-section to the delivery of a healthy baby girl is 7 minutes, saving the mother's and infant's lives.

These are all examples of future District residents who will receive the care and necessary follow-up they need at the new hospital and community health resources to continue living healthy and productive lives.

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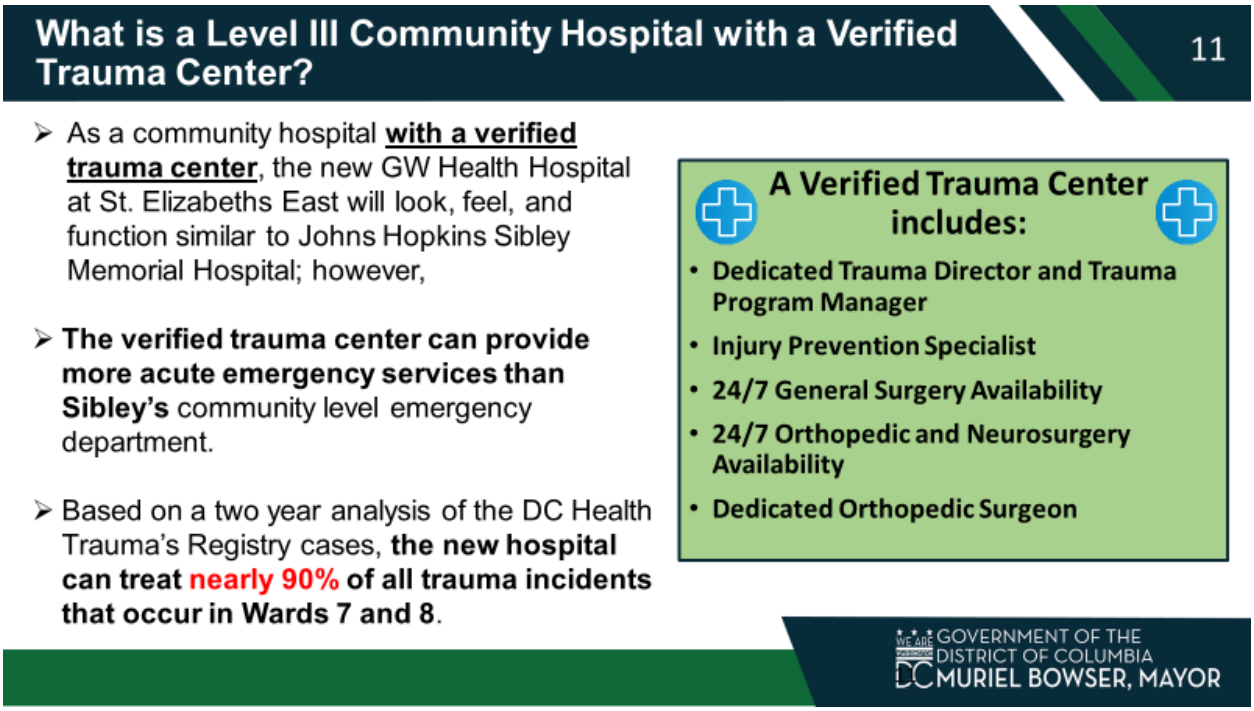


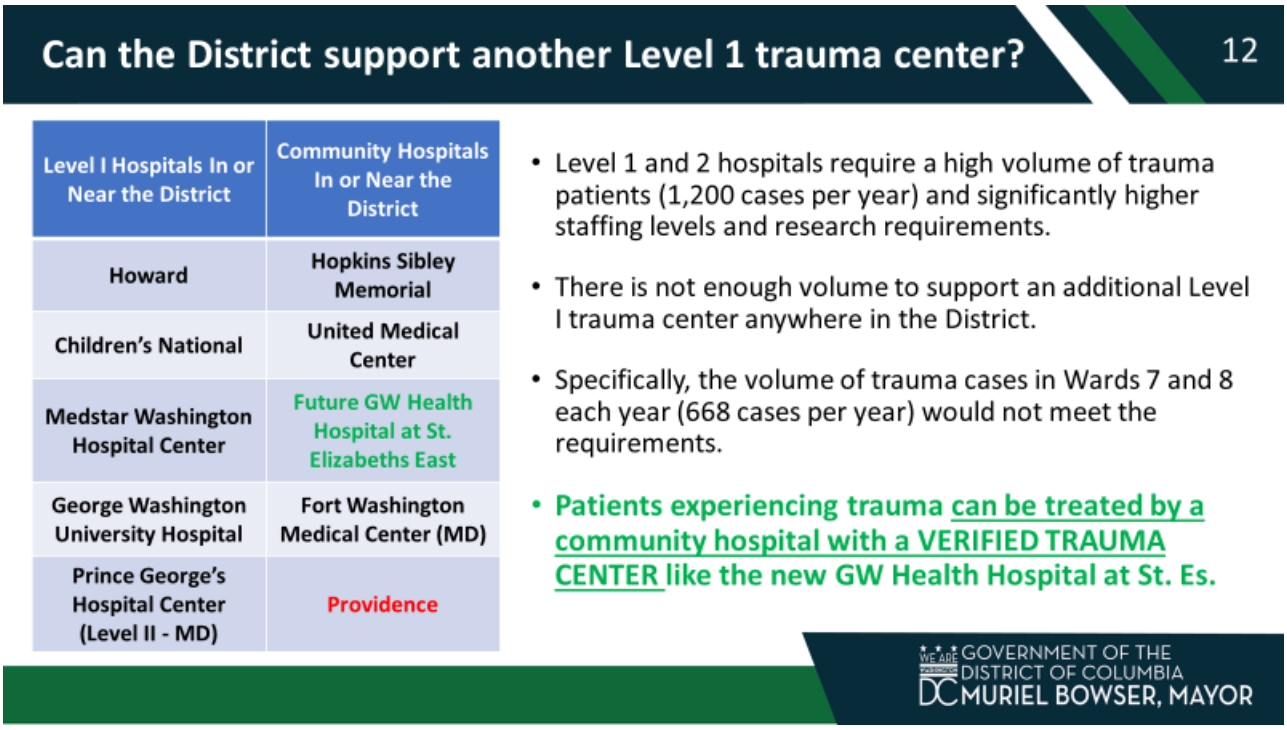
I want to take some time today to discuss an important issue that was raised over a year ago by Councilmember Trayon White and many community members. That is how we will the new hospital address cases of trauma that occur in the community.

As I mentioned earlier, the new hospital will look, feel and function like Johns Hopkins Sibley Memorial Hospital, except it will have an important distinction by having a verified trauma center that can provide more acute emergency services than Sibley's community level emergency department. A verified trauma center can provide trauma care because it includes on site:

- A dedicated trauma director and trauma program manager,
- 24/7 general surgery,
- 24/7 orthopedic and neurosurgery, and a
- Dedicated orthopedic surgeon.

Based on a two-year analysis of DC Health's Trauma Registry, which records each case of trauma throughout the District and its level of severity, **the new hospital will be able to treat nearly 90% of all trauma incidents that occur in Wards 7 and 8.**

Assuming every trauma patient from Wards 7 and 8 went to the new hospital, which we know wouldn't happen, trauma would comprise of only 1.5% of all emergency room related visits (42,000) in the first year. Next slide please.

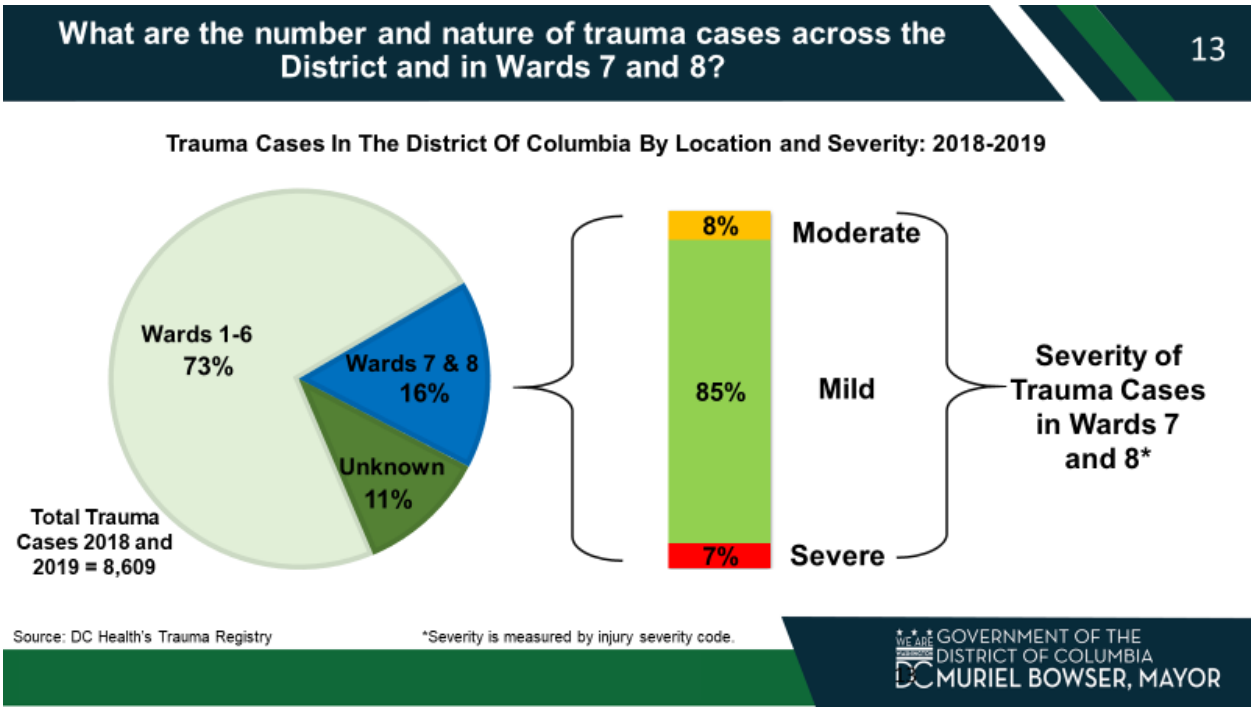


I want to spend a little time today talking about hospital levels, what they mean and the type of services they can provide. What truly separates the District's existing Level 1 and 2 hospitals from our community hospitals, such as Sibley and the new GW Health Hospital, are the sheer number of trauma patients they are required to treat each year and the significantly higher levels of staffing and research they must maintain and complete for accreditation.

As the chart on the left shows, the District has five Level 1 or 2 hospitals in or near its borders, more than nearly any major U.S. city. In comparison there are only seven Level 1 facilities in all of Virginia, one for every 1.2 million residents.

As I mentioned, Level 1 and 2 hospitals require a high volume of trauma patients, 1,200 cases per year; however, the District only averages 4,300 trauma cases per year. This means, there are not enough trauma cases to support an additional Level 1 trauma center in the District without moving or closing an existing facility.

While the volume of trauma cases within Wards 7 and 8 each year— 668 cases per year — does not meet the requirements for a Level 1 or 2 facility, the District determined that the new hospital should have a verified trauma center so that nearly 90% of patients experiencing trauma can be treated locally. Finally, during the District's discussions with regional hospital operators, none expressed an interest in building a Level 1 hospital at St. Elizabeths unless it meant an existing Level 1 facility was closed or moved. Next slide please.



To understand how many trauma patients could be treated at the new hospital, the District analyzed the 8,600 trauma cases that occurred in the District in calendar year 2018 and 2019. We took a detailed look at the 16% or 1,300 cases that occurred in Wards 7 and 8.

Every trauma case in the District is recorded by the hospital at which the patient is treated and assigned a trauma severity score by the responding health care team. Trauma scores are typically grouped in three categories: mild, moderate, or severe. For 2018 and 2019, the data show across all Wards 7 and 8 trauma cases, 85% were classified as mild, 8% moderate and 7% severe.

Some examples of each level of trauma include:

<u>Mild Trauma</u>

- A 25-year-old patient in a motorcycle crash who experienced a brief loss of consciousness but is now awake with a broken wrist and road rash. There is concern for possible brain injury because he was not wearing a helmet, and the patient needs a head CT scan and wrist x-rays, neurosurgery and orthopedic surgery evaluation.
- A 20-year-old patient who sustained a stab wound to the abdomen and who is awake and stable but there is concern for possible injury to the intestine. The injury needs to be explored in the operating room.
- A 70-year old who falls from standing with a hip deformity, where there is a concern that there may be a hip fracture. The patient needs orthopedic evaluation and a possible operation.

- A 30-year-old who put their arm through a glass window, who has an open, bleeding gash on his forearm. The patient needs suture repair and possible tendon repair. This patient will need general surgery and possibly orthopedics.

All of these patients could be cared for and treated and the new hospital.

Moderate

- A 20-year-old male with a gunshot injury to the abdomen or an extremity that is stable and awake, but experiences significant pain. This patient would require operative intervention, which could be done 24 hours per day at the new hospital.

- A 70-year-old female who falls from standing and arrives with multiple broken ribs and a punctured lung. The patient needs aggressive pain control, possible chest wall reconstruction, and a tube to drain her chest. The trauma service at the new hospital can treat this case.

These cases can be treated at the new hospital.

Severe

- A 70-year-old who takes anticoagulants and is involved in a motor vehicle crash. Upon admission, he is noted to have bleeding around the brain on a CT scan. The patient needs admission to the ICU for close monitoring and possible neurosurgical intervention, along with reversal of the anticoagulants. This treatment can be provided at the new hospital.

- A patient who is initially cared for at the new hospital but develops complications or progression of disease that requires advanced care. For example, a patient who is severely injured (e.g. a gunshot wound to the head or severe abdominal injury) that requires ongoing mechanical ventilation and then develops severe lung infection requiring advanced mechanical ventilation or ECMO treatment that uses a pump to circulate blood through an artificial lung back into the bloodstream. These two treatments require not just specialized equipment but also very specialized doctors, nurses, and respiratory therapists. This patient would be better served by being transferred to a level 1 trauma center.

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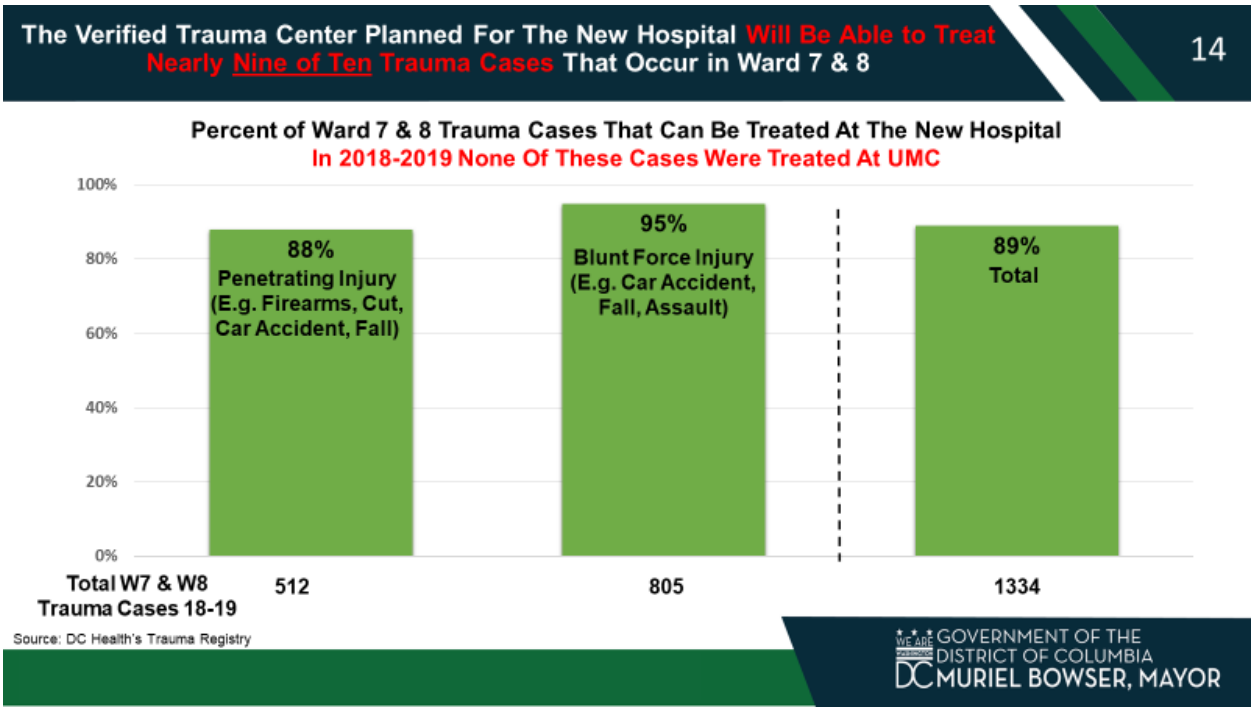

Across all trauma cases in Wards 7 and 8, 40% were classified as penetrating injuries, such as those sustained from firearms, cuts, car accidents and falls and 60% were blunt force injuries such as those sustained in falls, car accidents and assaults. Based on the resources present at the verified trauma center, nearly 9 of 10 trauma cases could be treated at new hospital, the remaining 1 would be stabilized and transferred to a Level 1 facility for treatment.

It is important to note that none of these cases are currently treated at United Medical Center as FEMS does not transport trauma cases to UMC and patients who present at UMC with trauma (either by walking in or being dropped off by friends of family) are stabilized and transferred for care at other facilities.

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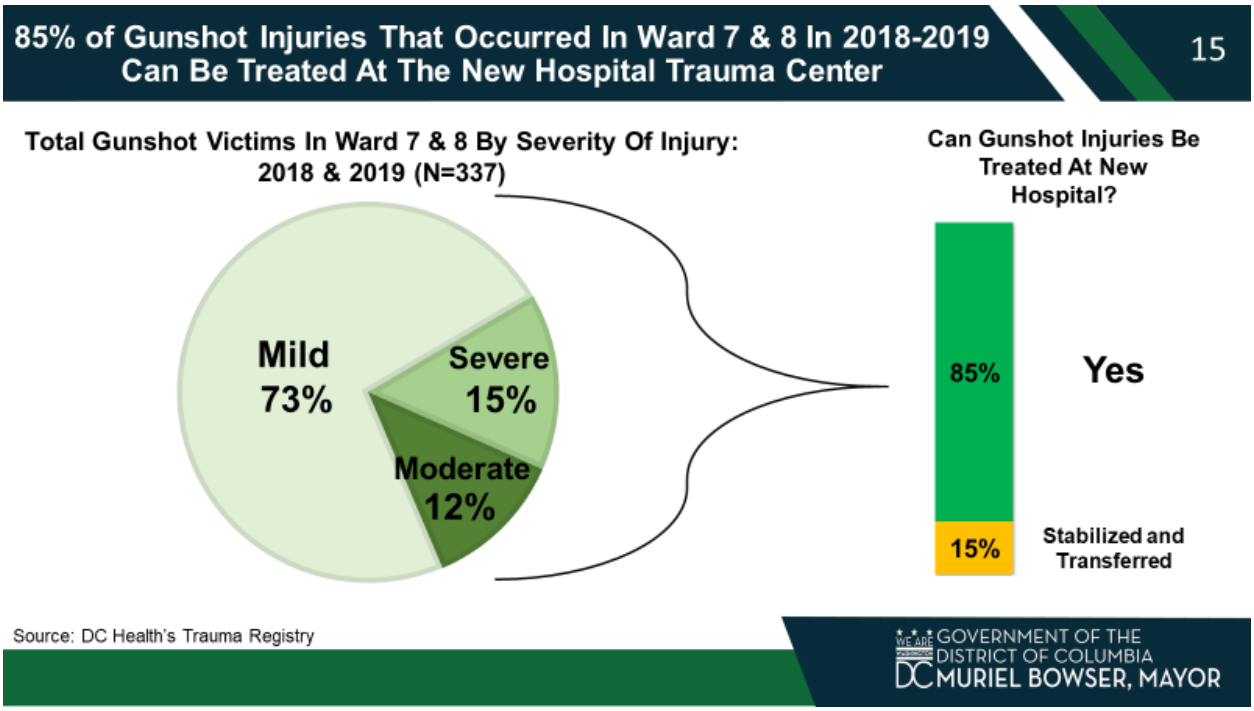

We dug a little deeper to analyze trauma patients from Wards 7 and 8 who suffered from firearm wounds. What we found is that over 70% of traumatic gunshot cases were mild, 12% moderate, and 15% severe. Based on this data, and in alignment with some of the examples I provided earlier, the verified trauma center at the new hospital will be able to treat 85% of gunshot injuries. The remaining 15% of patients would be stabilized and transferred. Again, none of these trauma cases are currently treated at United Medical Center.

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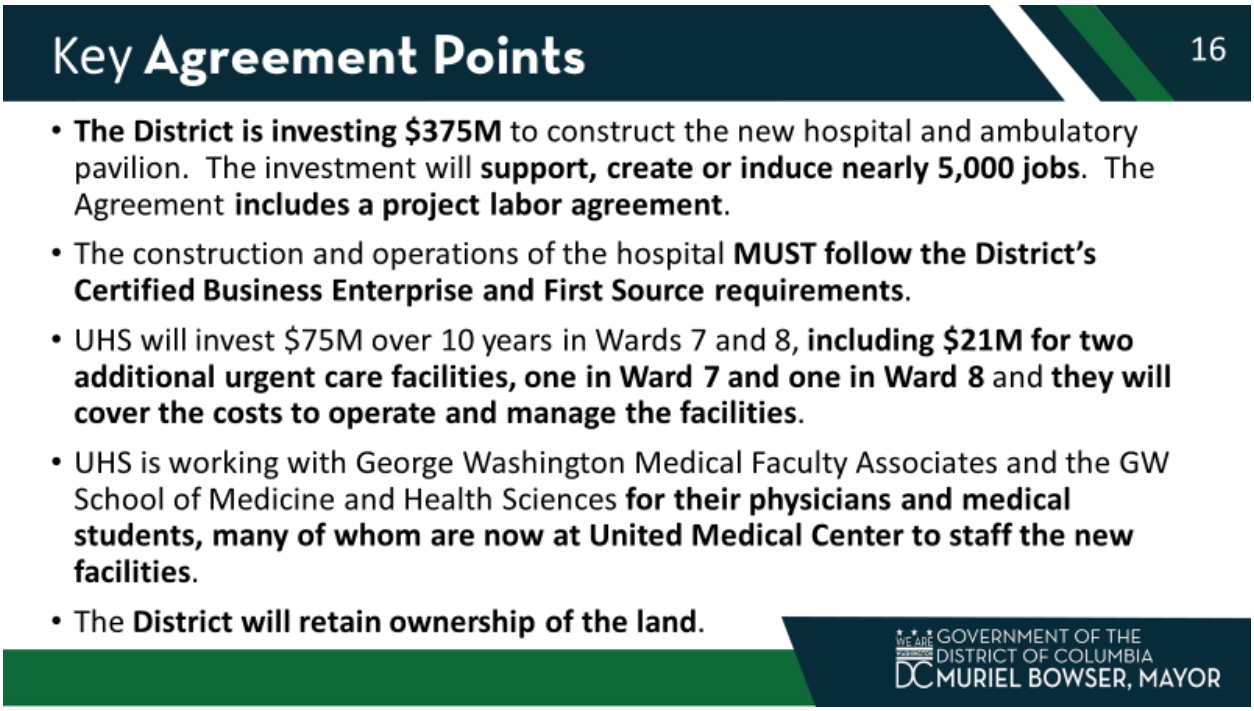


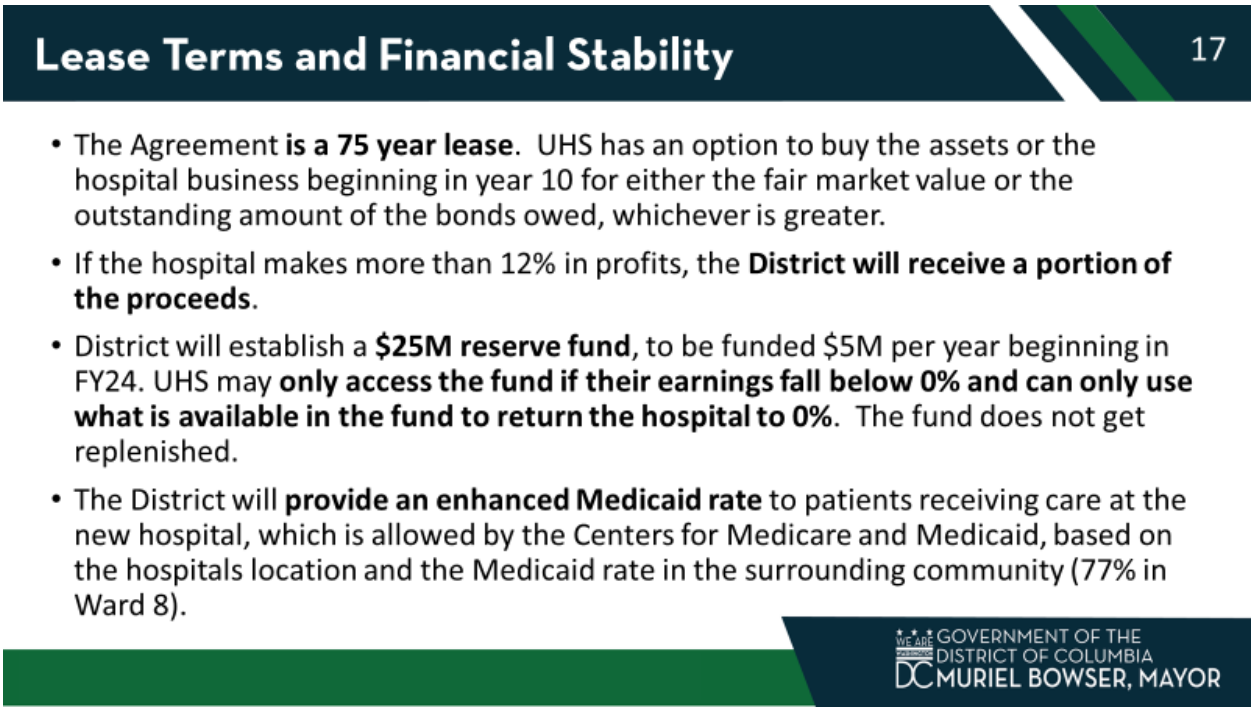
The next five slides provide an overview of the key terms proposed in the legislation and corresponding agreements that are before you today.

To build the facilities, the District is investing $375 million to construct the new hospital, ambulatory pavilion and garage. This investment will support, create or induce nearly 5,000 jobs. As required by the Council and supported by the Mayor, the agreement mandates a project labor agreement. In addition, the construction and operations of the hospital MUST follow the District's Certified Business Enterprise and First Source requirements.

In addition, Universal Health Services is required to invest $75 million over 10 years in Wards 7 and 8, including $21 million for the two additional urgent care facilities, one in Ward 7 and one in Ward 8, the electronic medical records system at the new hospital, the cost of managing the construction, and other community investments that will be determined in discussion with the community. In addition, the new hospital is required to annually provide 3% of its total operating expenses to uncompensated care, charity care, and other community benefits. UHS is also responsible for covering the costs to operate and manage the facilities.

UHS is also working with the George Washington Medical Faculty Associates and the George Washington University School of Medicine and Health Sciences for their physicians and medical students, many of whom are now at United Medical Center, to staff the new facilities.

Finally, at all times during the agreement, the District will retain ownership of the land. Next slide please.



The agreement is implemented in part through a 75-year lease. The lease includes an option for UHS to buy the assets or the hospital business beginning in year 10 for either the fair market value or the outstanding amount of the bonds owed, whichever is greater and then pay fair market rent to the District. The lease would then extend to 99 years.

If in any year, the new hospital exceeds an EBITDA margin of 12% or higher, the District will receive the following proceeds.

- 12-18% EBITDA, District receives 25% of gross revenues
- 18-20% EBITDA, District receives 35% of gross revenues
- 20-22% EBITDA, District receives 45% of gross revenues
- 22-25% EBITDA, District receives 50% of gross revenues
- 25%+ EBITDA, District receives 75% of gross revenues

For context, Universal Health Services' overall EBITDA margin, across all facilities was most recently 14.9%, before COVID-19.

In order to ensure long-term financial stability, the agreement contains two structural supports by the District. First, the agreement requires that the District establish a $25 million reserve fund, to be funded $5 million per year, for five years, beginning in FY24. UHS may only access the fund if its earnings fall below 0% at the new hospital and can only use what is available in the fund to return the hospital to 0%. For example, if in year 1, the new hospital loses $7 million, UHS can use $5 million from the reserve fund, but it would be responsible for the remaining $2 million. If

say, in year one the new hospital lost $3 million, UHS could use $3 million from the reserve fund and the remaining $2 million would remain available for future use. The agreement does not provide for the fund to be replenished, and the fund would be dissolved after 10 years.

Second, the District will provide an enhanced Medicaid rate of 147% to Medicaid patients receiving inpatient and outpatient care at the new hospital and ambulatory pavilion through a State Plan Amendment with the Centers for Medicaid and Medicaid Services. This rate is based on the rate that GWUH is already receiving from its Medicaid health plans. Setting a specific rate is allowed by CMS due to the high volume of Medicaid patients in Ward 8 – currently 77%, which makes it an "underserved" area. If the percent of residents in Ward 8 receiving Medicaid goes below 55%, the enhanced payment rate will be eliminated. An important aspect of this structural support is that the District only shoulders 30% of the enhanced rate, while the federal government funds the remaining 70%.

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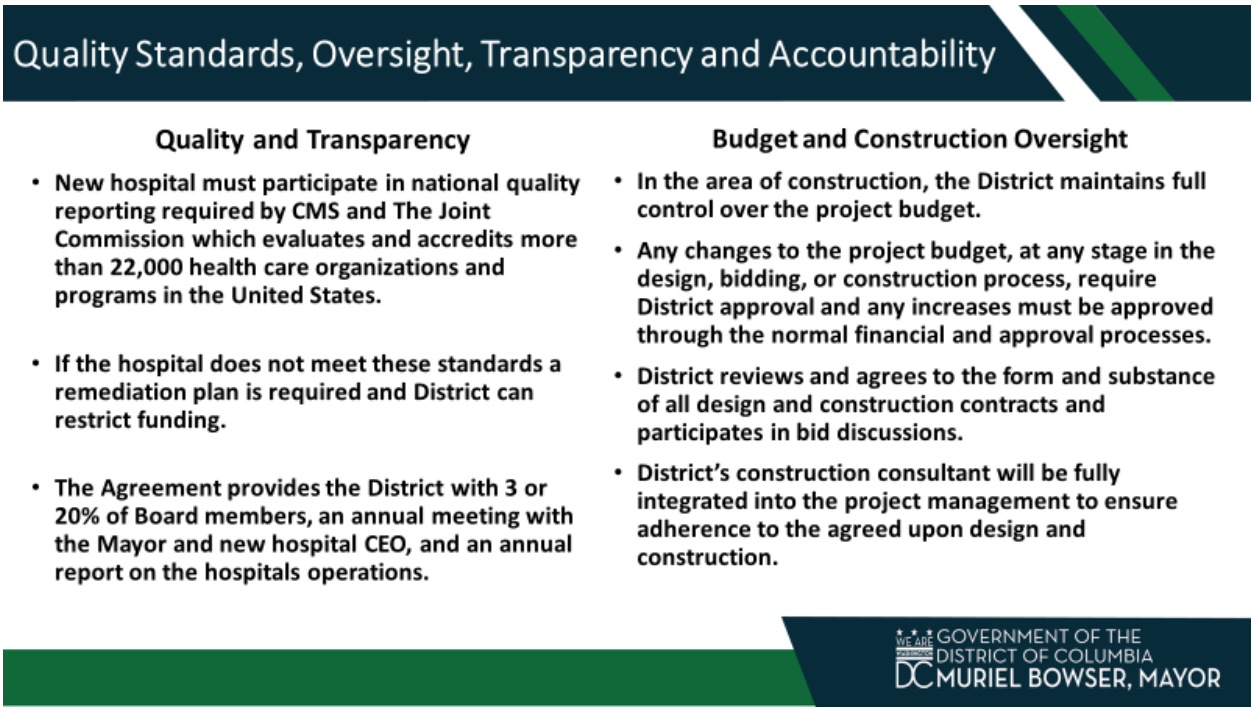

Critically important to the District was ensuring that it maintained strong oversight, transparency and quality standards for both the construction and operations of the hospital.

Specifically, the hospital will be required to participate in all national quality reporting such as those required by CMS and The Joint Commission which evaluates and accredits more than 22,000 health care organizations and programs in the United States. If the hospital does not meet these standards a remediation plan is required. If the hospital continues to not meet standards the District can restrict funding in the reserve fund and reimbursement rates to remediation activities. The agreement also provides the District with 3 or 20% of Board members, an annual meeting with the Mayor and an annual report on the hospital's operations.

In the area of construction, the District maintains full control over the project budget. This includes control over any changes to the project budget, at any stage in the design, bidding, or construction process. Any increase to the overall budget that would require further appropriations, must be approved by the District through the normal financial and approval processes.

It also provides the District with and responsibility for reviewing and agreeing to the form and substance of the construction contracts and participating in bid discussions. The agreement also allows for the District's construction consultant to be fully integrated into the project management to ensure adherence to the agreed upon design and construction.

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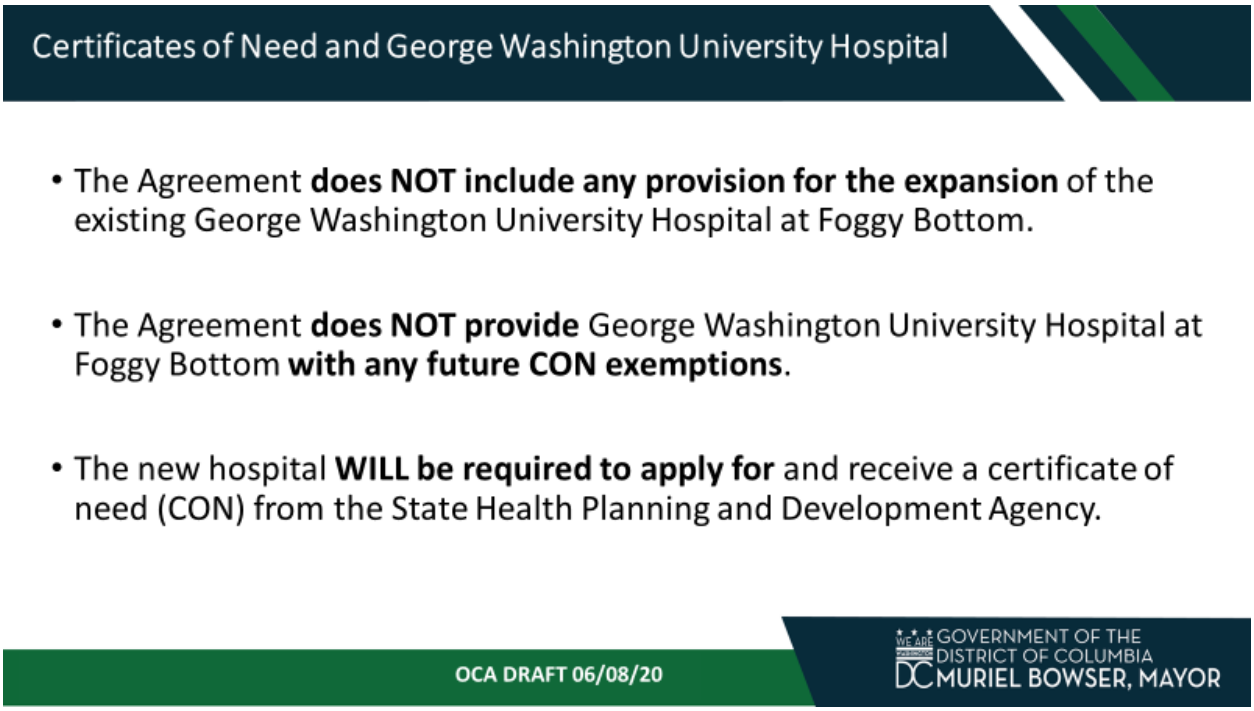

Importantly, the legislation and agreements before you today, do NOT include any provision for the expansion of the existing George Washington University Hospital (GWUH) at Foggy Bottom. Nor does it provide GWUH with any future exemptions from the CON process.

In addition, the new hospital at St. Elizabeth's will be required to apply for and receive a Certificate of Need from the District's State Health Planning and Development Agency.

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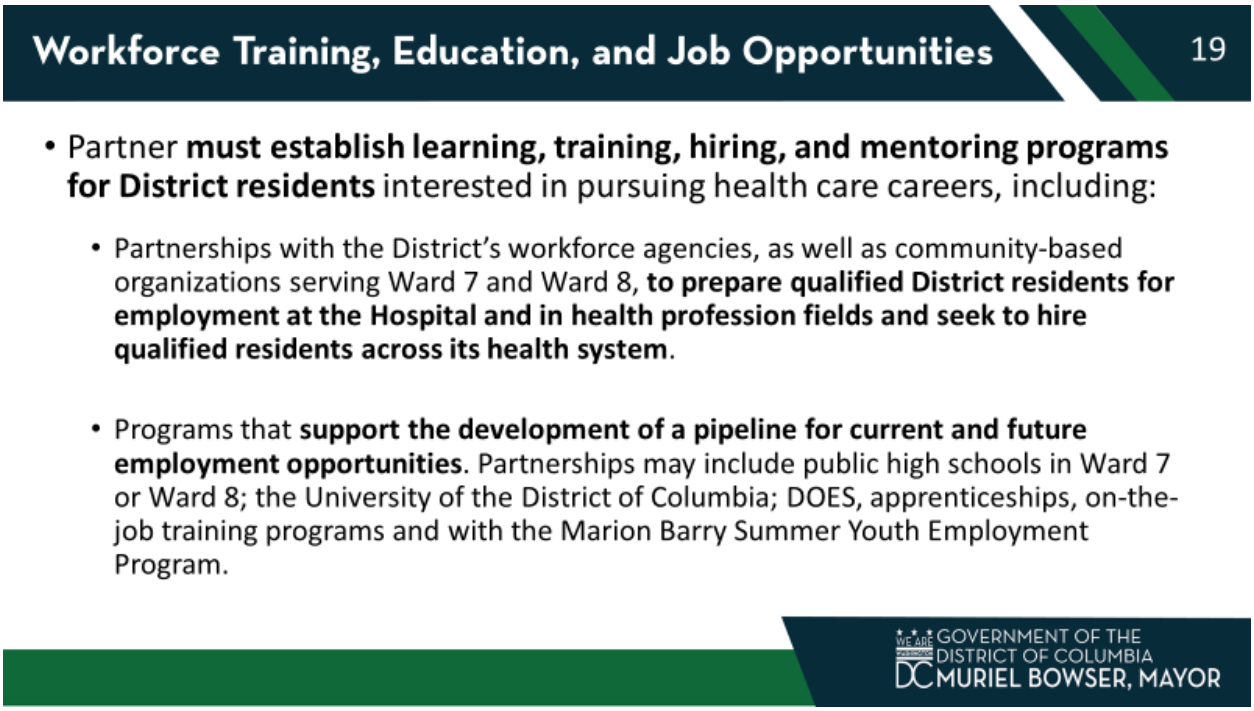

As mentioned earlier, the agreements requires that UHS adhere to the District's CBE and First Source requirements for both the construction and operations of the hospital. As required by law, once established, these plans will be reviewed, overseen and enforced by DSLBD and DOES respectively.

In addition to these requirements, the Agreements require that UHS establish robust learning, training, apprenticeship, hiring, and mentoring programs for District residents interested in pursuing health care careers, including:

- Partnerships with the District's workforce agencies, as well as community-based organizations serving Ward 7 and Ward 8, to prepare qualified District residents for employment at the hospital and in health profession fields and the hospital shall seek to hire qualified residents across its health system, and
- Programs that support the development of a pipeline for current and future employment opportunities. Partnerships may include public high schools in Ward 7 or Ward 8; the University of the District of Columbia; DOES, apprenticeships, on-the-job training programs; and the Marion Barry Summer Youth Employment Program.

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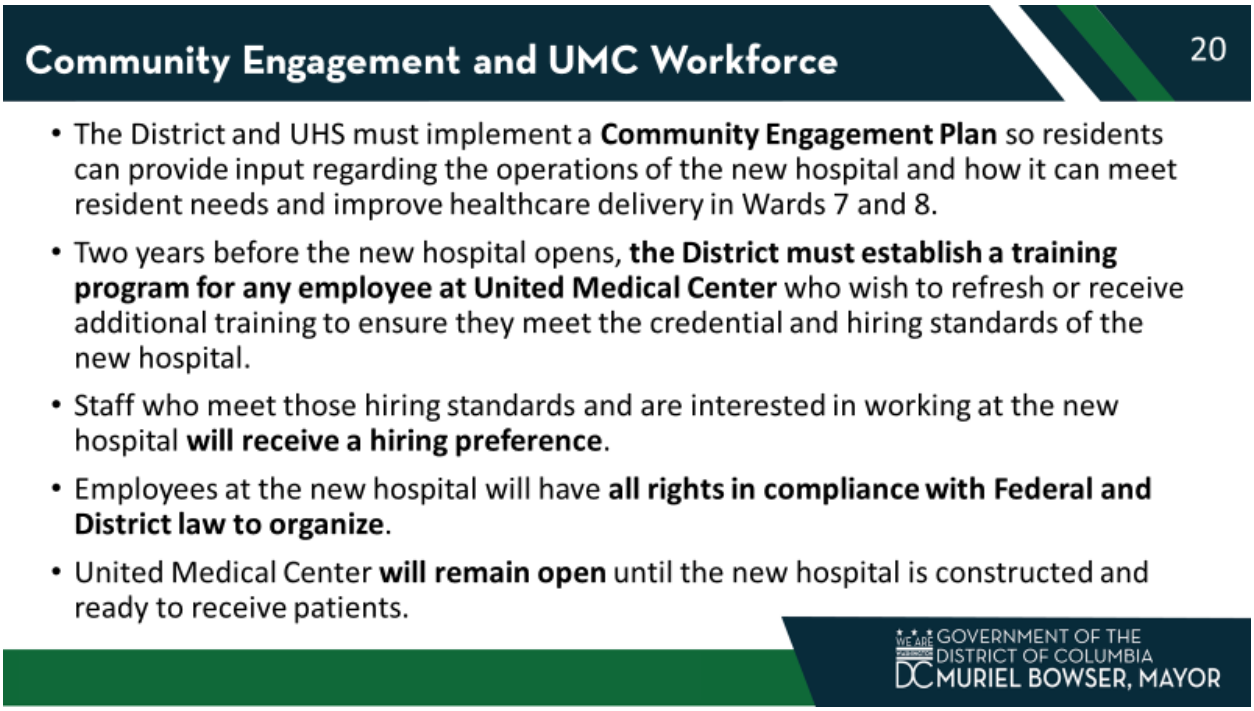


The agreement requires that a Community Engagement Plan be established for both the construction and operations of the hospital to ensure that there is transparency, communication and knowledge sharing between residents and UHS so that it can meet the healthcare needs of the community.

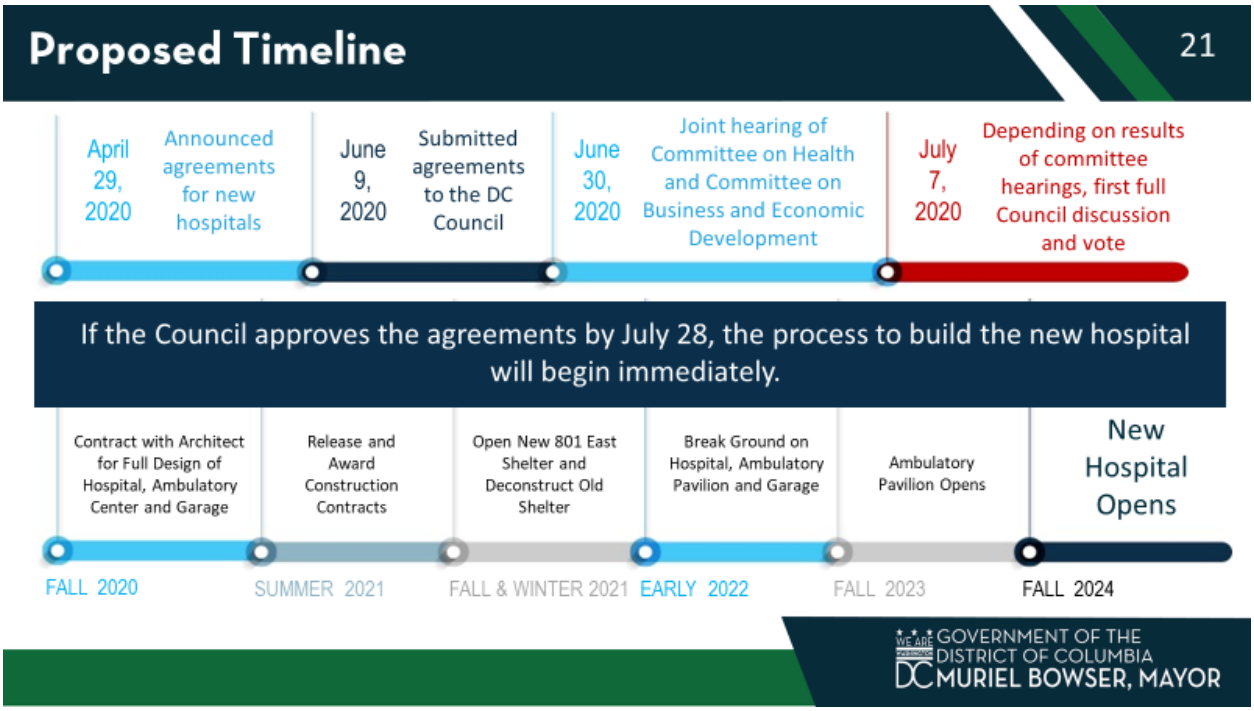
As it relates to staff at United Medical Center, two years before the new hospital opens, the District, in consultation with the hospital, must establish a training program for any employee at United Medical Center who wishes to refresh or receive additional training to ensure they meet the credential and hiring standards of the new hospital. Staff who meet those hiring standards and are interested in working at the new hospital will receive a hiring preference. A hiring preference means that if they meet the hiring conditions, they would be at the "front of the line" for positions at the new hospital. In addition, employees at the new hospital will have all rights in compliance with Federal and District law to organize.

Finally, as I stated in my opening remarks, United Medical Center will remain open until the new hospital is constructed and ready to receive patients.

Before I move to the timeline, I'd like to take a moment and provide some context for members about the critically important, but sometimes competing workforce policy goals we faced when negotiating this Agreement. First as a city, the Mayor and I also know that the Council is committed to creating opportunities for District residents to receive quality training and corresponding opportunities that result in strong middle-class healthcare jobs. We seek to accomplish this goal by requiring First Source and establishing strong training, education and apprenticeship requirements throughout the Agreement.

To achieve a second workforce goal, we have created a path for interested and qualified United Medical Center staff to continue their service to the community, despite 80% of all staff and 95% of UMC nurses living outside of the District, by establishing a training program and preferential hiring for those who meet the standards.

These goals are important but can be mutually exclusive. For example, due to how inpatient care in now delivered, the new hospital will be significantly smaller than UMC in both size and staff. Prior to COVID, UMC had 210 licensed beds, with only 60-70 operational, and over 900 staff. By contrast, the new hospital will have 136 licensed beds with 550 staff. While difficult, we believe the agreement strikes the right balance in achieving these two important policy objectives and ensures opportunities for both UMC staff and District residents for years to come.



Assuming Committee and Council approval by the end of July 2020, the District would begin contracting for design of the facilities this fall with construction contracts being released next spring and awarded in the fall of 2021. Once the new 801 East men's emergency housing shelter is completed and the current facility is deconstructed late next year, we would break ground on the ambulatory pavilion, hospital and garage in early 2022 with the ambulatory pavilion opening first in the fall of 2023 and the hospital opening in the fall of 2024.

Conclusion

That concludes my remarks. Mayor Bowser is committed to moving this critically important legislation and project forward so that it can begin serving District residents as soon as possible.

I look forward to answering any questions the Committee may have.