

# Delaware Health Care Commission

## Annual Report and Strategic Plan, 2004

*Working to promote access to affordable,  
quality health care for all Delawareans*

Thomas Collins Building  
540 South Dupont Highway  
Dover, Delaware, 19901  
302-744-1220 - phone  
302-739-6927- fax  
[www.state.de.us/dhcc](http://www.state.de.us/dhcc)



# Members of the Delaware Health Care Commission

**Lt. Governor, John C. Carney, Jr., Chairman**  
*Appointed by the Governor*

**Carol Ann DeSantis**  
*Ex officio as Secretary, Department of Services for Children, Youth and Their Families*

**Jacquelyne W. Gorum, DSW**  
*Appointed by the Governor*

**Joseph A. Lieberman, III, MD, MPH**  
*Appointed by the Governor*

**Vincent P. Meconi**  
*Ex officio as Secretary, Department of Health and Social Services*

**Robert F. Miller**  
*Appointed by the Governor*

**A. Herbert Nehrling, Jr.**  
*Appointed by the Governor*

**Dennis Rochford**  
*Appointed by the Speaker of the House*

**David Singleton**  
*Ex officio as Secretary, Department of Finance*

**Lois M. Studte, RN**  
*Appointed by the Senate President Pro Tem*

**Donna Lee Williams**  
*Ex officio as Insurance Commissioner*

# Delaware Health Care Commission Staff

*Paula K. Roy, Executive Director*

*Judith Ann Chaconas, Director of Planning and Policy*

*Marlyn Marvel, Community Relations Officer*

*Jo Ann Baker, Administrative Specialist*

*Robin L. Lawrence, Secretary*

# Table of Contents

<b>Mission Statement and Key Objectives.....</b>	<b>5</b>
<b>Introduction.....</b>	<b>6</b>
<b>Executive Summary.....</b>	<b>7</b>
<b>Health Care in Delaware.....</b>	<b>9</b>
• Access	
• Cost	
• Quality	
<b>Key Areas of Focus.....</b>	<b>21</b>
<b>Strategic Plan.....</b>	<b>23</b>
<b>1) Uninsured Action Plan.....</b>	<b>23</b>
❖ <i>Community Access Program</i>	
❖ <i>State Planning Program</i>	
<b>2) Information and Technology.....</b>	<b>30</b>
❖ <i>Delaware Health Information Network</i>	
--Clinical Information Sharing Utility	
--Website: <a href="http://www.dhin.org">www.dhin.org</a>	
<b>3) Health Professional Workforce Development.....</b>	<b>31</b>
❖ <i>Delaware Downstate Residency Rotation Program</i>	
❖ <i>Delaware State Loan Repayment Program</i>	
❖ <i>Delaware Institute of Medical Education and Research</i>	
❖ <i>Delaware Institute for Dental Education and Research</i>	
❖ <i>Nursing Implementation Committee</i>	

<b>4) Research and Policy Development.....</b>	<b>36</b>
❖ <i>Delaware Health Fund Advisory Committee</i>	
❖ <i>Research Reports</i>	
-- Delawareans without Health Insurance	
--Total Cost of Health Care	
--Consumer Assessment of Health Plans Survey	
<b>5) Specific Health Care Issues.....</b>	<b>38</b>
❖ <i>Diabetes</i>	
❖ <i>Mental Health</i>	
❖ <i>Health Disparities</i>	
<b>Related Boards and Panels.....</b>	<b>41</b>
• Delaware Perinatal Board	
• Delaware Health Resources Board	
<b>2004 Action Steps: At-A-Glance.....</b>	<b>42</b>

**Appendices**

- A. Delaware Health Care Commission History and Background**
  
- B. Delaware Institute of Medical Education and Research (DIMER) Annual Report**
  
- C. Board and Committee Lists**

# Mission Statement and Key Objectives

*The Commission's mission is to promote accessible, affordable, quality health care for all Delawareans.*

## Key Objectives

**Access:** Promote access to health care for all Delawareans.

**Quality:** Promote a comprehensive health care system assuring quality care for all Delawareans.

**Cost:** Promote a regulatory and financial framework to manage the affordability of health care.

# Introduction

The Delaware General Assembly requires the submission of an annual report on the Commission's progress in meeting its mission statement, as well as identifying new challenges and recommending strategies to close any remaining gaps in access, cost or quality of the health care system in Delaware.

This annual report is submitted at a time when health care issues are playing an increasingly important role in the state and in the nation. Technological advances improve health outcomes while increased utilization and other factors are driving up costs and making it more difficult for people to find adequate insurance coverage.

Presently, Delaware continues to outperform the region and the nation in terms of the proportion of the population that is uninsured, but new cost trends suggest challenges lie ahead.

This report offers key information about the uninsured in Delaware and how consumers of health care services rate their health care experiences in the State. In addition, it outlines areas in need of attention and sets out strategies for addressing some key unmet needs.

# Executive Summary

Although Delaware is doing better than the nation in terms of the number of uninsured, the Commission strives to assure access to needed services for all Delawareans. In addition, concerns are mounting about the ability to maintain current coverage levels.

It is also necessary to address the quality of health care that is being delivered and the cost of that care. It is the Commission's viewpoint that emerging information technologies may hold the key.

Another important aspect of ensuring access to affordable, quality health care is achieving an adequate number and geographic distribution of health care providers. Shortages of providers curb access, raise concerns about quality and contribute to rising costs.

Our ability to understand the various aspects of the health care system and track trends will enable us to be proactive and on target with policy recommendations. This requires accurate information and timely research.

And from time to time, certain health care conditions can become so important that they warrant focused attention.

The Commission's 2004 Strategic Plan reflects the need to address these issues. It is a multi-pronged approach to improving access to affordable, quality health care. It includes:

**Uninsured Action Plan** – *linking the uninsured with reliable health homes through the Community Healthcare Access Program (CHAP) and exploring strategies to maintain and improve coverage through the State Planning Program*

**Information and Technology** – *the Delaware Health Information Network, creating a statewide clinical information sharing utility and maintaining an easy to use one-stop shopping health care website*

**Health Professional Workforce Development** – *assuring an adequate health care workforce through the Downstate Residency Rotation Program, State Loan Repayment Program, Delaware Institute of Medical Education and Research, Delaware Institute for Dental Education and Research, and the Nursing Implementation Committee*

**Research and Policy Development** – *performing research and providing accurate information and policy recommendations*

**Specific Health Care Issues** – *addressing specific health care conditions that are so prevalent they warrant special attention*

# The State of Health Care in Delaware

*The rising costs of health care services and insurance premiums have brought health care issues back into the limelight of public discussions in the state, the region and the nation. Our research suggests that Delaware continues to outperform the region and the nation in terms of the number of uninsured and that overall patient satisfaction with the quality of health care is good. At the same time, however, we are spending more as a state on health care due to increased prices and utilization.*

The Commission is required to report on the state of health care in Delaware annually. It uses the following means to issue this report:

**Access:**

Health Benefit Coverage

Health Professional Supply

**Cost:**

Total Health Spending in Delaware

Cost Shift rates

## Quality:

Consumer Assessment of Health Plans Survey (CAHPS)

Health Indicators

## Access

Access to health care is measured by two indicators:

- 1) Access to health benefit coverage,
- 2) Number of health professionals.

### Health Benefit Coverage

Research shows that the presence of health insurance increases the likelihood that people will have access to health care services when they need them. The uninsured generally face greater barriers to preventive and primary care and are less likely to receive needed health care services on a timely basis. The uninsured are less likely to receive proper tests and treatments for chronic conditions, such as diabetes, which can increase their chances of having medical complications. The uninsured are less likely to receive timely screenings for cancer and cardiovascular disease, and are more likely to experience later stage diagnosis.<sup>1</sup>

### Uninsured in Delaware

Fortunately, Delaware is doing better than the nation and the region<sup>2</sup> in providing health insurance for its residents, with less than 9 percent of Delaware's population without health insurance in 2002. This is a significant drop from almost 14 percent in 1999. The new rate represents approximately 76,000 uninsured Delawareans<sup>3</sup>. Delaware has the seventh lowest uninsured rate in the United States.<sup>4</sup>

---

<sup>1</sup> This information has been documented in several studies, including *Care Without Coverage: Too Little, Too Late*. Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine. National Academy Press, 2002.

<sup>2</sup> The uninsured rate for the region, which includes Maryland, Delaware, Pennsylvania, New Jersey and New York, was 12.9 percent during the same period. The most recently reported national rate (US Census Bureau, September 2003) was 15.2%.

<sup>3</sup> This figure is based on a three-year moving average (2000-2002), which tends to remove some of the year-to-year fluctuations due to random variation associated with sample surveys.

<sup>4</sup> "Health Insurance Coverage in the United States: 2002, US Census Bureau report, September 2003.

Of the uninsured in Delaware:

76% are over the age of 17

61% are male

81% are white

13% are Hispanic

72% own or are buying their own home

14% live alone

83% are above the poverty line

32% have household incomes over \$50,000

40% are working full time

7% are self-employed

10% are non-citizens

Sixty three percent of the uninsured will remain uninsured for a year or more. This is important because presumably the longer that a person is without coverage the greater the probability is that they will need care.

In Delaware, more than 33 percent of the uninsured report not being able to see a doctor when they need to because of cost, compared to 5 percent of the insured.

In developing policies and programs to reduce the uninsured, one way to look at the population is by income level and insurance coverage eligibility.

In Delaware:

- 24 percent of the uninsured population, approximately 18,648 people, is eligible for existing public coverage but is not enrolled. This includes about 13,750 people who have incomes below 100 percent of the federal poverty level, \$18,100 annual income for a family of four. Most of this group should be eligible for Medicaid. In addition, 4,898 children with incomes between 100 and 200 percent of the federal poverty level are uninsured. Most of these children are eligible for the Delaware Healthy Children Program (DHCP). The exception in both cases is for non-citizens.
- 19 percent of the uninsured adult population, or about 14,623 people, have incomes between 100 and 200 percent of the federal poverty level. Their income is too high to be eligible for Medicaid. Many people in this group cannot afford private insurance.

- 57 percent of the uninsured population, or about 43,029 people, have family income above 200 percent of poverty<sup>5</sup>. This group probably includes many people who work for smaller businesses that tend not to provide coverage, or are self-employed. They also may be part-time or seasonal workers or employees in the service or construction industries, which tend to have the highest levels of uninsured.

**Uninsured by Age and Poverty Level<sup>6</sup>**  
(3-year average 1999-2002)

Uninsured by Poverty	Uninsured Age 0-18	Uninsured Age 19+	Total	Family of 4, FPL (2002)
<100 FPL	3,831 Income eligible for Medicaid	9,919 Income eligible for Medicaid	13,750	\$18,100@100%
100-199% FPL	4,898 Income eligible for DHCP	<b>14,623*</b> Not income eligible for public coverage	19,521	\$36,200@200%
200-249% FPL	1,366	6,771	8,137	\$45,250@250%
250-299% FPL	1,577	4,947	6,524	\$54,300@300%
300-399% FPL	1,168	10,933	12,101	\$72,400@400%
400-499% FPL	1,522	4,708	6,230	\$90,500@500%
500+FPL	1,740	8,297	10,037	500%+

T  
O  
T  
AL UNINSURED 76,300

***\*The initial target population for expanding coverage and access has been identified by the Commission as this population of 14,623 uninsured people. This group, which represents about 19% of the total uninsured population, has the lowest income for which public coverage is not available.***

<sup>5</sup> The table on the following page 14 defines poverty level.

<sup>6</sup> Extrapolated from "Distribution of Persons by Poverty Status and Age and Health Insurance Status", Center for Applied Demography and Survey Research, University of Delaware Current Population Survey 2000-2002.

In addition to income level, other factors play a role in being uninsured, including, but not limited to, where you work, where you live, household composition, your age and your race or ethnicity:

Employment

People who work for small firms are at a greater risk of being uninsured than people who work for larger firms. More than 29 percent of the uninsured in Delaware work for firms with fewer than 100 employees. And the highest rates of un-insurance are among construction workers and those in the trade industry (retail and wholesale). Those who are self employed are more likely to be uninsured, with 5 percent of government employees uninsured, 8.6 percent of private sector workers uninsured, and 21.6 percent of self-employed workers uninsured.

County Residence

Looking at the uninsured in Delaware by county, people who live in Kent County are more likely to be uninsured (15 percent) than people in Sussex County (8.2 percent) and New Castle County (8.8 percent). However, even though the rate of un-insurance is lower in New Castle County, the numbers of uninsured is higher. Almost 60 percent of the uninsured live in New Castle County.

Household Composition

Two and four person households are the least likely to report lacking health coverage, while single person households are the most likely to report not having coverage. The two-person household has a higher probability of including a married couple with two incomes and opportunity to obtain coverage through work.

Age

Young adults (18-29 years old) are more likely to be uninsured than are children and older adults. This is the result of multiple factors: they are less likely to be married, more likely to have lower paying jobs which do not provide health coverage and their income levels are generally lower making it more difficult for them to purchase insurance. Because persons in this age group tend to be healthy, it may be seem reasonable not to expend their relatively limited resources on purchasing coverage.

<b>Age</b>	<b>Percent Uninsured</b>
0-4	6.6%
5-17	7.3%
18-29	21.9%
30-64	9.8%
65+	Not measured due to Medicare

Delaware has the second lowest adult uninsured rate in the United States.<sup>7</sup>

### Race/Ethnicity

With regard to race and ethnicity, Delawareans who classify themselves as “African American or black” have a 26 percent higher risk of being uninsured than whites. Those who classify themselves as Hispanic are more than twice as likely to be uninsured.

### **Policy Implications**

Because of the adverse consequences of being without health insurance, significant focus is appropriately placed on reducing the number of uninsured.

Key areas in need of attention are those eligible for existing coverage programs who are not enrolled and low-income uninsured individuals who are not eligible for existing programs.

Another key area of concern is small businesses and their employees, because employees of small businesses typically have less access to coverage than employees of large firms.<sup>89</sup> Strategies to maintain current levels of employer-based insurance are as important as those to expand coverage levels.

Our current system of accessing health “insurance” is generally through employer-sponsored private insurance or a government program. Given this fact, it is reasonable to expect that there will always be a portion of the population that is uninsured. This is because at least some portion of the population will be eligible for coverage but not enrolled, even when coverage is offered at a relatively low cost. And state residents who are non-citizens typically are not eligible.

### **Number of Health Professionals**

Achieving adequate access requires a sufficient number and distribution of health care professionals. Overall, Delaware probably has a sufficient number of primary care providers but there are pockets within the state that have deficiencies. For example, the federal Health Resources and Services Administration (HRSA) has designated the Wilmington-Southbridge area of New Castle County and all of Kent County and Sussex County as Health Professional Shortage Areas for primary care. HRSA has designated most of the Wilmington-Southbridge area and all of Sussex County and Kent County as Health Professional Shortage Areas for dental care

---

<sup>7</sup> “States That Stand Out”, Governing, The Magazine of States and Localities, February 2004.

<sup>8</sup> For example, for the period 2000-2002 in Delaware, 18% of employees working for firms with fewer than 25 workers were uninsured. During the same period 12.8% of employees in firms with 100-499 employees and 6.4% of employees in firms with 500-999 employees were uninsured. Source: Center for Applied Demography and Survey Research, University of Delaware.

<sup>9</sup> 67,000 Delawareans are employed by small businesses with 2 to 9 employees, according to the Current Population Survey, March 2000-2002 from the Center for Applied Demography and Survey Research at the University of Delaware.

providers. There are shortages of obstetric-gynecologists<sup>10</sup> and mental health providers<sup>11</sup>, particularly in downstate Delaware, and there is a statewide shortage of nurses.<sup>12</sup> There are indications of shortages developing in other fields, such as radiological technicians, pharmacists and laboratory technologists.

To help recruit providers and ensure an adequate health professional workforce, the Commission administers a number of programs. These include the Downstate Residency Rotation Pilot Project and the Delaware State Loan Repayment Program for Physicians and Dentists. The Commission also oversees the Delaware Institute of Medical Education and Research and the Delaware Institute for Dental Education and Research, each of which have responsibilities for strengthening factors favoring the decision of qualified clinicians to practice in Delaware.

Meanwhile, the Commission's Nursing Implementation Committee is charged with promoting strategies to alleviate the nursing shortage.

The Commission is also represented on the Board that oversees the Delaware State Conrad 20 Program, which places foreign medical graduates in Delaware.

## **Cost and Cost Shift<sup>13</sup>**

Overall, Delaware is in the mainstream regarding health care expenditures.

After a decade of declining medical price inflation (MPI) that brought MPI in line with the general rate of inflation, the rate of increase of medical prices is again accelerating. And despite a decline in health care industry employment, the size of the industry, as measured by the proportion of the economy dedicated to it, continues to grow.

Relaxation of managed care restriction has brought increased demand for health care services, and a decade of managed care constraints. This resurgent growth in hospital and physician demand is a major driver in rising health care expenditures.

Nevertheless, the health care industry is growing leaner and more efficient. Delaware's health care providers are treating a growing population with fewer resources and the average length of stay is declining. In addition, patients are increasingly being treated on an outpatient basis, which allows hospitals to curb payrolls.

---

<sup>10</sup> Primary Care Physicians in Delaware 2001, prepared for the Delaware Department of Health and Social Services Division of Public Health by Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

<sup>11</sup> Assessment of Delaware Mental Health Parity prepared for the Delaware Health Care Commission by William M. Mercer, May 2001.

<sup>12</sup> Solving the Nursing Shortage in Delaware, Key Findings and Recommendations, prepared by the Delaware Health Care Commission's Committee on Nursing Workforce Supply, March 2002.

<sup>13</sup> Source: The Total Cost of Health Care in Delaware, 2002, prepared for the Delaware Health Care Commission by Simon Condliffe and Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

Personal health care expenses are classified into a number of distinct categories. Each represents a share of the personal health care dollar and that share changes through time, as seen below:

**Percent of Personal Health Care Expenditures by Sector in Delaware**

	Hospital	Physician	Dental	Home Health	Drug & Other	Vision & Other	Nursing Home	Other
1980	46.3	23.9	6.3	0.9	10	1.8	8.2	2.9
1990	41	28.5	4.7	1.8	9.5	1.7	10	2.6
1998	37.5	25.5	5	3.5	12.6	1.6	9.3	4.9

Overall, the pattern of health care expenditures in Delaware is very similar to that seen through the nation.

Overall, about \$4.4 billion was spent on personal health care in Delaware in 2002. The rate of increase is 10 percent per year.

Delawareans spend less of the Gross State Product, at 10 percent, when compared to the U.S. in general, at 12 percent. At the same time, Delaware is higher than the United States in per capita expenditures, but compares favorably with Pennsylvania and New Jersey and is only slightly higher than Maryland.

The health care sector is an important employer in Delaware. Information reported to the Delaware Department of Labor shows that the health care sector provides employment for 7.3 percent of the labor force of 415,000. Those workers' earnings represent 10 percent of reportable wages.

Where health workers are employed, however, is changing. This is a reflection of the changing structure of the industry.

- In 1990, hospital employment accounted for 38 percent of the state's health care industry. By 2002, this number had fallen to 35 percent. Hospital growth has again turned positive however, with the addition of 2,500 jobs between 2000 and 2002.
- Home health care and nursing services industries are enjoying strong growth as many treatments now occur outside the hospital environment. For example, home health, which in 1980 employed 2 percent of health care workers, employed 10 percent in 2000.
- Physician employment grew by six percent during the 2001-2002 timeframe.

Meanwhile, the drug sector is expanding rapidly, and drug expenditures are expected to continue to grow for the foreseeable future. Spending on prescription drugs has more than doubled since 1990. Although prescription drug spending is a small proportion of personal health care spending (9 percent) it is one of the fastest growing components, and has an effect on the cost of insurance. Prescription drug costs represented 40 percent of the premium increase for employer-based insurance during the 1998-1999 timeframe. Many states, including Delaware, have instituted pharmaceutical assistance laws to help eligible residents who meet age and income criteria purchase prescription drugs and are developing strategies to control Medicaid prescription drugs. And in 2003, Medicare prescription drug legislation was passed.

### **Cost Shift**

Cost shift is the process by which health care providers recover the unpaid costs of care, or portion of costs, delivered to one patient population through revenues above cost collected from another patient population.

The analysis of cost shift is important because it is Delaware's "de-facto" method of paying for hospital services for the uninsured. Unlike most states, Delaware has no public acute care hospitals or uncompensated care funds.

Payment shortfalls can occur through nonpayment by uninsured or underinsured patients, or government or insurance payments below costs. The most typical sources of uncompensated care are the uninsured, underinsured and government programs such as Medicare and Medicaid.

The Commission in 1999 released a report<sup>14</sup> prepared by The Lewin Group on the subject that indicated that Delaware's 1997 hospital cost shift rate was 128 percent. This means that private, commercial insurance paid \$128 for every \$100 of corresponding hospitals costs. The main source of revenue shortfall (68 percent) that necessitated cost shift was the "self-pay" category, which tends to represent uninsured individuals who pay medical bills out of their own pocket, including the indigent. There was insufficient evidence to detect cost shift among physicians and no evidence of cost shift on the part of payers, either from large insurers onto small insurers or from health maintenance organizations to traditional insurance.

To update the 1999 analysis,<sup>15</sup> statistics were drawn from the Medicare Payment Advisory Commission analysis of the American Hospital Association (AHA) annual survey data, and the AHA Hospital Statistics publication. The analysis shows that the Delaware rate of hospital cost shift has fallen to 121 percent. Delaware's rate of cost shift exceeds that of states in the region. However, as mentioned earlier, Delaware does not operate a public subsidy program to help offset bad debt and charity care expenses. Maryland, Pennsylvania and New Jersey do. Delaware's cost shift rate is

---

<sup>14</sup> Cost Containment Committee report to Delaware Health Care Commission, Cost Shift in Delaware and Its Impact on Health Care Financing, June 16, 1999. This analysis covered the period 1991 to 1996.

<sup>15</sup> As reported in The Total Cost of Health Care in Delaware, 2001, prepared for the Delaware Health Care Commission by Simon Condliffe and Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

comparable to these states' net of public subsidy, and comparable to the United States average.

## Quality

In Delaware the Commission measures quality through the Consumers Assessment of Health Plans Survey (CAHPS).

Measuring the quality of health care is a relatively new and evolving science. Nevertheless, important tools do exist:

*Joint Commission on the Accreditation of Healthcare Organizations: (JCAHO)* Evaluating and accrediting more than 17,000 health care organizations throughout the nation, including hospitals, nursing homes, home care organizations, behavioral health organizations, clinical laboratories and health networks (i.e. health maintenance organizations, preferred provider organizations).

*National Committee for Quality Assurance:* Responsible for updating and releasing the Health Plan Employer Data and Information Set (HEDIS), performance measures used by Medicaid, Medicare, and private health plans to track and report on the quality of their health care and services. HEDIS is the core of many health plan "report cards".

Other measures include:

*Consumer Assessment of Health Plans Survey (CAHPS):* A means for states to collect data on consumers' opinions of their health plans and their health care as a means for gauging quality. The survey is used by 48 states, including Delaware.

*Health Indicators:* Measures of disease morbidity and mortality.

**In Delaware**, private hospitals and nursing homes are subject to JCAHO accreditation. Major health plans use HEDIS. The Commission measures quality through the use of the Consumer Assessment of Health Plans Survey (CAHPS).

### Consumer Assessment of Health Plans Survey<sup>16</sup>

CAHPS is administered to adult Delawareans on a statewide basis. It measures consumers' satisfaction with their health plans and with their health care. Unlike many polls, it measures patients' actual experiences with the health care system, instead of relying on anecdotes and hearsay. The 2001 report is based on responses

---

<sup>16</sup> What Delawareans Say about the Quality of Their Health Plans and Medical Care, 2001 Delaware CAHPS (Consumer Assessment of Health Plans Survey) notes, prepared for the Delaware Health Care Commission, by Eric D. Jacobson, et. al, at the Institute of Public Administration and Edward C. Ratledge at the Center for Applied Demography and Survey Research, University of Delaware.

from Delawareans who had encounters with the health care system within the previous six months.

In Delaware CAHPS was introduced in 1996 and has since been used on a statewide basis for Medicaid, Medicare and commercial populations.

Research for CAHPS is conducted for the Delaware Health Care Commission through two research centers at the University of Delaware's College of Human Services, Education and Public Policy (CHEP): the Institute for Public Administration and the Center for Applied Demography and Survey Research. The Commission in conjunction with the centers participated in the development of the list of topics to be included in the survey. The topics and questions were guided by research showing what health care consumers want to know, prior work conducted by CHEP, and a set of standard questions provided by the national CAHPS Survey.

Use of CAHPS has grown from four early users and three demonstration sites in 1997 to a network of CAHPS users in 48 states. The user group includes the largest federal health care purchasers, including the Centers for Medicare and Medicaid Services, the Office of Personnel Management, and the Department of Defense. The user group also includes Medicaid agencies, state employee benefits offices, purchasing coalitions and private employers, among others.

According to the 2001 CAHPS, most Delawareans rate their health highly and report positive experiences with their doctors and other health care providers. Eighty-three percent of Delawareans reported that getting the care they needed is "not a problem."

Residents in each of the state's three counties gave good marks for their personal doctor and specialists. However, more Sussex county resident gave the most positive rating to heir health plans, health care, and personal doctors.

To the question, "how would you rate your health care?," 48.1 percent of New Castle County respondents rated their health care a 9-10, 46.8 percent of Kent County residents rated their health care a 9-10, and 52.9 percent of Sussex County respondents rated their health care a 9-10.

The least positive experiences were reported for health plan customer service. Respondents rate their health plans' customer service lower than their doctors and overall health care. Only 55 percent of respondents reported that customer service was not a problem and 38 percent gave their health plan the most positive ratings.

Fee for service plans continue to receive higher ratings than managed care plans, but within managed care plan types, the gap in ratings between loose and strict plans has lessened.

Not surprisingly, uninsured Delawareans rated their experiences with overall health care lower than their insured counterparts. This is likely because their chance of accessing needed medical care is greatly reduced when compared with their insured

counterparts. Consequently, health status suffers. They also often must pay more than insured persons when they do receive services. However, those uninsured who have access to providers give high ratings for their personal doctors and specialists.

### Health Indicators

Another way to monitor health care quality in Delaware is through public health indicators. According to Delaware Vital Statistics Annual Report 2001, for the 1999-2001 time period the first and second leading causes of death continue to be heart disease and cancer, at 29 percent and 25 percent respectively, accounting for more than half of all deaths in 2001.

For the same period, the number of infants dying within the first year of life was the highest it has been in 10 years. Though the Delaware infant mortality rate was significantly higher than the national rate throughout most of the 1980s, Delaware then followed the nation's downward trend to a point where the U.S. and Delaware rates became almost identical. The 1994-1998 period saw a reversal of Delaware's declining trend, and the infant mortality rate has risen over every 5-year period since. For the most recent period, 1997-2001, statistics are showing a rate of 9.0 infant deaths per 1,000 births, significantly higher than the U.S. rate and the sixth highest in the nation.

For the 1999-2001 time period Delaware's age adjusted cancer mortality and HIV death rate was significantly higher than the U.S. rate. On the other hand, Delaware's age-adjusted stroke mortality rate was significantly lower than the US rate. Delaware's diabetes mortality rate was the same as the U.S. rate for the same time period.

### Health disparities

Health conditions do not affect everyone equally, and the life expectancy rates for babies born in 2000 exemplify that fact:

- White males, 74.5 years      Black males, 69.4 years
- White females, 79.6 years      Black females 75.5 years

Black Delawareans are 40 percent more likely to die from heart disease and 65 percent more likely to die of complications from diabetes than white Delawareans. Black males are 30 percent more likely to die from lung disease than white males.

Infant mortality rates are higher among black babies than white babies. During the 1997-2001 time period the black infant mortality rate in Delaware was almost three times the white infant mortality rate; the U.S. infant mortality rates demonstrate the same racial disparity.

White women are more likely to be diagnosed with breast cancer, but the death rate among black women is higher. And black males are 30 percent more likely to die of lung cancer than white males.

# Key Areas of Focus

*The Commission has identified five major areas of focus in order to meet its mission. Its strategic plan is based on these five areas.*

## **1) Uninsured**

Rising health care and premium costs are fueling concerns about the erosion of health insurance coverage. This is particularly true for employees of small businesses, who typically have less access to coverage than employees of large firms and tend to experience larger premium increases than large firms. However, insurance premiums have been increasing for most firms, regardless of their size.

It is important to develop strategies to provide appropriate primary preventive care to promote better health by preserving existing coverage and identifying opportunities to expand access to coverage and services.

## **2) Information and Technology**

A major factor contributing to medical errors is the lack of information at the time and place of service. This problem also contributes to unnecessary cost increases as redundant diagnostic tests and procedures are performed in the absence of data that exists but is unavailable to the physician. Fostering strategies that make use of technology to improve the coordination and use of medical information will be paramount to improving the quality and efficiency of the health system.

## **3) Health Professional Workforce Development**

Access to health care services relies on an adequate health professional workforce. Currently, shortages of certain types of health care professionals are contributing to rising health care costs, hospital emergency department overcrowding and ambulance diversions.<sup>17</sup> It will be essential to promote and support strategies to ensure there is an adequate supply and geographic distribution of health professionals.

---

<sup>17</sup>Hospitals go on diversions when there are not enough beds or staff in the emergency department or the overall hospital to adequately care for patients in a timely manner. When a hospital goes on diversion, it notifies the Emergency Medical Services units so they can consider transporting patients to other hospitals that are not on diversion.

#### **4) Research and Policy Development**

Accurate information and timely research is essential to inform the health policy development process. Particularly important is having accurate data to understand the various aspects and track trends with regard to health care access, cost and quality.

#### **5) Specific Health Care Issues**

Certain health care issues can become so important that they warrant especially focused attention. Currently, diabetes and other chronic diseases, mental health issues and health disparities are of particular concern to the Commission. It will be important to play a key role in programs and activities to address these prominent problems in Delaware.

# Delaware Health Care Commission 2004 Strategic Plan

*The Delaware Health Care Commission recommends the following strategies for 2004, addressing the five identified areas for improving access to affordable, quality health care for all Delawareans:*

1. *Uninsured Action Plan*
2. *Information and Technology*
3. *Health Professional Workforce Development*
4. *Research and Policy Development*
5. *Focused Activities around Specific Health Care Issues*

## **1. The Uninsured Action Plan**

*Access to appropriate health care leads to improved health status. Good health is essential to assuring children can learn at school and employees can work at their fullest capacity.*

The Commission's strategy of promoting adequate access to health care for the uninsured incorporates two broad approaches:

- a) Promote improved health through the Community Healthcare Access Program (CHAP), and
- b) Preserve and identify opportunities to expand coverage through the State Planning Program

**Commission-supported strategies for increasing access for the uninsured**

Uninsured Persons	Number/Percent Uninsured Persons	Strategies
<ul style="list-style-type: none"> <li>▪ Eligible for existing programs – Medicaid, CHIP, etc.</li> </ul>	18,648 24%	Outreach and enrollment through CHAP and support of the Covering Kids and Families Program, which aims to maintain and increase enrollment in public coverage programs
<ul style="list-style-type: none"> <li>▪ Adults with income between 100%-200% Federal Poverty Level; ineligible for existing public coverage</li> </ul>	14,623 19%	CHAP – linkages to health homes
<ul style="list-style-type: none"> <li>▪ Income above 200% Federal Poverty Level</li> </ul>	43,029 57%	Strategies to expand coverage

Strategies for addressing the needs of the uninsured are discussed in the chapter entitled Health Care in Delaware that begins on page 12.

In Delaware, many uninsured persons are assured reasonable access to preventive and primary care services through a network of “safety net” providers. These include community health centers, private volunteer physicians and other provider organizations whose mission it is to assist vulnerable populations.

For example, approximately 9,000 uninsured people in Delaware receive care at safety net health homes. The majority are served by the state’s three Federally Qualified Health Centers in Delaware and one “look-alike center” which together saw about 5,070 unduplicated patients. The remaining ‘health homes’ served 3,845 users. At last check, all of the ‘health homes’ were at or very near full capacity.<sup>18</sup>

The Community Health Care Access Program (CHAP) helps find low-cost health care services for uninsured people with incomes between 100 percent and 200 percent of the federal poverty level. A network of community care coordinators links uninsured people with public coverage programs or with health homes. Participants include all community hospitals, community health centers, and over 400 private physicians. The program, which began enrolling patients on June 11, 2001, was initially funded through a federal

---

<sup>18</sup> Delaware Health Care Commission Analysis of the Delaware’s Safety Net System, February 2003, submitted by John Snow, Inc., February 2003.

grant from the Health Resources and Services Administration (HRSA). It is now funded through a blend of HRSA funds and the Delaware Health Fund. The fund, established to receive monies flowing to Delaware from the national tobacco settlement agreement, allocates funds to support health care activities.

### **CHAP Goals:**

#### Health

- Increase the number of uninsured receiving primary and preventive care
- Decrease the number of emergency room visits
- Improve health status and reduce health disparities

#### Perceived Value

- Improve patient satisfaction
- Continue support by major stakeholders

#### Finance

- Decrease the number of individuals eligible for public coverage but not enrolled
- Increase the efficiency and coordination with which care is provided
- Increase the capacity of the safety net to serve the uninsured

#### Issues/Findings

As of December 31, 2003, 7,536 applications for initial enrollment had been received and 4,769 people were enrolled at some point in CHAP.

An additional 1,221 applicants were approved for Medicaid and 61 were referred to the Veteran's Administration (VA).

A total of 3,034 applicants were found not eligible for a variety of reasons, such as they may have obtained other insurance or were income ineligible.

A total of 1,452 who have gone through the re-determination process have been re-enrolled.

The remaining applications were pending or under review.

The employment status of CHAP enrollees breaks down as follows (self reported, 7/1/2002-6/30/2002 enrollees)<sup>19</sup> :

- 59% were employed for wages
- 35% were homemakers
- 11.4% were out of work for less than a year
- 11% were unable to work

---

<sup>19</sup> Provided to the Commission by EDS, CHAP Annual Report. July 1, 2002 – June 30, 2003.

- 8% were students
- 3.5% were out of work for more than a year
- 2.5% self employed
- 2% retired

To determine the capacity of CHAP to meet its intended goals, the Commission is conducting a multi-faceted program evaluation. Initial findings are summarized below.

#### Health Status<sup>20</sup>

- CHAP enrollees appear to have improved health status
- They have an increased rate of preventive health screenings
- CHAP patients visit hospital emergency departments three times less than other uninsured individuals
- Hospital admissions only slightly changed as most admissions for CHAP and non-CHAP uninsured are for pregnancy

#### Patient Satisfaction<sup>21</sup>

- CHAP enrollees are very satisfied with the program.
- Those rating health care “excellent” increased from 9% to 46%
- Those rating health care as “fair” or “poor” decreased from, 9.5% to 3.7%

#### Financial Impact on ED visits and hospitalizations<sup>22</sup>

- CHAP’s impact on reduced costs is the least clear of all measures.
- It is the least clear of all dimensions, due to data problems, lack of good benchmarks and the limited time frame for the study
- Some minimal savings (data caveats, emergency department fixed costs)
- Savings should increase if CHAP enrollment expands, as savings for each hospitalization are considerable

#### Safety Net Capacity<sup>23</sup>

- The Delaware safety net is sound. However, there are factors that could destabilize it, including reductions in federal funding or changes in Medicaid policies.
- Although the safety net is relatively comprehensive, some gaps do exist, particularly in Kent and Sussex Counties for oral health, behavioral health and prenatal care.
- The capacity of the safety net could be expanded to double the number of uninsured people served by health homes over the next five years, if given more resources. This would increase the number of people served from approximately

---

<sup>20</sup> Conducted for the Commission by Dr. James Gill, via a review of CHAP enrollment data from June 2002 to September 2002

<sup>21</sup> Conducted for the Commission by Dr. James Gill, via a review of CHAP enrollment data from June 2002 to September 2002

<sup>22</sup> Conducted for the Commission by Paula L. Solano, Ph.D., et al

<sup>23</sup> The Commission retained John Snow, Inc., Boston, Massachusetts to conduct the evaluation.

9,000 people (some of whom are enrolled in CHAP) to 18,000 people. This would cost approximately \$3.8 million per year (at a cost of \$425 per person) to maintain the additional 9,000 people.

#### Program Mechanics (based on interview findings)

There are varying views of the value of the CHAP membership card, varying levels of commitment to the program, and varying roles/functions of care coordinators.

#### Key Commission Findings

- Support of the safety net is key to serving the uninsured.

The current safety net system is well equipped to deliver services to uninsured Delawareans in a competent and culturally appropriate way. Continued support of the safety net is an integral component of serving the uninsured and underinsured, particularly in underserved geographic areas of the State.

- Collaboration among health centers should be promoted.

One of the key aims of the CHAP program was to foster greater collaboration and coordination among safety net providers. Early indications suggested progress was being made, but recently there is evidence that willingness to collaborate may be on the wane. Rising costs create a renewed need to achieve administrative efficiencies. The Commission believes strategies should be identified to promote greater collaboration among community health centers.

- Care coordinators function differently, depending on the setting.

Care coordinators located in community health centers provide valuable services beyond guiding patients through the eligibility and enrollment process. They help patients address many needs and play an “enabler” role. Hospital care coordinator functions vary by whether they have a social work background or whether they are viewed primarily as a means to enroll uninsured patients into programs. The Commission needs to determine if this flexibility is an advantage or disadvantage for future program success.

- There are varying levels of commitment to the program among partners.

Experience thus far suggests that some CHAP partners believe in the program while others have not demonstrated that commitment.

- There are questions about whether the vision of CHAP works in the hospital emergency department setting.

Hospitals by and large have reported relatively low enrollment numbers, although there are notable exceptions. Recent evidence suggests this may be changing. Nonetheless, it is important to determine whether the original intent of CHAP as a means of easing emergency department use is valid.

- There is a need to better understand the demographics of enrollees.

Two important points emerge about typical CHAP enrollees. They are predominately female, many of whom are seeking pregnancy related services, and are non-citizens. The value of prenatal care has long been established. The high percent of non-citizen enrollment was an initial surprise. Initial theories suggest that since large numbers of non-citizens are performing work in Delaware and are ineligible for coverage the only option is CHAP.

- Geographic distribution of community health centers limits access for some.
- There is the potential for additional research by Dr. James Gill to aid the evaluation.
- Collaboration with the Covering Kids and Families Program is an important consideration. The Commission has committed to supporting the Covering Kids and Families Program through CHAP. Any changes to CHAP must acknowledge this commitment.

#### Changes to Date

As a result of ongoing monitoring of the CHAP program, several changes have occurred since its inception. Most notable are the addition of paper applications to increase outreach opportunities, a streamlined application/health status tool has been developed and extending the eligibility re-determination period from 6 months to 12 months.

#### 2004 Action

The program will continue until June 30, 2004. Recommendations with regard to any changes will be made in the spring of 2004. The CHAP Workgroup, comprised of a subset of the Commission, will focus on:

- Collaboration among providers
- Complementary coverage options
- Positioning of care coordinators and other design issues
- Better understanding the target population
- Determining the most beneficial way to support community health centers
- Improving geographic distribution
- Continuing to work with research team to address questions
- Performance efficiency of enrollment system
- Cost of this program versus some other means of direct support to safety net providers

The **State Planning Program (SPP)** is a process of identifying models for expanding health insurance coverage. After narrowing the range of model options from more than twenty to four, broad cost/coverage-impact analyses were performed.

### Issues/Findings

The four options determined to be most affordable, have the greatest impact on coverage and enjoy the greatest public acceptance were:

- a) Limited benefit plan: either a low-cost insurance product or a program of direct reimbursement, emphasizing primary and preventive care
- b) One-third share plan: state and federal governments and employers/employees would share premium costs
- c) Expansion of the Delaware Healthy Children Program to parents and guardians of eligible children
- d) Government subsidized purchasing pools

In 2003 the Commission addressed the unique issues faced by small businesses through the task force established by House Resolution 82. The Task Force was charged with examining the difficulties small employers are having providing coverage to their employees.

### **2004 Action**

Using supplemental funding the Commission received from the federal Health Resources and Services Administration, the Commission will act on the Task Force's recommendations:

- Conduct an analysis of (Chapter 72 of the Delaware Insurance Code, Title 18) the small group health insurance law, to determine if any unintended consequences are contributing to rising insurance costs and barriers to access
- Conduct an in-depth and objective update of a study on a single payer system for Delaware
- Investigate further the feasibility of pooling small businesses for purposes of purchasing insurance, building upon previous Commission work
- Study the potential of using medical management to control costs and improve patient outcomes through a legislated chronic disease task force created by House Joint Resolution 10, adopted in 2003
- Create a forum or discussion that brings together the many stakeholders with an interest in health insurance

Additionally, the Commission will partner with the Delaware State Chamber of Commerce to develop a "tool kit" to help employers make informed decisions when purchasing insurance.

## 2. Information and Technology

*Information and technology in health care promises to improve the reliability and timeliness of health information, making the system more efficient and of better quality.*

Information and technology is the heart of the **Delaware Health Information Network**, also known as the DHIN. The Delaware General Assembly created the DHIN to develop a community-based health information network to facilitate the communication of patient clinical and financial information that, while protecting patient privacy, would:

- Promote more efficient and effective communication among multiple health care providers
- Create efficiencies in health care costs by eliminating redundancy in data capture and storage and reduce administrative billing and data collection costs
- Create the ability to monitor community health status; and provide reliable information to health care consumers and purchasers about the quality and cost effectiveness of health care, health plans and health providers.

Currently, the DHIN is supporting two projects – a Community Clinical Information Utility and a health information website at [www.dhin.org](http://www.dhin.org).

### Issues/Findings

The DHIN is designing a statewide electronic clinical information sharing utility to facilitate the electronic exchange of patient clinical information in a secure and timely fashion. The goal is to reduce delays in obtaining patients' medical information in order to improve patient safety and the quality of care. No longer will doctors have to rely on patients' memories about their medical history or contact multiple medical offices and then wait for days or even longer for their patients' files to arrive once the utility is in place. This not only will improve quality, but it will reduce costs associated with a reduction in duplicate diagnostic tests and procedures and medical errors.

The utility also will support the Delaware Electronic Reporting Surveillance System, a state-of-the-art communicable disease reporting system being developed in Delaware within the Delaware Department of Health and Social Services to detect threats of emerging infectious diseases and bio-terrorism.

Ultimately, it is envisioned that the system will connect to the National Health Information Infrastructure, the development of which is being spearheaded by the federal Department of Health and Human Services.

To carry out this project, the Health Care Commission has contracted with the Patient Safety Institute, a national non-profit membership organization.

A "proof of concept" demonstration pilot of the utility's functionality is almost complete, proving that the system will work.

The next goal is to hire a full time project director to oversee the movement of the project from the demonstration phase to a fully developed system. It is anticipated that this will require approximately \$6 million over a three-year period.

#### **2004 Action**

- Hire a project director for the DHIN CCIS Utility Project
- Secure funding to move the project from a demonstration/pilot phase to a real, fully operational system
- Authorize supplemental funding if necessary to do so
- Continually recruit new partners
- Launch a “real” fully developed system
- Deliver DERSS capability

#### **Issues and Findings**

The DHIN also supports the website, [www.dhin.org](http://www.dhin.org). This is an easy to use, one-stop-shopping location for health information. It provides linkages to state and national health related reports and hot links to other health related organizations’ websites. The website has been found particularly useful to health care policy makers and researchers.

#### **2004 Action**

- Continue [www.dhin.org](http://www.dhin.org)

### **3. Health Professional Workforce Development**

*An adequate number and distribution of health care professionals is fundamental to assuring appropriate access to health service. A number of Commission activities address this goal.*

Established in 1997, the **Downstate Residency Rotation Pilot** was designed to enable primary care physicians in residency training programs at Delaware’s teaching hospitals in urban, northern Delaware to participate in clinical rotations with physician preceptors and community hospitals in Kent and Sussex Counties.

The goal of the pilot was to test whether physicians will consider locating in southern Delaware if exposed to the quality of life and medical community there. If successful, the goal would be to catalyze the private sector activity.

#### **Issues/Findings**

In total, 66 residents have participated in clinical rotations with physician preceptors in Kent and Sussex Counties. Five established practices downstate, and one of those physician’s spouse is a physician. An additional resident who participated in the program established practice in Maryland, near the Maryland-Delaware line. This brings the total to seven new physicians serving Delawareans downstate.

The program has also yielded an educational value that was not anticipated at the program's outset. The program offers educational enrichment of residents' training experiences. For example, some residents participating in the program reported being exposed to a larger scope of the practice of medicine than would be the case in teaching hospitals. There is also the opportunity for preceptors to teach and learn from the residents.

Since the creation, the landscape has changed considerably. On the one hand, relationships between the upstate teaching hospitals and community hospitals in central and southern Delaware have strengthened. One result is that it is now more commonplace for residents to conduct part of their training in community settings.

The fact that this pilot program is now in its seventh year suggests it is a reasonable time to determine whether the participants find sufficient value in the program to continue it on their own.

#### **2004 Action**

While continuing to encourage rotations, the Commission will discontinue providing reimbursements to the teaching institutions to offset lost federal indirect medical education payments resulting from the offsite training of residents while on downstate rotations. The Commission will however continue to provide honorarium support to downstate preceptors and stipends to residents.

The **State Loan Repayment Program for Dentists and Physicians** is designed to recruit physicians and dentists to underserved areas of the state by repaying a portion of their educational debt in exchange for their commitment to practice in an underserved area. The physician component of the program was launched in 2000 and is within DIMER's budget. The dentist component was launched in 2001 and is within DIDER's budget.

#### **Issues/Findings**

As a result of the program the following placements have been made:

1 dentist in Dagsboro	2 OB-GYN in inner city Wilmington
1 dentist in Rehoboth	2 OB-GYN in Dover
1 dentist in Smyrna	1 D.O. in inner city Wilmington
1 dentist in Dover	1 Family Practice MD in Dover
	1 Family Practice MD in Milford
Total: 4 dentists	Total: 7 physicians

In terms of placements, the State Loan Repayment Program has been successful. It could accommodate more applications, however. One idea that has been suggested is lifting the requirement that participants be either U.S. citizens or permanent legal residents. This is not a requirement for licensure to practice

medicine or dentistry in the state and may prohibit the recruitment of otherwise qualified candidates.

This program is coordinated with the J-1 State Conrad 30 program, which facilitates placement for foreign medical school graduates, in order to maximize our placement opportunities.

### **2004 Action**

- Continue interface with J-1 and other workforce programs
- Encourage DIMER and DIDER to explore the implications of lifting the U.S. citizenship requirement
- Enhance marketing of the program in order to generate more applications

The **Delaware Institute of Medical Education and Research (DIMER)**<sup>24</sup> provides for enhanced opportunity for Delaware residents to obtain a medical education. It is a cost effective alternative to Delaware establishing its own medical school.

A key function is to provide financial support for Jefferson Medical College (JMC) and Philadelphia College of Osteopathic Medicine (PCOM) in exchange for reserved admission slots. The relationship with Jefferson Medical College was established in 1969. The relationship with PCOM was established in 1999. The program also provides scholarships and tuition supplements for Delawareans at these schools.

Over the life of the program, Jefferson Medical College has accepted 200 Delaware students and Philadelphia College of Osteopathic Medicine has accepted 17 students. In 2002, Jefferson accepted 23 students and PCOM accepted 7 students. A total of 31 Delawareans attended medical schools somewhere in the nation. Twelve of the 23 who were accepted by Jefferson began attending Jefferson in 2002. All of the 7 students accepted by PCOM began attending PCOM in 2002.

### **Issues/Findings**

Delaware's relationship with Jefferson Medical College and Philadelphia College of Osteopathic Medicine continues to be good. Each school has accepted the requisite number of Delaware students and the quality of education is high.

Additionally, the co-administration of the scholarships between the Commission and the Delaware Higher Education Commission for students at the colleges is smooth.

DIMER recognizes that both the current and projected shortages of health care professionals point to the need for activities to promote health careers, particularly

---

<sup>24</sup> See Appendix B to review the DIMER Annual Report.

among middle and high school students. There also have been discussion about the desire to increase the number of Delawareans who enroll in University of Delaware nursing programs and keep them in Delaware after graduation, and increase the faculty at the college to enable the training of more students and nurse educators.

A review of the admission statistics show a lower number of Delaware minority students and residents of Kent and Sussex Counties in lower Delaware apply than residents of more urban New Castle County. In Delaware, like in the nation, it is an ongoing challenge to recruit minority (African-American and Latino) and rural residents to apply for medical school. DIMER is hopeful that an opportunity may exist to address this issue through renewed dialogue with Delaware State University, whose student body is predominately black.

Finally, it has been noted that payments to Jefferson Medical College have remained flat over the years despite rising costs incurred by the college.

#### **2004 Action**

- Continue the relationship with Jefferson Medical College and Philadelphia College of Osteopathic Medicine
- Continue promotion of minority & rural recruitment efforts
- Explore the concept of a “Health Professional Career Week” with DIMER, DIDER (Delaware Institute for Dental Education and Research), the Governor, Department of Education and others

The **Delaware Institute for Dental Education and Research (DIDER)** in the past had the sole function of supporting the general practice residency program at Christiana Care Health System. This is considered important, in part because Delaware is the only state that requires one-year of residency training as a condition of licensure.

In 2001, DIDER was transferred to the Commission, as recommended by the state’s Dental Care Access Improvement Committee.

The Committee’s report of key findings and recommendations also resulted in a reconstituted DIDER Board and expanded duties. Two key responsibilities are to:

- a) Expand opportunities for Delawareans to obtain dental education
- b) Develop ways to encourage dentists to practice in underserved areas and care for vulnerable populations

#### **Issues and Findings**

- The shortage of dentists in Delaware is well established
- A 1998 report on dentists in Delaware will be updated soon
- DIDER’s statute change and “shining a light” on the shortage issue has produced some positive changes

- Practicing in Delaware remains a challenge; some barriers continue to exist, such as Delaware’s clinical exam for experienced dentists
- DIDER has discussed new activities, such as forming a relationship with out of state dental schools, such as DIMER has with the two medical schools in Pennsylvania, recruitment activities, and preceptor programs, but has no money to pursue them
- Preliminary discussion about dental residency “rotations” in community settings has occurred and guidelines have been developed.

### **2004 Action**

- Invite DIDER Board Chair to Commission meetings to give periodic reports
- Review progress toward implementing 2000 Delaware Health Care Commission’s Dental Care Access Improvement Committee recommendations
- Review new data to see if improvements have been made
- Prepare proposals for new programs, aimed at such items as recruitment, dental school affiliations, and a clinical rotation program

The **Nursing Implementation Committee** is charged with promoting activities to solve the nursing shortage. The Commission’s Committee on Nursing Workforce Supply in March 2002 issued a report documenting that the nursing shortage is posing a threat to the ability of virtually every health care facility in Delaware to provide timely access to quality care. At that time, Delaware’s private hospitals and long-term care facilities needed at least 500 more registered nurses and 150 licensed practical nurses. There also are shortages in home health, hospice care and other areas. The recommended strategies fall under the four general categories of public policy, education, retention and recruitment. They include:

- Intensified recruitment efforts, focusing especially on men and ethnic and racial minorities that are underrepresented in health care professions
- Scholarships and loan repayments, to allow more need-based students to obtain entry-level nursing educations
- Opportunities to attend nursing school in the evening, weekends, or via the Internet, to help students who hold jobs during the day
- Improving work environments, by examining compensation strategies, achieving higher staffing levels, and developing mentoring programs for new nurses and new nurse managers
- More nurse educators, to allow all eligible applicants on nursing school waiting lists the opportunity to receive a nursing education

In recognition of the need to immediately address the nursing shortage, the Delaware Health Care Commission established this special committee to help carry out the March 2002 recommendations.

### **Issues/Findings**

- Much progress has been made on programs to end shortage since original committee was empanelled

- There is a need for centralized data collection, analysis, promotion and forecasting of health professions; this has been cited as a need by multiple sources, including the nursing committee.
- Other states have created “nursing centers” to address the need for data around nursing
- Nevertheless, there is valid concern about the scope and effectiveness of establishing a health professional workforce “center” in Delaware

#### **2004 Action**

- The current Nursing Implementation Committee will continue to meet quarterly to focus on implementing original nursing committee recommendations and provide updates on progress in implementing the original recommendations.
- A small workgroup will be convened to explore the development of an entity to centralize data collection, health profession education opportunities, etc.

### **4. Research and Policy Development**

*Accurate information and research is critical to the ability to make sound health care policy decisions.*

#### **Delaware Health Fund Advisory Committee**

The Commission has statutory responsibility and the strategic goal of providing research and policy guidance for the **Delaware Health Fund Advisory Committee (DHFAC)**. The DHFAC makes recommendations to the Delaware General Assembly and the Governor on the best use of tobacco settlement monies flowing to Delaware.

#### **Issues/Findings**

The Commission is represented on the Delaware Health Fund Advisory Committee, with three Commissioners as members, one being the chair.

The Commission played a key policy role at the inception of the Health Fund Advisory Committee’s work. The original spending framework used by the Committee was based on the Commission’s recommendations. No major changes have occurred since the original framework was established.

However, the Commission should be prepared to offer recommendations regarding expenditures for the uninsured by August 2004. This will coincide with Committee plans that funding recommendations be made to the Delaware General Assembly in December 2004 to coincide with the budget cycle.

Passage of the Medicare prescription drug benefit may have implications for the Delaware Prescription Assistance Program, which is funded with tobacco settlement funds flowing to Delaware. The program was created to help low-income seniors and disabled persons afford their prescription medications.

### **2004 Action**

The Commission will continue its role in providing research and making recommendations regarding funding priorities. It will be prepared to offer its recommendations by August 2004 in order to be in synch with the budget process.

The Commission will also recommend that the Delaware Health Fund Advisory Committee evaluate the impact of the federal Medicare prescription drug law on the Delaware Prescription Assistance Program,

### **Research Reports**

The Commission also conducts **survey research and publishes reports** to measure Delaware's progress in each of the key areas of access, cost and quality.

Reports traditionally published by the Commission include:

*Delawareans without Health Insurance:* A survey of the uninsured, their demographic characteristics, and factors influencing coverage levels.

*Total Cost of Health Care:* Tracking where health care dollars are spent, how much is spent, and the impact on the state's economic capacity.

*Consumer Assessment of Health Plans Survey:* Measuring Delawareans' satisfaction with their health care and their health plans.

All reports are produced by the University of Delaware, Center for Applied Demography and Survey Research for the Commission.

### **Issues/Findings**

*Delawareans without Health Insurance* and the *Total Cost of Health Care* reports provide valuable information. The utility of CAHPS, at least currently, is less clear. It was needed in the mid-1990s, during the emergence of managed care when anecdotes about managed care suggested widespread consumer dissatisfaction. However, the environment is much different now; the distinction in plan types is somewhat more blurred and there is no longer a critical need to provide objective information about consumer experience. It also is the most expensive of the three survey reports and usage of the report is minimal when compared with the others.

### **2004 Action**

- Continue Delawareans without Health Insurance & Total Cost reports
- Phase out Delaware Health Care Commission participation as a sponsor of the CAHPS report, working with the University of Delaware to develop a transition strategy

## 5. Specific Health Care Issues

*Certain health conditions at times become so problematic that the Commission is engaged to address them. Diabetes, mental health and health disparities are of particular concern.*

### **Diabetes**

In May 1999, the Delaware Health Care Commission Diabetes Task Force issued a report to the Delaware General Assembly that identified barriers to diabetes diagnosis and treatment in Delaware, and options for overcoming them.

Approximately 45,000, or 1 in 20, Delawareans are estimated to have diabetes. Diabetes requires monitoring, lifelong treatment and is a common cause of disability and death. Yet many Delawareans do not get widely recommended tests and treatments. Diabetes also takes an economic toll. Payments to Delaware hospitals for care to persons with diabetes were more than \$100 million between 1995 and 1999.<sup>25</sup>

To fight diabetes, the Health Care Commission, in collaboration with the state's Diabetes Prevention and Control Program at the Division of Public Health, launched a multi-faceted diabetes campaign. Monies allocated to the Commission from the Delaware Health Fund support the effort. During the first year, the focus was on employer-education and community screenings. Subsequently the campaign has been expanded to include:

*Statewide Diabetes Control Plan* – development and consensus building, resource identification

*Media campaign* – cable television, print, radio, billboard and cinema, with the key message of “Manage your diabetes for life”

*Community Screenings, Education and Physician Referrals* – Community-based events targeting high-risk populations

*Certified Diabetes Educator-Community Health Center Program* – diabetes education and assistance for high-risk populations and health center staff mentoring

*Worksite Education* – encouraging employers to make the workplace diabetes friendly so employees can appropriately manage their diabetes and to buy insurance that covers basic diabetes supplies and education

*Uniform Treatment Guidelines, Phase II* – evaluating the level and impact of integration of the guidelines into physicians' practices

---

<sup>25</sup> The Burden of Diabetes in Delaware, released by the Delaware Health and Social Services, Division of Public Health Diabetes Control Program in March 2002.

*Inpatient Guidelines* – development of guidelines to assist with diabetes in the hospital inpatient setting

*Diabetes Research* - promoting research to diagnose juvenile diabetes before symptoms occur and paving the way for the development of treatments

*Diabetes Resource Guides* – for patients and providers, in English and Spanish

*Diabetes and the Aging* – education about Medicare coverage for diabetes education and supplies

*Diabetes and Youth* – seminars to educate our youth about healthy behaviors and reducing the risk of developing Type 2 diabetes

*School manual* – education and distribution of National Diabetes Education Program manuals to school nurses (2004 launch)

*Emergency Diabetes Fund* – emergency supplies for persons who present at State Service Centers

*Delaware “Diabetes Central” Website* – centralize information about diabetes resources in Delaware and link to national sites (launch in 2004)

#### Issues/Findings

The programs that have been funded to date have been successful. Key goals of the Commission’s were to assist the Division of Public Health strengthen its diabetes control program by securing additional federal funding and developing a statewide plan for the prevention and control of diabetes in Delaware. These goals have been met and the Division of Public Health Diabetes Prevention and Control Program is in a strengthened position to carry out programs.

#### 2004 Action

- Plan to spin diabetes programs off to the Division of Public Health, pending legislative approval

#### **Mental Health**

Heightened concerns about mental health issues, particularly appropriate access to mental health care, led the Commission in 2003 to empanel its Mental Health Issues Committee. The goal was to identify issues impacting access to mental health services and recommend ways to improve.

#### Issues/Findings

The Committee’s work is progressing smoothly. Its recommendations are anticipated in early 2004.

### **2004 Action**

- Receive report and respond appropriately

### **Health Disparities**

Health disparities between people of color and whites are both evident and disturbing.

### **Issues/Findings**

- Health problems that disproportionately affect people of color include asthma, some cancers, diabetes and high blood pressure.
- African-Americans experience higher rates of cancer, heart disease, HIV/AIDS and stroke than all racial groups.
- Hispanics are twice as likely as whites to die from diabetes. Native Americans disproportionately die from liver disease and diabetes.
- According to the Institute of Medicine's "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" released in March 2003, racial and ethnic minorities tend to receive a lower quality of health care than non-minorities even when access-related factors, such as patients' insurance status and income, are controlled.
- According to the IOM, the "sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve participants at many levels, including health systems, their administrative and bureaucratic processes, healthcare professionals and patients."
- As the IOM notes, the sources of these disparities are extremely complex and work must be done to understand how they came to be before a plan to address them can be created.

### **2004 Action**

- Commission Chair John Carney has joined with the Metropolitan Wilmington Urban League to plan a statewide summit to discuss the complex issues surrounding disparities. The summit, which would include experts and others interested in better understanding why these disparities exist, would be the first step in an effort to craft a strategy to reduce and eventually eliminate them.
- Health Care Commission staff will monitor the summit and its findings, and Commission members will determine an appropriate roll for the Commission to fill based on any products or strategies that result from the summit.
- To gain a better understanding of the factors contributing to health disparities, the University of Delaware's Center for Applied Demography and Survey Research has been retained to expand the universe of data and take into account various circumstances that may affect disparities in health. Once the data gathering is complete, analysis will be performed to enable greater understanding about the causes of health disparities and to inform efforts to reduce them.

# Related Boards and Panels

*The Delaware Health Care Commission is represented on two boards whose purposes are related to the Commission's.*

## Delaware Perinatal Board

The Perinatal Board was established by Executive Order in 1995 to address issues influencing infant mortality. Overarching activities include tracking infant mortality rates, identifying influencing factors and promoting strategies to reduce infant deaths.

## Issues/Findings

- The Commission is represented on the Board.
- Disparities in infant mortality rates between African-American babies and others persist.
- Opportunities may exist to coordinate Commission activities with those of the Perinatal Board, particularly as they may relate to access to prenatal services
- Infant mortality rates are increasing.
- The current relationship between the Board and the Commission is satisfactory.

## 2004 Action

- Continue current relationship and receive periodic reports and updates

## Health Resources Board

The Health Resources Board is charged with establishing a public process to assure public notification of major new construction or purchase of major medical equipment.

## Issues/Findings

- The Commission is represented on the Board
- The current relationship between the Board and the Commission is satisfactory

## 2004 Action

- Continue current relationship and receive periodic reports and updates

# 2004 Action Steps: At-A-Glance

## **Uninsured Action Plan**

- CHAP – evaluate and determine future direction; issue recommendation in the spring of 2004
- State Planning Program – Empanel committee to carry out HR 82 Small Business Health Insurance Task Force recommendations
- Discuss insurance purchasing “tool kit” for employers and promote with the Delaware State Chamber of Commerce

## **Information and Technology**

- Clinical Information Sharing Utility – complete the pilot, hire a project director, secure funding and move toward development of fully operational system
- DHIN website – continue

## **Health Professional Workforce Development**

- Downstate Residency Rotation – continue to encourage rotations while scaling back financial support
- Delaware State Loan Repayment Program – continue, increase marketing, encourage lifting citizenship requirement
- DIMER – continue relationships and programs with Jefferson Medical College and Philadelphia College of Osteopathic Medicine; promote health professional careers (Health Professions Week); and identify opportunities to recruit minorities and residents from rural Delaware
- DIDER – working with the Board, promote opportunities to improve access to dental care, receiving reports from the DIDER Board Chair and examining data to determine level of progress
- Nursing – continue support of implementation of recommendations to solve the shortage
- Empanel a small workgroup to explore the concept of a Health Professional Development “Center”

## **Research and Policy Development**

- Continue relationship with the Health Fund Advisory Committee
- Prepare to make new recommendations to the committee in August 2004
- Continue Delawareans without Health Insurance report
- Continue Total Cost of Health Care report
- Phase out the CAHPS report

## **Focused Activities around Specific Health Care Issues**

- Infant Mortality – continue relationship with the Delaware Perinatal Board
- Mental Health Issues – receive report in January 2004
- Diabetes – support implementation of projects to carry out the Statewide Diabetes Control Plan; spin activities off to the Division of Public Health
- Health Disparities – monitor health disparities summit outcomes and determine appropriate role for the Commission



# APPENDICES

A) Delaware Health Care Commission: History and Background

B) DIMER Annual Report

C) Board and Committee Rosters

- DHIN Board of Directors
- DIDER Board of Directors
- Delaware State Loan Repayment Committee
- Nursing Implementation Committee
- Health Care Access Improvement Coalition
- Mental Health Issues Committee

# History and Background

The Delaware Health Care Commission is an independent public body reporting to the Governor and the Delaware General Assembly, working to promote accessible, affordable, quality health care for all Delawareans.

Membership and work strategies build upon public and private knowledge and partnerships, and promote interagency governmental thinking and expertise in the health care arena.

The Commission provides an objective and informed forum for all stakeholders – patients, insurers, employers, legislators, government agencies, health care providers, and others -- to identify issues, conduct research and achieve consensus around workable solutions. The Commission ensures that the policies that shape our health care system reflect the best thinking about ways to address the health care needs of Delawareans.

The Commission's activities come primarily in two forms: (1) research and (2) program management. Commission research provides intelligence on new and cutting-edge issues, measures progress, and provides objective knowledge and data upon which to base sound health care policy decisions. Program management assures the efficient implementation of projects to test new ideas and assures that existing programs achieve desired results.

The Delaware General Assembly created the Health Care Commission in 1990 to develop a pathway to basic, affordable health care for all Delawareans. It was one of several steps taken following a report issued by the Commission's predecessor, the Indigent Health Care Task Force.

At the core of the Task Force recommendations was the recognition that the uninsured do in fact receive health care services in Delaware -- because hospitals do not turn them away. The Task Force cautioned, however, that this is not the most appropriate way to provide care. The hospital emergency department is one of the most expensive provider settings. In addition, many uninsured individuals forgo preventive and primary care, receiving treatment only after they are very ill and the care very costly. The group concluded that achieving a comprehensive effective solution would not be possible without taking a systemic, thorough look at the entire structure, financing and delivery of health care in Delaware.

The Commission's function as a policy-setting body rather than a service-delivery body gives it unique status within state government. The Commission was designed to allow creative thinking across agency lines and across the public and private sectors. Its initiatives are recommendations issued after intensive study of a particular aspect of the health care system or pilot projects designed to test new ideas. The Commission's unique status within state government, combined with the public/private nature of its membership, enables the Commission to make sound recommendations for positive change -- and facilitate and oversee their successful implementation.

The Commission has focused on access, cost, and quality in a variety of ways. In the early 90's access was addressed by targeted strategies designed to reduce the uninsured. The rapid emergence of managed care brought a shift in focus to addressing the disparity between the new evolving structure of the health care delivery and financing system and the existing government regulatory structure. This produced a new but important debate over how much should be regulated by government and how much should be left to free market forces.

In the mid 90's through the first few years in the 21<sup>st</sup> century, the Commission addressed access through strategies designed to ease the many health professional shortages that existed, and continue to exist today. The Downstate Residency Rotation pilot, loan repayment programs and special projects on access to dental care and the nursing shortage are all examples of initiatives designed to assure that Delaware has a sufficient supply of health professionals. The Commission also launched its Uninsured Action Plan.

The Commission also strives to alleviate specific health conditions that are particularly problematic. Currently, the Commission is focused on diabetes and mental health services.

The Commission's mission is to promote access to affordable, quality health care for all Delawareans.