

Delaware Health Care Commission

# Annual Report and Strategic Plan, 2006

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

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# Mission Statement & Key Objectives

**Mission:** 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 Health Care Commission respectfully submits the 2006 Annual Report to the Governor and to the Delaware General Assembly. This report summarizes the extent to which the Commission's mission and goals have been met, the challenges that exist, and strategies that are needed to address them.

Today, health care issues continue to gain the attention of state and national leaders. While technological advances are improving health outcomes and extending life, an aging population, increased utilization of prescription drugs, and other factors drive up the cost of care. Higher costs place a burden on the entire health care system, and as the number of uninsured Americans increases nationwide, states strive for creative solutions to ensure access to quality health care for all citizens.

Presently, the health care system in Delaware has strengths and challenges. Delaware outperforms regional and national averages on the proportion of the population that is uninsured. However, new cost trends suggest that challenges lie ahead in maintaining insurance coverage levels, particularly for small businesses. Access to appropriate prenatal care has improved, but the State has a high infant mortality rate. Other concerns include a high cancer death rate, health disparities among black and Hispanic populations, and shortages of nurses and other allied health professionals to care for the state's growing and aging population.

This report offers key information about access to health care in Delaware, the cost of health care, and the Commission's strategic plan for the future. The report outlines the areas in need of the most attention and sets out strategies to address them.

# Five Things You Need to Know About Health Care in Delaware

- 96,400 Delawareans (14.5 percent of the population) are without health insurance. About 24.7 percent of those who are uninsured are actually eligible for public coverage through either Medicaid (17 percent) or the Delaware Healthy Children Program – S-CHIP (7.7 percent). Another 17.5 percent (about 16,980 people) are eligible for CHAP, the Community Healthcare Access Program administered by the Commission.
- The probability of being uninsured is linked to individuals' income levels, which are linked to their level of education and where they work. Employees of small firms are less likely to have insurance than employees of large firms. The higher the level of education, the higher the income and the greater the chance of having a job that offers insurance or the financial stability to purchase it. The exception is for the very poor, who are eligible for public insurance coverage programs such as Medicaid and S-CHIP.
- Delaware, like other states, faces a shortage of nurses and allied health professionals. Specifically, Kent County, Sussex County, and parts of the City of Wilmington have been federally designated as health professional shortage areas. These shortages threaten the ability of health care facilities in Delaware to provide timely access to quality care. Over 3,600 health professionals (2,200 of which are registered nurses) need to be recruited from 2005-2010 to meet the demands of Delaware's growing and aging population.
- There are disparities in the burden of illness and death experienced by black, Hispanic, and Asian populations when compared to the population as a whole. For example, a black newborn in Delaware is expected to live 72.1 years, while a white newborn is expected to live 77.1 years. While the causes are complex and difficult to identify, disparities may be attributed to health care delivery, socioeconomic status, culture, language, environment, genetics, and personal behavior.
- Overall, \$5.3 billion was spent on personal health care in Delaware in 2004, compared to \$5 billion in 2003. The total cost of personal health care has increased 20 percent since 2001, and the annual rate of growth averages about 7 percent per year. Notably, the health care sector is a significant source of employment for the Delaware economy, accounting for 11 percent of the total workforce and 11 percent of all reportable wages.

# Executive Summary

All Delawareans need and deserve access to reliable, affordable, quality health care. Achieving this goal requires a comprehensive set of strategies to address health care access, cost, and quality in the state. The Health Care Commission oversees five major initiatives to meet its mission and goals:

- 1. Uninsured Action Plan** – linking uninsured citizens with reliable health homes and affordable care through the *Community Healthcare Access Program (CHAP)* and exploring strategies to preserve and expand health insurance coverage through the *State Planning Grant*.
- 2. Information & Technology** – creating a statewide clinical information sharing utility through the *Delaware Health Information Network (DHIN)* and maintaining a user-friendly, one-stop-shopping health care website for providers and consumers.
- 3. Health Professional Workforce Development** – assuring an adequate supply of health care professionals through the *State Loan Repayment Program* and the *Nursing Implementation Committee* and expanding educational opportunities for Delawareans through the *Delaware Institute of Medical Education and Research (DIMER)* and the *Delaware Institute for Dental Education and Research (DIDER)*.
- 4. Research & Policy Development** – performing ongoing research and providing accurate information for state policy-makers.
- 5. Specific Health Care Issues & Affiliated Groups** – addressing specific health care conditions that are so prevalent they warrant special attention and working in cooperation with other bodies created by the state for this purpose.

## 1. Uninsured Action Plan

### ***Community Healthcare Access Program (CHAP)***

As the number of uninsured Americans continues to grow, some states are striving to create a health system “safety net” that provides affordable and appropriate care to uninsured citizens. CHAP is Delaware’s health system “safety net” and it connects low-income uninsured Delawareans with physicians and health care resources such as prescription medication, physical therapy, radiology, and laboratory services offered at reduced cost. Patients with incomes below 200 percent of the federal poverty level (FPL) who are ineligible for other state or federal medical assistance are matched with doctors at hospitals, private practices, and community health centers throughout the state. The target population for CHAP is comprised of approximately 17.5 percent of the state’s uninsured population, about 16,980 adults. As of December 31, 2005, CHAP has served over 8,434 uninsured patients and enrolled 2,362 in other state and federal medical assistance programs like Medicaid and the Veteran’s Administration.

In 2006 a new disease management and health promotion component will be added to CHAP to help improve the quality and cost-effectiveness of health care delivery. This will allow the program's focus to shift to those CHAP enrollees with chronic conditions and the highest medical need. Additional funds will be requested from the state to support CHAP based on the added disease management function and an increased number of uninsured citizens in the program's target population. Additionally, opportunities to assist the participating community health centers market themselves will be examined. CHAP will continue to recruit uninsured participants and, when appropriate, enroll eligible citizens in other medical assistance programs. Lastly, additional hospitals and physicians will be engaged with the goal of geographically expanding and strengthening the CHAP safety net throughout Delaware.

### ***State Planning Grant***

The State Planning Grant, launched in 2001, permits continued identification and analysis of both short-term and long-term health insurance coverage options for Delaware. Over the course of the Planning Grant period the Commission has reviewed and analyzed over twenty options. After extensive consideration, two approaches were identified as the most appropriate for Delaware. In the short term, the Commission defined a two-pronged strategy to address the issue of access to health care including the preservation of existing insurance coverage and the expansion of coverage to the uninsured.

The Commission recommends the creation of a small group purchasing pool and the evaluation of current laws governing small group health insurance as a preservation strategy. In 2006 the Commission will cooperate with the State Insurance Department, endorsing legislation for a small group purchasing pool. Rising health care costs and insurance premiums have made it difficult for some businesses and non-profit organizations to afford coverage for their employees. High costs are often passed on to low-income employees, and as a result, coverage may be dropped. The goal of a purchasing pool is to assist small businesses with purchasing health insurance for their employees.

The second part of the two-pronged, short-term strategy is the expansion of insurance coverage. A strategy is being considered to extend coverage to parents of children who qualify for the S-CHIP program, a coverage initiative under the Delaware Healthy Children Program. This approach would create seamless family coverage for families at less than 200 percent FPL. In 2006 the Commission will work closely with Delaware's Department of Health and Social Services as necessary to finalize cost estimates and explore funding sources for this proposal.

The Commission's long-term coverage strategy is the comprehensive analysis of a universal insurance coverage system for Delaware, a fundamentally new approach when compared to the existing fragmented system of health coverage in the state. A first-phase study has been completed, and in 2006 the Commission will complete Phase II, a detailed analysis of design and implementation strategies.

## **2. INFORMATION & TECHNOLOGY**

### ***Delaware Health Information Network (DHIN)***

Health information technology is an emerging national priority. Delaware strives to be a leader in the development of a statewide system. DHIN will create a statewide health

information sharing utility and electronic data interchange network for public and private use. The goal is to address the state health system's need for timely, reliable, and relevant health care information. A major contributing factor to medical errors is the lack of information at the time and place of service. This problem also contributes to an increase in costs resulting from the unnecessary duplication of diagnostic tests and procedures that are performed in the absence of data that exists but is unavailable to the physicians.

DHIN will allow physicians to receive data and patient results electronically from hospitals, labs and radiology centers. Currently, contractors are developing an analysis of existing systems, a definition of technical requirements, a cost-benefit analysis, a sustainability plan, and an advanced planning document. Once these projects are complete, work will proceed with the development of a request for proposals to design and build the utility. In 2006 the Commission will continue to promote DHIN, provide staff support, and facilitate communication between DHIN and the General Assembly. Additionally, the project is supported by a federal contract recently awarded to the project from the U.S. Agency for Healthcare Research and Quality.

### **3. HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT**

#### ***Delaware Institute of Medical Education and Research (DIMER)***

#### ***Delaware Institute for Dental Education and Research (DIDER)***

DIMER and DIDER were established by the Delaware General Assembly to address the shortage of health professionals in Delaware. They provide enhanced opportunities for Delaware residents to obtain medical and dental education as a cost effective alternative to the state establishing its own schools for these professions. Through DIMER, financial support is provided to Jefferson Medical College and Philadelphia College of Osteopathic Medicine (PCOM) in exchange for reserved admission slots for Delaware students. Scholarships and tuition supplements are also available for the students. In 2006 the Commission will continue to promote health professions among young people and strive to increase the geographic, racial, and ethnic diversity of Delawareans participating in the Jefferson and PCOM partnerships.

In 2006 the Commission will support a proposal from DIDER requesting state funds to pursue a partnership (similar to DIMER's) with Temple's School of Dentistry, providing students in Delaware an opportunity to receive training at a regional dental school. If implemented, the program may also include an opportunity for participating dental students to complete externship training programs at dental facilities in Delaware. In addition to this new partnership, DIDER will cooperate with the Delaware Division of Public Health as they update a report outlining the demographics and distribution of dentists to redefine shortage areas in the state.

#### ***State Loan Repayment Program (SLRP)***

This program is designed to recruit health care professionals to federally designated health professional shortage areas throughout the state. Participating clinicians provide health services in an underserved area for a minimum of two years in exchange for payments toward their educational loans. Recently, the loan repayment awards were increased to a maximum of \$70,000 for a two-year contract, and twelve new specialties were added to the list of eligible clinicians. In 2006 the Commission will focus on marketing SLRP and improving outreach to a diverse group of health professionals.

### ***Addressing Shortages in Nursing and Allied Health Professions***

In 2006 the Commission's Nursing Implementation Committee will collaborate with Delaware's newly established Area Health Education Center (AHEC) to conduct a survey assessing the status of licensed nurses in the state. This survey will update data collected in 2002 as part of the Commission's report, "Solving the Nursing Shortage in Delaware."

Additionally, the Commission will collaborate with AHEC to research the status of other allied health professions and complete a study of health education programs, including the full array of programs available in Delaware; the supply of nursing and health professional faculty at colleges and universities; and the length of time required for students to complete their education and enter the workforce. The Commission will work closely with AHEC staff to maintain open dialogue and coordinate activities.

In 2006 a new Health Professional Workforce Committee will be established to determine health professional workforce needs, collect data and provide resources to coordinate strategies to predict and prevent shortages. This new committee will help streamline the fragmented data collection systems that exist throughout the state today, creating a comprehensive and objective workforce data resource for stakeholders.

## **4. RESEARCH & POLICY DEVELOPMENT**

In order to provide accurate and up-to-date information to policy and decision-makers, the Commission performs ongoing research and publishes findings in reports made available to the public. In 2006 the following reports will be continued and updated:

*Total Cost of Health Care in Delaware*  
*Delawareans Without Health Insurance*  
*Racial and Ethnic Health Disparities in Delaware*

## **5. SPECIFIC HEALTH CARE ISSUES/AFFILIATED GROUPS**

Occasionally, specific health care conditions are so prevalent in Delaware that they warrant special attention. In 2006 the Commission will focus attention on the following issues: mental health, chronic illness, physical activity & education, racial & ethnic disparities, healthcare associated infections, and medical liability insurance. Additionally, the Commission is frequently assigned to cooperate with various bodies created by the General Assembly. Staff will participate and a representative of the commission will be designated to serve on the *Health Resources Board*, which serves as an advisory body for new health-related capital construction projects in the state. Additionally, three commissioners are assigned to serve on the *Health Fund Advisory Committee*, which provides guidance on the allocation of funds received from the state's Tobacco Master Settlement Agreement. Finally, the Commission will cooperate with members of the *Delaware Rural Health Initiative* to complete a collaboratively designed agenda of local initiatives and advocacy to improve the health of rural Sussex County residents.

# Status of Health Care in Delaware

The rising costs of health care services and insurance premiums have brought health care issues to the forefront of public discussions statewide, regionally, and nationally. The Commission's research indicates that Delaware continues to outperform other states in the region and the nation in terms of the percentage of uninsured citizens. Delaware, however, spends more money per capita on health care than other states, due in part to increased utilization and cost of care.

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 Insurance Coverage  
Health Professional Supply

**Cost:**

Total Health Spending in Delaware

**Quality:**

Health Indicators  
Previously the Consumer Assessment of Health Plans Survey (CAHPS) was used; however, this study was discontinued in 2003.

# Health Care – Access

Access to health care is measured by two indicators:

1. Access to health insurance coverage
2. Number of health professionals

## **1. Health Insurance Coverage**

The Commission tracks the number and characteristics of the uninsured population in Delaware annually through a contract with the Center for Applied Demography and Survey Research, College of Human Services, Education and Public Policy, University of Delaware. 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 also less likely to receive timely screenings for cancer and cardiovascular disease, and are more likely to experience later stage diagnosis.<sup>1</sup> Additionally, a person without insurance is more likely than their insured counterparts to use the emergency department, the most costly source of health services. Research indicates that in Delaware, 10,000 uninsured people could potentially arrive at Delaware's emergency departments in a typical year.<sup>2</sup>

### Uninsured in Delaware

In 2005 about 14.5 percent of Delaware's total population (840,000 people) went without health insurance, representing approximately 96,400 uninsured Delawareans<sup>3</sup>. This is an increase from 11.1 percent (80,000 people) in 2004. Fortunately, Delaware performs better than regional states and the nation in providing health insurance for its residents<sup>4</sup>. The uninsured rate for the region, which includes Maryland, Delaware, Pennsylvania, New Jersey, and New York, was 15.7 percent during the same period.

A general profile of the uninsured population in Delaware:

- 78% are over the age of 18
- 57% are male
- 73% describe their race as White
- 16% describe their ethnicity as Hispanic

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<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> Delawareans Without Health Insurance 2003, prepared for the Delaware Health Care Commission, by Edward C. Ratledge, Center for Applied Demography and Survey Research (CADSR), University of Delaware, Newark, DE

<sup>3</sup> To improve accuracy, the uninsured figures are based on a three-year moving average (2003-2005), which removes year-to-year fluctuations due to random variation associated with sample surveys.

<sup>4</sup> Delawareans Without Health Insurance 2005, Edward C. Ratledge, CADSR, University of Delaware.

68% own or are buying their own home  
16% live alone  
85% are above the poverty line  
36% have household incomes over \$50,000  
56% are adults working full-time  
9% are self-employed  
15% are non-citizens

In developing policies and programs to reduce the number of uninsured in Delaware, one way to examine the population is by income level and insurance coverage eligibility.

Consider the following:

- Nearly 25 percent of the uninsured population, approximately 23,680 people, are eligible for existing public coverage but are not enrolled. This includes about 11,932 adults and 4,325 children in families with incomes below 100 percent of the federal poverty level (FPL), which is \$19,350 for a family of four<sup>5</sup>. Most of this group is eligible for Medicaid. Additionally, 7,428 children in families with incomes between 100 - 200 percent FPL are uninsured and eligible for the Delaware Healthy Children Program (Delaware's S-CHIP coverage plan).
- About 16,980 people, or 17.5 percent of the uninsured population have incomes between 100 - 200 percent FPL. Their income is too high to be eligible for Medicaid and many in this group can not afford private health insurance. This is the current target population for the Delaware Community Healthcare Access Program (CHAP).
- Approximately 58 percent, or 55,797 uninsured people in Delaware have family incomes above 200 percent FPL. This includes 10,180 children and 45,617 adults. This group includes many people who are self-employed or work for small businesses that tend not to offer or provide insurance coverage. They may also be part-time or seasonal workers or employees in the service or construction industries, which tend to have the highest levels of uninsured employees.

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<sup>5</sup> *Federal Register*, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

**Uninsured in Delaware by Age and Poverty Level-**  
(3-year average 2003-2005)

<b>Uninsured by Poverty</b>	<b>Uninsured Age 0-18 years</b>	<b>Uninsured Age 19+ years</b>	<b>Total</b>	<b>Family of 4, FPL (2005)</b>
<100 FPL	4,325 *	11,932*	16,257	\$19,350 @ 100%
100-199% FPL	7,428 #	16,978 ^	24,406	\$38,700 @ 200%
200-299% FPL	5,827	15,918	21,745	\$58,050 @ 300%
300-399% FPL	2,113	9,333	11,446	\$77,400 @ 400%
400-499% FPL	805	6,688	7,493	\$96,750 @ 500%
500+ FPL	1,435	13,678	15,113	500%+

TOTAL UNINSURED = 96,460 people

\* Income eligible for Medicaid.

# Income eligible for the Delaware Healthy Children Program (S-CHIP coverage plan).

^ Income eligible for the Delaware Community Health Access Program (CHAP).

In addition to age and income level, many factors play a role in the likelihood that a person is uninsured. Factors include, but are not limited to place of employment, place of residence, household composition, race and ethnicity.

Employment

Employees of small firms are at a greater risk of being uninsured than people who work for larger firms. Over 22 percent of Delawareans that work for firms with fewer than 25 employees and 15 percent of those that work for firms with 25-100 employees are uninsured. This is up from 19 percent and 12 percent respectively in 2004, serving as an indicator that small businesses are having greater difficulty providing coverage for their employees. The highest percent of the uninsured are construction workers (28 percent) and those in the service industry (14 percent). Those who are self employed are more likely to be uninsured (18 percent) compared to 11 percent of private sector workers and 6 percent of government employees. Overall, the number of employers offering health insurance to their workers is decreasing steadily. According to a recent study by the Kaiser Family Foundation, 60 percent of companies offered insurance to their employees in 2005, compared with 66 percent in 2003 and 69 percent in 2000.<sup>6</sup>

County Residence

People who live in Sussex County are more likely to be uninsured (12.5 percent) than people who reside in Kent County (11.7 percent) and New Castle County (11.5 percent). However, although the rate of un-insurance is lowest in New Castle County, the actual number of uninsured people is higher than the other counties. Approximately 60,000

<sup>6</sup> Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits- 2005 Summary of Findings.

people who live in New Castle County are without health insurance compared to Kent County where 15,500 people are uninsured and to Sussex County where 21,000 people are uninsured.

### Household Composition

Two-person and four-person households are the least likely to report lacking health coverage (both 10 percent), while single person households are the most likely to report being uninsured (13 percent). The two and four person households have a higher probability of including a married couple with two incomes and more opportunities to obtain insurance coverage through employment.

### Age

Young adults (18-29 years old) are more likely to be uninsured than 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 that do not provide health coverage, and their income levels are generally lower, making it more difficult for them to purchase insurance. Because people in this age group tend to be healthy, it may seem reasonable to them not to expend their relatively limited resources on purchasing health insurance.

<b>Age</b>	<b>Percent Uninsured</b>
0-4 years	10.7%
5-17 years	10.2%
18-29 years	22.7%
30-64 years	11.9%
65+ years	Not measured due to Medicare coverage

### Race and Ethnicity

Delawareans who classify their race as black have a 15 percent chance of being uninsured, compared to 11 percent of those who report being white. In terms of ethnicity, 33 percent of Hispanics are uninsured, compared to 11 percent of non-Hispanics. (Note- race and ethnicity are measured as separate and independent variables.)

### Policy Implications

Because of the adverse consequences of being without health insurance, significant focus is appropriately placed on reducing the number of uninsured Delawareans. A key area of attention is on those people eligible but not enrolled in existing coverage programs. Another key area of concern is small business employees with less access to coverage than employees of large firms. The Commission's strategies to preserve current levels of employer-based coverage are just as significant as those to expand coverage to the uninsured.

## **2. Number of Health Professionals**

Achieving adequate access requires a sufficient number and distribution of health care professionals. In Delaware, there are pockets within the state that are underserved. For example, the federal Health Resources and Services Administration (HRSA) has designated the Wilmington-Southbridge area of New Castle County and all of Kent and Sussex Counties as health professional shortage areas for primary care physicians. HRSA has also designated the same regions as shortage areas for dental care providers. Research and data collection is underway to provide HRSA with evidence of mental health professional shortage areas in Delaware.

Throughout the state there are shortages of obstetric-gynecologists<sup>7</sup> and mental health providers<sup>8</sup>, particularly in downstate Delaware. There is also a statewide shortage of nurses and allied health professionals.<sup>9 10</sup> According to a Delaware Healthcare Association report, Delaware is predicted to have a shortage of 3,036 registered nurses by 2010 and 4,692 nurses by 2020 – a shortage of over 50 percent.<sup>11</sup> Consequently, over 3,600 health professionals (2,200 of which are registered nurses) need to be recruited from 2005-2010 to meet the needs of Delaware's growing and aging population.<sup>12</sup> Additionally, critical shortages among radiological technicians, laboratory technicians, pharmacists, and other allied health professionals are reported among practitioners "in the field," but comprehensive, accurate, statewide data is not currently collected for these professions.

To help recruit health care providers and ensure an adequate health professional workforce, the Commission administers a number of programs such as the State Loan Repayment Program. Since the program's inception, 6 dentists and 16 physicians have been placed in underserved areas of the state. The Commission also oversees the Delaware Institute of Medical Education and Research (DIMER) and the Delaware Institute for Dental Education and Research (DIDER), which provide enhanced opportunities for Delawareans to pursue a medical education and help recruit qualified clinicians to practice in the state.

Meanwhile, the Commission's Nursing Implementation Committee is charged with promoting strategies to alleviate the nursing shortage. In 2006 a new Health Professional Workforce Committee will be established to coordinate and centralize statewide data on Delaware's health care professionals. Both committees will continue to cooperate with the newly established Area Health Education Center (AHEC) in Delaware. While still in the development stages, the national AHEC mission is to "improve access to quality health care, particularly primary and preventive care, by improving the supply and distribution of health care professionals through community and academic education partnerships."

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<sup>7</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, CADSR, University of Delaware.

<sup>8</sup> Assessment of Delaware Mental Health Parity prepared for the Delaware Health Care Commission by William M. Mercer, May 2001.

<sup>9</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>10</sup> Delaware Healthcare Association. "Acute Care Hospitals and Health Systems Workforce Needs." June 2004.

<sup>11</sup> U.S. Health Resources & Services Administration. *Projected Supply, Demand and Shortages of Registered Nurses 2000-2020*. July 2002.

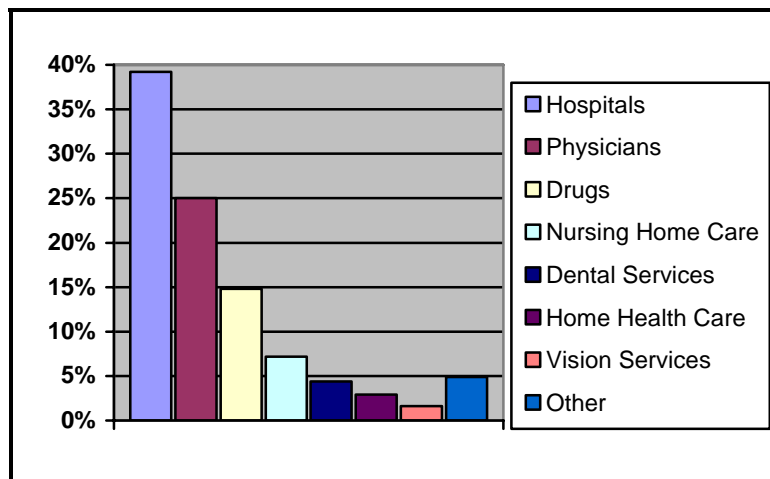
<sup>12</sup> Delaware Healthcare Association. "Acute Care Hospitals and Health Systems Workforce Needs." June 2004.

## Health Care – Cost

Overall, the pattern of health care expenditures in Delaware is very similar to states throughout the nation. While Delaware is higher than the U.S. in per capita expenditures, the state compares favorably with Pennsylvania and New Jersey and is only slightly higher than Maryland.

After a decade of declining medical price inflation that brought the measure in line with the general rate of inflation, the rate of increase of medical prices is now accelerating. Factors such as the relaxation of managed care restrictions, development of new technologies and prescription drugs, and an aging population have created an increased demand for health care services. Hospitals, physicians, and other specialists are experiencing rising patient demand, which is a driver in rising health care expenditures.

**Delaware Personal Health Care Expenditures:  
Share of Total Expenditures in 2004 by Category**



**Source: Center for Applied Demography and Survey Research, University of Delaware.  
US Centers for Medicare and Medicaid Services**

In 2004, about \$5.3 billion was spent on personal health care in Delaware, an increase from about \$5 billion in 2003 and \$4.4 billion in 2002. The total cost of health care has increased 20 percent since 2001, but there is some evidence that the rate of growth is slowing. Annual growth averages about 7 percent.

Despite a decline in health care industry employment, the size of the industry, as measured by the proportion of the economy, continues to grow. The share of health care as a percent of total Gross State Product increased to 12 percent in 2004 (compared to 11 percent in 2003). Nationally, health care spending increased to 15 percent of Gross Domestic product in 2004 (compared to 12 percent in 2003).

Meanwhile, some statistics indicate that the health care system 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 in a hospital is declining. Additionally, patients are increasingly being treated on an outpatient basis.

Individuals pay out-of-pocket for the majority of costs for drugs, vision products, and dental services. The government pays for the majority of hospital charges and private insurers are the primary payers for physicians.

#### Aging Population

Demand for health care services will escalate as the “Baby Boomer” generation moves into retirement later this decade, placing further strain on health care providers. In 2004, the proportion of elderly Delawareans over 65 years was 13 percent. By 2020, this figure will rise to 18 percent, or more than 176,000 people.

#### Prescription Drugs

The drug sector is the fastest growing source of spending on health care and shows no sign of abating. Between 1992 and 2001, the number of prescriptions purchased increased 68 percent (from 1.9 billion to 3.2 billion.) The average number of prescriptions per person increased from 7.3 to 11.1. Several factors foster this growth. For example, the U.S. Food and Drug Administration (FDA) accelerated its approval process of new drugs and the drug industry increased its promotion of these drugs with direct-to-consumer advertising. The outlook for drug expenditures is for continued strong growth.

Rising drug costs are exerting pressure on employers and health plan providers alike. These costs lead health plan providers to limit drug coverage and/or demand higher premiums from employers. Employers, in turn, pass on the costs to employees by asking for greater health care enrollment fees, or by opting for higher co-payment plans. In either case, consumer spending on health care increases.

It is important to note, however, that additional spending on prescription drugs does not necessarily translate into additional dollars spent on total health care. For some ailments, drugs are a substitute for more costly procedures or treatments (depression is one example). Therefore, some breakthroughs in drug therapies may reflect a switch away from traditional treatment techniques.

## Health Care – Quality

### Health Indicators

One way to monitor health care quality in Delaware is through public health indicators. According to Delaware Vital Statistics Annual Report (DVSAR) 2003, for the 1999-2003 time period the first and second leading causes of death continue to be heart disease and cancer, at 29 percent and 24 percent respectively, accounting for more than half of all deaths. Stroke accounts for 6 percent, followed by chronic respiratory disease (5 percent), accidents (4 percent) and diabetes (3 percent). The “all other causes” category represents the remaining 29 percent.

For the same time period, the number of infants dying within the first year of life was the highest it has been in 10 years. Though Delaware’s 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, 1999-2003, DVSAR 2003 statistics show a rate of 9.1 infant deaths per 1,000 births, significantly higher than the U.S. rate of 6.9. Delaware has the 6<sup>th</sup> highest infant mortality rate in the nation. For the same time period, Delaware’s age adjusted cancer mortality and HIV death rate were significantly higher than the U.S. rate. On the other hand, Delaware’s age-adjusted stroke mortality rate was significantly lower than the U.S. rate.

Overall, according to *America’s Health: State Health Rankings - 2005 Edition* Delaware ranks 33<sup>nd</sup>; it was 34<sup>th</sup> in 2003. The report, the 16<sup>th</sup> in a series, is produced by the United Health Foundation in partnership with the American Public Health Association and the Partnership for Prevention. The study methodology weights the contributions of various factors, including a number of risk factors -- such as the presence of health insurance and the prevalence of smoking -- and health outcomes, such as cancer deaths and heart deaths.

According to the report, Delaware’s strengths include a low percentage of children in poverty, strong financial support for per capita public health spending, low prevalence of obesity and high access to adequate prenatal care. Challenges include the state’s high infant mortality rate, a high rate of cancer deaths, and a high incidence of infectious disease.

Delaware is 35<sup>th</sup> for the combined measures of risk factors and 33<sup>rd</sup> for the combined measure of outcomes, “implying the state is on a positive course and may be able to improve its relative healthiness in future” years, according to the report.

## Health Disparities

The issue of racial and ethnic health disparities is a concern because of its impact on length and quality of life and the relationship with cost and quality of health care. While the causes are complex and difficult to identify, disparities may be attributed to health care delivery, socioeconomic status, culture, language, environment, genetics, and personal behavior.

According to the DAVSR 2003 Report<sup>13</sup>, life expectancy rates for babies born in 2003 exemplify the fact that health disparities exist in Delaware:

White males, 75.3 years	Black males, 69.2 years
White females, 80.7 years	Black females 75.8 years

The differences in life expectancy are directly related to differences in mortality for a wide range of diseases. For example, black Delawareans are 16 percent more likely than whites to die from heart disease and 65 percent more likely to die of complications from diabetes than white Delawareans.

Key findings from the DHCC's 2004 Health Disparities in Delaware Report<sup>14</sup> indicate:

- Since 1997, disparities ratios for blacks and whites in Delaware have decreased for many health indicators, including cancer, stroke, infant death, teen births, prenatal care and low birth weight. However, disparities ratios have increased for heart disease, HIV/AIDS, homicide, and asthma hospitalization.

### **Delaware Health Disparity Ratios**

<b>Health Indicator</b>	<b>DE 1997</b>	<b>DE 2002</b>	<b>Trend</b>
Heart Disease	1.11	1.16	Increase
Cancer	1.45	1.20	Decrease
Stroke	1.57	1.39	Decrease
Diabetes	2.33	2.33	No Change
HIV/AIDS	8.23	15.56	Increase
Homicide	3.56	3.94	Increase
Alcohol Induced	1.57	1.34	Decrease
Infant Death	2.63	2.41	Decrease
Teen Births	2.74	2.35	Decrease
Prenatal Care	3.11	2.19	Decrease
Low Birth Weight	2.08	1.95	Decrease
Asthma Hospitalization	2.53	2.93	Increase

\*Note- the disparities ratio represents the black rate divided by the white rate. For example, in 2002, the heart disease ratio was 1.16; therefore blacks are 16 percent more likely to die of heart

<sup>13</sup> Due to data limitations, statistics in the DAVSR 2003 are only presented for black and white populations.

<sup>14</sup> Health Disparities in Delaware 2004, Eric Jacobson, John Jaeger, and Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

disease than whites. The further the ratio is from one, the greater the disparity for that health indicator.

- The black/white disparity ratio for cancer has improved significantly between 1997 and 2002, reduced from 1.45 to 1.20. Cancer is the second leading cause of death in Delaware, and the decrease in disparity will have a large effect because of the generally high cancer rates in the state.
- While the ratio of disparity for diabetes remained stable between 1997 and 2002, the rate of 2.33 means that blacks are more than twice as likely to die from diabetes as whites in Delaware. This is cause for concern because diabetes is a life threatening chronic disease that impacts quality of life and can be very costly if the disease is unmanaged and medical complications arise.
- Delaware blacks are significantly more likely to die from HIV/AIDS than whites in the state. In fact, the ratio (15.56) has nearly doubled since 1997 (8.23). The ratio is attributed to extremely high death rates among blacks coupled with very low death rates among whites in the state.
- Infant mortality rates are higher among black babies than white babies. Between 1999-2003, the black infant mortality rate in Delaware (16.7 per 1,000 births) was almost two and a half times greater than the white infant mortality rate (6.9). While the U.S. infant mortality rates demonstrate the same racial disparity, the overall rates in Delaware are significantly higher than the national rates.

Another section of the 2004 Disparities Report analyzes data on personal behavior from the national Behavior Risk Factor Surveillance Survey (BRFSS) sponsored by the Centers for Disease Control and Prevention. This section includes results from non-Hispanic Caucasians, non-Hispanic African Americans, non-Hispanic others (largely Asian), and Hispanics. Key findings from this section indicate:

- There are significant differences among the races in their general perception of their overall health. Caucasians and Others (primarily Asians) are more likely to consider themselves in excellent or very good health than either African Americans or Hispanics. African Americans have by far the largest percentage in the least healthy categories (fair and poor combined).
- Caucasians have the highest percentage of health insurance, while Hispanics are the group most without coverage (nearly 20 percent of the adult population). Similarly, Caucasians are most likely to report having a "personal doctor or health care provider". Hispanics were least likely to report having a personal doctor and most likely to report needing to see a doctor but finding it too costly.
- African Americans and Hispanics are substantially less likely to say they exercised in the last 30 days than Caucasians or Others (primarily Asians). Additionally, African Americans were most likely of the racial/ethnic groups to be designated as being at risk for overweight.

For more information see the Commission's Health Disparities in Delaware 2004 report.

# Targeted Strategies to Promote Access to Affordable, Quality Health Care in Delaware

## 2006 Strategic Plan –

The Commission focuses activity on five (5) major areas to promote and improve access to affordable, quality health care:

- 1. Uninsured Action Plan**
- 2. Information & Technology**
- 3. Health Professional Workforce Development**
- 4. Research & Policy Development**
- 5. Specific Health Care Issues & Affiliated Groups**

## Uninsured Action Plan – Community Healthcare Access Program (CHAP)

The Community Healthcare Access Program (CHAP) helps find low-cost health care services for uninsured people with incomes below 200 percent of the federal poverty level. A network of community care coordinators links uninsured people with health homes or, if eligible, with medical coverage programs like Medicaid.

Medical services for CHAP enrollees are provided through community hospitals, community health centers, and private physicians who participate in the Voluntary Initiative Program (VIP). CHAP, which began enrolling patients on June 11, 2001, was initially funded through a federal grant from the Health Resources and Services Administration (HRSA). Today, the program is funded entirely by proceeds from the state's Master Tobacco Settlement Agreement.

**CHAP Purpose-** Provide medical homes for the low income uninsured to improve quality and reduce inappropriate hospital emergency department visits and hospitalizations.

CHAP was launched in June 2001 with these original goals:

- Increase access to primary and preventive care through health homes for the uninsured
- Decrease the number of unnecessary emergency department visits
- Improve patient health status and reduce health disparities
- Increase enrollment in other state or federal medical coverage programs if eligible
- Improve patient satisfaction
- Expand the capacity of the health “safety net” to serve the uninsured

### **Updated CHAP Goals for 2006-**

- Provide uninsured Delawareans with a regular source of primary care and easy access to other health services
- Increase enrollment in other state or federal medical coverage programs if eligible
- Improve the coordinated use of existing programs and resources
- Ensure that the most vulnerable populations are equipped with better health system navigation skills and better understanding of the importance of prevention
- Improve health status by implementing a health promotion and disease management component that focuses on high-risk and high-need patients

### Findings

As of December 31, 2005, a total of 13,568 applications for initial enrollment were received and 8,434 people were enrolled at some point in CHAP. Currently, 2,772 people are actively enrolled and receive services through the program. According to the most recent report of the uninsured in Delaware, about 16,980 people (17.5 percent of the uninsured population) are eligible for CHAP.

An additional 2,257 applicants were approved for Medicaid and 105 were referred to the Veteran's Administration (VA).

A total of 4,438 applicants were found not eligible for a variety of reasons, such as they were income ineligible or they may have obtained other insurance (i.e. 2257 of them were enrolled in Medicaid).

The CHAP Annual Report for Fiscal Year 2005 (July 1, 2004 – June 30, 2005) provides the following demographic information on program enrollees:

Some notable changes in FY 2005 include –

- The average age of enrollees was 38 years, an increase of 1 year from FY 2004.
- The average household income of CHAP enrollees was \$14,382, an 8 percent increase from FY 2004. (Note: 200 percent FPL equals \$25,660 for a two-person household.)
- The citizenship status of enrollees also changed. In FY 2004, 62 percent of enrollees were non-citizens. In FY 2005, the number of non-citizens decreased to 54 percent.

While it is estimated that men account for 57 percent of the uninsured in Delaware, those applying for and enrolling in CHAP are primarily women. In FY 2005, 64 percent of *applicants* and 67 percent of *enrollees* were females.

The greatest percentage of CHAP enrollees (24 percent) live in the City of Wilmington. Georgetown has the second largest enrollee population with nearly 10 percent residing there. By county, enrollees are distributed as follows:

- 46 percent in New Castle County
- 12 percent in Kent County
- 42 percent in Sussex County

Out of all the CHAP applicants, the largest group (44 percent) said they are employed for wages. The next largest groups are "Out of work < 1 year" and "Homemakers" respectively.

Of the active enrollees in FY 2005, 50.4 percent chose to see a private physician through the VIP program, and 49.6 percent sought care at a Community Health Center.

Participating hospitals and health centers include: Bayhealth Medical Centers (in Kent and Milford locations), Beebe Medical Center, Christiana Care Hospital (Newark and Wilmington locations), Claymont Family Health Services, Westside Health Clinic, Henrietta Johnson Medical Center, Delmarva Rural Ministries, and La Red Health Clinic.

In addition to these health facilities, CHAP partners with the Delaware Covering Kids and Families Initiative, led by the Medical Society of Delaware. This initiative serves as a link to existing programs and a mechanism to conduct outreach, increase access to care, and expand enrollment in insurance coverage programs.

### Program Successes

To determine if CHAP is meeting its intended goals, the Commission conducts ongoing evaluation of the program. Some findings are summarized below.

Health status and quality of care, as measured by preventive care, has improved.

- CHAP enrollees have an increased rate of preventive health screenings
- Immunizations have increased

Emergency department visits have been reduced.

- CHAP patients visit hospital emergency departments three times less than other uninsured individuals

Patient satisfaction has improved.

- Those rating their health care “excellent” increased from 9 percent to 46 percent
- Those rating health care as “fair” or “poor” decreased from 9.5 percent to 3.7 percent

Uninsured people with medical homes have increased.

- As of December 31, 2005, over 8,434 uninsured patients have been enrolled and received care at a participating health home or private practitioner.

An adequate geographic distribution of providers exists in Delaware, and the number of volunteer physicians participating in VIP is increasing:

- Fall 2003 – 334 physicians (20 percent of practicing physicians)
- Fall 2005 – 460 physicians (25 percent of practicing physicians)

There have been several developments to increase the safety net capacity to deliver services in a competent, comprehensive, and culturally appropriate way.

- The Commission has awarded one time grants of over \$1 million to help community health centers increase the number of people served.
- Westside Health Center has expanded and now operates a satellite facility in Newark.
- Federal support of \$200,000 will be granted to Delmarva Rural Ministries to implement prenatal services and a mental health program.
- La Red Health Center has been designated as a Federally Qualified Health Center and will receive \$1.8 million for the local health system from 2006 – 2009.

To-date, the program has reached a large percentage of the target population – uninsured Delawareans with incomes up to 200 percent of the FPL who are not eligible for other public insurance coverage programs.

Target CHAP population– 16,980 people

Total applications received as of December 31, 2005 – 13,568 applications

## Challenges & Issues

### Disease Management –

It is difficult to calculate the relative importance of a health home for healthy populations. Similarly, it is difficult to determine how many CHAP enrollees would have had a medical home despite their participation in CHAP because many have enrolled at community health centers where they already sought care regularly. For this reason, CHAP will begin to focus resources on the development of health promotion and disease management activities focused on enrollees with the highest need.

### Demographics –

Enrollment statistics suggest improvement is needed in reaching all demographic sub-populations of the CHAP target population. There is also a need to better understand the demographics of enrollees. Many clients are non-citizens (54 percent) who use CHAP to access prenatal care, the value of which has long been established because it can result in fewer low-birth weight babies needing expensive hospital intensive care. Of the non-citizen enrollees, 23 percent have responded at the time of application that they reside here lawfully. Frequently, low-income, non-citizens are performing work in Delaware but are ineligible for private or public coverage. In these cases, CHAP is their only option. The trend during FY 2005 has been toward the enrollment of more citizens (vs. non-citizens). Should this trend continue, CHAP will begin to reflect a truer demographic of the uninsured population in Delaware.

### Provider Distribution –

While the CHAP provider distribution largely matches the location of CHAP enrollees, geographic pockets of the state remain under-served. While strides have been made toward expanding the health “safety net”, some gaps do exist, particularly in Kent and Sussex Counties for oral health, behavioral health, mental health and prenatal care. Additionally, there is no community health center in the rural, western part of Sussex County, and transportation is often difficult for the CHAP population.

### Role of the Care Coordinators –

Care coordinators provide a variety of services to patients and services vary depending on the setting. Located in community health centers and hospitals, they provide valuable services beyond guiding patients through the eligibility and enrollment process. They help patients address many basic needs (i.e. food and shelter assistance). Hospital care coordinator functions appear to vary by whether they have a social work background or whether they are viewed primarily as a means to enroll uninsured patients into programs.

### Evaluation –

The potential exists to increase and improve research to aid in program evaluation. To date, evaluation activities have been somewhat limited to a relatively small sample size due to the newness of the program and limited number of individuals who have been enrolled for a measurable period of time. Future research will involve larger sample sizes and focus on the impact of CHAP on preventive care, i.e. the proportion of enrollees receiving colon and breast cancer screenings.

### Financial Impact on ED Visits and Hospitalizations –

The impact of CHAP on reducing costs is not entirely clear, due in part to data problems, a lack of good benchmarks, and the limited time frame for study. Using available data, it appears that hospital admissions were only slightly reduced since most admissions for the

uninsured are for pregnancy related conditions, including labor and delivery, which are viewed as appropriate health care. However, minimal savings (data caveats, emergency department fixed costs) are evident and reduced emergency department use is well documented. Consequently, savings are expected to increase as CHAP enrollment expands, as savings for each hospitalization are considerable.

## **2006 ACTION- Community Health Access Program (CHAP)**

### **1. Continue CHAP for another year with following changes:**

- Add a health promotion/disease management component to further improve health outcomes for those with chronic conditions, allowing focus to shift to CHAP enrollees with highest health need and risk.
- Continue the enrollment system, adding survey administration, health promotion and health home referral responsibilities.
- Community Health Centers will retain care coordinators, who serve primarily as health navigators and system support, although enrollment activities may be undertaken.
- Focus on outreach through new community outreach contracts- an RFP was issued on October 31, 2005 and responses are being evaluated as of this printing.
- Re-engage partners that have not been active in recent years; pursue new opportunities to re-engage them.
- Request additional funds from the state for the addition of a health promotion and disease management component.

### **2. Refine cost and budget information.**

- Fine tune per person cost estimates for CHAP, developing a cost trend of CHAP over time. Develop cost per enrollee, showing cost in each fiscal year since program inception (June 2001).
- Through State Planning activities, prepare per member per month cost of SCHIP expansion for parents as example of cost of coverage for comparison purposes.
- Create a total budget that demonstrates the total cost of the program, including estimates of in-kind services donated by CHAP providers and VIP II physicians.

### **3. Continue and enhance program evaluation.**

- Continue program evaluation with increased focus on high-risk and high-need populations, i.e. those with chronic conditions, through the development of disease management programs.
- Improve data collection distinguishing between the entire CHAP population and the high need sub-population. Ensure that reporting and re-enrollment processes are consistent among providers and care coordinators so that information is comparable.

**4. Identify ways to close geographical gaps in the existing safety net.**

- Additional physicians and hospitals will be engaged with the goal of expanding and strengthening the CHAP safety net.

**5. Execute appropriate contracts to implement the items listed above.**

## Uninsured Action Plan – State Planning Grant

**Purpose-** the State Planning Grant, launched in 2001 after securing funding from the U.S. Health Resources and Services Administration (HRSA), permits continued analysis of health insurance coverage options for Delaware. Over the course of the Planning Grant period the Commission has rigorously reviewed and analyzed over twenty short term and long term options. After extensive consideration, four options were found to be worthy of further investigation. Subsequently, cost estimates, advantages and disadvantages were analyzed and the Commission concluded that the following strategies were most appropriate for Delaware:

### **Short term: Preserve and Expand Coverage-**

The Commission has defined a two-pronged strategy to address the issue of access to health care: preservation of existing insurance coverage; and expansion of coverage to the uninsured.

Preservation will focus on an analysis of the market environment for small group insurance issues, including a purchasing pool. Rising health care costs and insurance premiums have made it difficult for some small businesses and non-profit organizations to afford coverage for their employees. High costs are often passed on to low-income employees, and as a result, coverage may be dropped. The goal of a purchasing pool is to assist small businesses with purchasing health insurance for their employees. In 2005, the Commission endorsed legislation to create a purchasing pool presented by the State Insurance Department.

Expansion will focus on a strategy to extend coverage to parents of children who qualify for the Delaware Healthy Children Program, Delaware's State Children's Health Insurance Program (S-CHIP). This approach would create seamless family coverage for families less than 200 percent of the federal poverty level.

### **Long term: Universal Coverage-Single Payer Analysis**

The long term coverage strategy is the comprehensive analysis of a universal insurance coverage system for Delaware, a fundamentally new approach when compared to the existing fragmented system of health coverage in the state. A first phase study has been completed, and next the Commission will complete Phase II: a detailed analysis of design and implementation strategies for a single payer financing system to achieve universal health insurance coverage. In accordance with the FY 2006 Budget Act, the Commission submitted a report to the State Office of Management and Budget and the General Assembly on proposed strategies for reducing the uninsured.

## **SMALL GROUP HEALTH INSURANCE ISSUES**

Recently, a report was prepared by Elliott Wicks, PhD, of the Economic and Social Research Institute, under contract with the Commission. The report was submitted to the Small Business Health Insurance Committee for consideration. This group will review the material and present recommendations to the Health Care Commission.

The report offers insights on:

- Chapter 72 small group health insurance reforms enacted in 1992 in Delaware
- The current market environment
- Recommendations for stabilizing the existing market, including observations on key critical success factors for pooling mechanisms

### **2006 ACTION- Small Group Health Insurance Issues**

- 1. Review the report from Elliot Wicks of the Economic & Social Research Institute and secure recommendations from the Small Business Health Insurance Committee.**
- 2. Continue the analysis of small group health insurance regulatory issues under contract with the Economic & Social Research Institute.**
- 3. Continue to provide support for the purchasing pool legislation presented by the Insurance Department and endorsed by the Commission in 2005.**

### **DELAWARE FIRST HEALTHY CHOICES**

While the Commission continues to address issues related to the small group health insurance market, a consortium of Sussex County businesses and local chambers of commerce is developing a health insurance plan targeting small businesses and based on a disease management model. The Commission has completed its support of an initial analysis of the disease burden in the target population. This product will serve as a useful test of whether a disease management model can reduce costs for small business and improve health insurance coverage.

### **2006 ACTION- Delaware First Healthy Choices**

- 1. Continue to monitor the development and implementation of this program and identify key policy implications.**

### **S-CHIP Expansion (Delaware Healthy Children Program)**

This project, the second of the two-pronged short term strategy, would expand coverage to parents of children enrolled in the Delaware Healthy Children Program, Delaware's State Children's Health Insurance Program (S-CHIP).

Advantages include:

- Adult participants will qualify for a 65 percent federal match for services, rather than the Medicaid match rate of 50 percent
- Expansion can be structured as a "capped, non-entitlement"

- Administrative structure is already in place
- Creates seamless family coverage for families below 200 percent FPL
- Family coverage promotes preventive care
- Reduces pressure on the CHAP network by expanding the number of insured

A report and recommendations for an expansion of the Delaware Healthy Children Program to parents of covered children and preservation of coverage through a purchasing pool for small businesses was submitted to the State Office of Management & Budget in August 2005 in compliance with budget epilogue language.

Under federal guidelines, an S-CHIP expansion requires states to demonstrate budget neutrality. Delaware should meet the federal budget neutrality requirements because of a significant unspent allotment balance.

### **2006 ACTION- S-CHIP Expansion**

- 1. Work with DHSS as necessary to obtain cost estimates and ensure accuracy of data and uniformity of methodologies.**
- 2. In consultation with Delaware’s Department of Health and Social Services staff, determine the best method of obtaining federal waivers and implementing the extension, using grant money to support.**
- 3. Report findings to the Office of Management and Budget and the Controller General’s Office.**

<b>UNIVERSAL COVERAGE- SINGLE PAYER ANALYSIS</b>
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The long-term coverage strategy consists of an examination of the feasibility of implementing a single payer health care financing system in Delaware, including an analysis of related costs.

A Phase I study is complete and a report has been received. Work is currently underway to develop a Request for Proposals (RFP) for Phase II, which will include a detailed analysis of design and implementation strategies for a single payer financing system to achieve universal health insurance coverage.

### **2006 ACTION- Universal Coverage – Single Payer Analysis**

- 1. Complete and issue the RFP for Phase II.**
- 2. Review RFP responses in consultation with the Universal Coverage Committee.**
- 3. Receive Phase II report and recommendations.**

## **WEBSITE –www.healthinsurancechecklist.com**

This website serves as an Internet based “tool kit” for small business owners by providing a checklist of considerations for businesses that wish to purchase health insurance for their employees. The website, developed in partnership with Delaware State Chamber of Commerce, has been up-and-running for one year and continues to receive hits regularly.

The State Chamber of Commerce has recommended forging reciprocal links with other insurance sites in state government and outside of state government to increase access to and value of this resource.

### **2006 ACTION- Website**

- 1. Continue to support and maintain the website.**
- 2. Implement recommendations from the State Chamber of Commerce.**

## **COMMUNITY HEALTH CENTER MARKETING**

The Community Health Access Program (CHAP) and the State Planning Grant compliment one another as ways to support the state safety net, improve access to care and provide seamless coverage to Delawareans. A need has been identified to assist some of the state’s community health centers in attaining their outreach goals and operating at full capacity. These health centers play an integral part in maintaining the success of CHAP.

An environmental analysis will be conducted to determine how and why various populations access health services, particularly in community health centers. Initial marketing efforts will focus on the Henrietta Johnson Medical Center (HJMC) in Wilmington.

### **Issues:**

- The success of health centers is necessary for CHAP outreach.
- There is a need for culturally and linguistically appropriate educational initiatives and health promotion.
- Additional ways to reach target populations must be identified.

### **2006 ACTION- Community Health Center Marketing**

- 1. Enter into more specific discussions with staff and the Board of HJMC to determine the scope of a marketing initiative.**
- 2. Explore alternative ways to close gaps in the safety net.**

## Information & Technology – Delaware Health Information Network (DHIN)

Health information technology is emerging as a national priority, and Delaware is a leader in the development of a statewide clinical information sharing utility. Access to accurate and up-to-date patient health information will improve the delivery of care and reduce the duplication of procedures thus helping to control health care costs. No longer will doctors have to rely on patients' memories for their medical history or contact multiple medical offices or labs and wait days for information to arrive. The DHIN utility will improve the quality of care in Delaware and reduce costs associated with a reduction in medical errors. Thus far, DHIN has enjoyed strong support from key stakeholders, including Delaware's federal congressional delegation.

### **DHIN Purpose –**

- Promote the design and creation of a statewide health information and electronic data interchange network for public and private use
- Serve as a public-private partnership for the benefit of all citizens of Delaware
- Address Delaware's need for timely, reliable and relevant health care information
- Reduce participants' administrative billing and data collection costs
- Ensure the privacy of patient health care information

The Commission has contracted with a firm to deliver the following:

- Environmental analysis of existing systems
- Architectural design document
- Technical requirements definition – what will it take to implement the utility?
- Cost-Benefit analysis – why should a provider want to be part of the utility?
- Sustainability Plan – what will it take for the utility to sustain itself in the long run?

The following critical success factors have been identified:

- Funding and sustainability – currently, the only money available to support DHIN is federal and foundation money, largely for use during the “research & development” phases. The project will most likely require state funding as well.
- Defining the utility – before private entities can derive cost-benefit estimates and determine willingness to pay, they must have a clear and detailed understanding of what the utility will do and how they can participate.
- Interoperability – ease of allowing different systems to exchange information. DHIN will need to develop standards needed to operate with the network.
- Value to the user – the utility must be easy to use, particularly because change of work flow is anticipated and a “critical mass” or support from the majority of stakeholders is needed in order to build and operate efficiently.
- Timing – despite the need to carefully and clearly define the utility, participants must understand that timely action is essential, otherwise stakeholders will

proceed independently to develop their own information sharing technology, rendering the DHIN utility of little use and value.

- Technology Investment Council (TIC) process – the State TIC provides expert review and assistance on major technological development projects in Delaware. The TIC will review the DHIN utility project prior to issuing a request for proposal (RFP). This process adds value to final product, although it adds an additional step in the planning process.

#### **Issues:**

- Long-term issues of DHIN governance, management and staffing need to be identified and addressed.
- Relationship of DHIN to DHCC – Currently, DHIN is an independent body functioning under the auspices of the Commission. Its issues and activities are very complex. Future success of the project will depend on a public/private partnership to meet the goals of the utility. The Commission will continue to promote the utility, while more specific details of the relationship are the subject of ongoing discussion.
- Communication is essential at critical points of the development and implementation processes. Presentations and updates should include members of General Assembly and describe observations about implications for Delaware.
- Leadership is needed from several sectors, including the State.

#### **2006 ACTION- Delaware Health Information Network (DHIN)**

- 1. Support DHIN throughout the Technology Investment Council review process.**
- 2. Support DHIN as an RFP is developed and vendor(s) are selected.**
- 3. Recognize that state financial support may be required and pursue appropriate means to secure funds.**
- 4. Facilitate communication at critical points as necessary, particularly with General Assembly.**
- 5. Continue to receive updates on key topics at monthly Commission meetings, including:**
  - Funding – amount and sources (willingness of all sectors to support)
  - Governance/ownership
  - Operations
  - Sustainability
  - Information Security (including the use of a unique patient identifier)
  - State role
  - State/federal relationship

# Health Professional Workforce Development –

## **Delaware Institute of Medical Education and Research (DIMER)<sup>15</sup>**

Created in 1969 as a cost effective alternative to establishing a medical school in Delaware, DIMER provides enhanced opportunities for Delaware residents to obtain a medical education.

A key function of DIMER is to provide financial support for Jefferson Medical College (JMC) and Philadelphia College of Osteopathic Medicine (PCOM) in exchange for reserved admission slots for Delawareans. The relationship with JMC was established in 1969. The relationship with PCOM was established in 1999. In cooperation with the Delaware Higher Education Commission, the program also provides scholarships and tuition supplements for participating students at both schools, located in Philadelphia, Pennsylvania.

### **Issues:**

Delaware's relationship with JMC and PCOM continues to be good. Both schools have consistently accepted the requisite number of Delaware students and the quality of medical education is high. Additionally, the co-administration of scholarships between the Commission and the Higher Education Commission for DIMER students is smooth.

The DIMER program successfully increases the likelihood that Delaware students will be accepted to medical schools. Through DIMER, the odds of a Delaware resident being accepted into Jefferson are about one-in-four. The odds of someone from another state begin accepted, without a cooperative agreement such as DIMER, are about one in 50. While PCOM matriculations are on target, matriculations at JMC were low in 2005. Although 27 students were accepted, only 13 matriculated.

Since JMC and PCOM are private colleges, the high tuition rates may be a deterrent to some students. Tuition for the 2005-06 school year is \$38,316 at JMC and \$34,122 at PCOM. The DIMER Board has recommended consideration of increasing the amount of funds allocated for DIMER student scholarships and tuition supplements. When the original scholarship line amount of \$400,000 was established, Jefferson's tuition was \$25,235. As tuition has increased, the funds available for scholarships have not kept pace, and have not been increased since 1996. The high tuition and corresponding prospect of having significant education debt upon graduation is regarded as barriers to recruiting key target populations.

Geographical, racial and ethnic diversity of participating students remains a challenge. 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. It is an ongoing challenge to recruit students of color (particularly black and Hispanic) and rural residents to medical school.

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<sup>15</sup> See the Appendix to review the DIMER Annual Report.

DIMER recognizes that both the current and projected shortages of health care professionals point to the need for activities to promote health careers, particularly among middle and high school students. The newly formed AHEC may aid in outreach and promotion of health professions among young people.

Notably, payments to Jefferson Medical College have remained flat over many years despite rising costs incurred by the college.

### **2006 ACTION- Delaware Institute of Medical Education and Research (DIMER)**

- 1. Invite the AHEC Executive Director to meetings to continue dialogue and the coordination of activities.**
- 2. Determine the best means of achieving organizational collaboration among DHCC, DIMER and AHEC.**
- 3. Explore why some students who were accepted chose not to enroll at Jefferson.**
- 4. Monitor trends in enrollments at both medical schools.**
- 5. Determine how to increase and improve outreach efforts to recruit a more diverse pool of applicants.**
- 6. Obtain more detailed information on applications, acceptances and matriculations from PCOM.**

<b>Delaware Institute for Dental Education and Research (DIDER)</b>
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In 2001, DIDER was transferred to the Health Care Commission, as a result of recommendations made by the state's Dental Care Access Improvement Committee. Subsequent legislation reconstituted and expanded the membership of the DIDER Board and expanded its scope in purpose. Two key responsibilities are to:

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

#### **Issues:**

The shortage of dentists in Delaware is well established. Currently, a 1998 report on the distribution and supply of dentists is being updated. A contract between the Delaware Division of Public Health and the University of Delaware is in place and the report is expected to be completed in the first quarter of 2006.

During FY 2005, the DIDER Board identified access to dental school as a key priority in achieving its mission, and began reviewing options for providing opportunities for Delawareans to attend dental school. Using the model developed by DIMER, the Board

conducted discussions with several dental schools in the region. Discussions with Temple University have yielded great results. The DIDER Board is now pursuing an initiative to purchase slots of students at Temple University School of Dentistry, similar to the DIMER arrangement with JMC and PCOM. DIDER wishes to purchase slots at the same rate as DIMER- \$12,500 per slot, not to exceed 6 slots per year. Additionally, since tuition at Temple (\$40,678 for the 2005-06 school year) is roughly equivalent to the tuition at JMC and PCOM, DIDER is also requesting funds for tuition supplements of \$12,500 per student per year for the DIDER students attending Temple.

If implemented, an agreement with Temple may also include an opportunity for participating dental students to complete an externship training program at dental facilities in Delaware.

Additionally, DIDER is working closely with Christiana Care Health System, which has expressed interest in expanding its residency training program.

### **2006 ACTION- Delaware Institute for Dental Education and Research (DIDER)**

- 1. Support the DIDER request to pursue an agreement with Temple University School of Dentistry to reserve 6 slots for Delaware students each year.**
- 2. Request funds to implement the agreement and provide a tuition supplement for participating students.**
- 3. Explore the possibility of implementing an externship program for dental students at dental facilities in Delaware.**
- 4. Once it is complete, receive and review the report from the Division of Public Health outlining the demographics and location of dentists throughout the state.**

## State Loan Repayment Program (SLRP)

SLRP is designed to recruit health professionals 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 in Delaware. Practice sites may include public or private non-profit settings and private practices (solo or group).

In cases where a practice site is located in a federally designated Health Professional Shortage Area (HPSA), state dollars provided for loan repayment can be matched dollar-for-dollar with federal funds. In these cases, the practice site must be a public or not-for-profit private facility. Additionally, health care providers must be HPSA appropriate for their discipline: primary care physicians in a Primary Care HPSA and dental providers in a Dental HPSA. Research is also underway to identify and establish a mental health HPSA in Delaware. Contracts with providers that will be supported using the federal match must include a stringent financial penalty for breach, in cases where a clinician fails to complete his or her contractual service commitment.

In 2005, the Health Care Commission approved and implemented several structural changes and enhancements to the program:

- The minimum service requirement has been reduced from three to two (2) years with allowances for one-year extensions.
- Award limits have been increased to a maximum of \$70,000 for a two (2) year contract. Payments are made every 6 months on a graduated scale.
- 12 new clinician specialties have been added to the program. *\*Italics indicate a new specialty.*

### **Eligible health professionals include:**

Primary Care Physicians (MD and DO)

- Family Medicine
- Osteopathic General Practice
- Internal Medicine
- Pediatrics
- Obstetrics & Gynecology
- General Psychiatry

General Practice Dentists (DDS and DMD)

*Registered Clinical Dental Hygienists*

*Primary Care Physician Assistants*

*Primary Care Certified Nurse Practitioners*

*Certified Nurse Midwives*

*Medical Oncologists*

*Pediatric Psychiatrists*

*Clinical or Counseling Psychologists*

*Psychiatric Nurse Specialists*

*Licensed Clinical Social Workers*

*Mental Health Counselors*

*Licensed Professional Counselors*

*Marriage & Family Therapists*

In October 2005, the Commission's website was redesigned, and subsequently, the SLRP materials and applications were revised and updated and posted on the site. The website will be updated regularly, recognizing its value as a resource to professionals seeking information and opportunities in Delaware. Additionally, marketing efforts are underway. A new program brochure has been created and will be distributed regionally.

To-date, the following placements have been made:

2 dentists in Dagsboro	2 OB-GYN in Wilmington (Westside)
1 dentist in Rehoboth	3 OB-GYN in Dover (OB-GYN Assoc)
1 dentist in Milford	1 OB-GYN in Kent County (Milford)
1 dentist in Smyrna	1 OB-GYN in Sussex County (Seaford)
<u>1 dentist in Dover (KCHC)</u>	1 OB-GYN in Sussex County (Lewes)
TOTAL- 6 Dentists	1 Family Practice DO in Wilmington (Westside)
	1 Family Practice MD in Kent County (KCHC)
	1 Family Practice MD in Kent County (Milford)
	1 Family Practice MD in Sussex County (Georgetown)
	1 Family Practice MD in Sussex County (Lewes)
	1 Internal Medicine DO in Sussex County (Lewes)
	1 Med-Peds Physician in Sussex County (Milton)
	<u>1 Pediatrician in New Castle County (Townsend)</u>
	TOTAL- 16 Physicians

#### **Issues:**

New award thresholds- For a 2-year commitment, health professionals may be granted up to \$70,000 total. This amount is the maximum award possible over 2 years, not a guaranteed level of funding. Since several of the twelve new clinician specialties are mid-level practitioners, their educational loans are likely significantly less than debt accrued by dentists or physicians, therefore they require fewer loan repayment funds.

In light of the addition of twelve new specialties, the Commission will need to decide which entity (DIMER or DIDER) will consider applications from these health professionals. Moreover, additional funds may be required to fund clinicians in the additional specialties.

Delaware has a high un-spent balance of federal matching funds due to the difficulty of making placements that comply with the federal guidelines. The state's Mental Health Task Force is in the data gathering and analysis phase of the process to obtain a federal mental health HPSA designation, which will increase the program's ability to place clinicians at sites that meet federal guidelines and qualify for the federal matching funds. Additionally, improvements to program marketing efforts will focus on the promotion of federally qualifying sites to help draw down the un-spent federal funds.

#### **2006 ACTION- State Loan Repayment Program**

- 1. Determine new award thresholds for mid-level health professionals.**
- 2. Continue support of state efforts to secure the federal designation of a Health Professional Shortage Area (HPSA) for mental health professionals.**
- 3. Focus on marketing and outreach for the program to generate more applications.**

## **Addressing Shortages in Nursing and Allied Health Professions**

### **Nursing Implementation Committee-**

The Commission's Nursing Implementation Committee was formed to oversee the implementation of recommendations from a 2002 Commission report, "Solving the Nursing Shortage." Currently, this group is charged with the promotion of activities to solve the nursing shortage in Delaware. The Committee is overseeing a survey to assess the status of licensed nurses in the state. The survey is intended to update data collected in 2002 as part of the nursing shortage report. Surveys have already been mailed to all of the nurses licensed in the state. Responses will be collected and analyzed by Wesley College in partnership with the Delaware Board of Nursing.

As a newly established organization, The Delaware Area Health Education Center (AHEC) is in the process of developing a mission and defining initiatives; however, they are currently working in collaboration with the Health Care Commission to complete a study of nursing education programs, including the full array of programs available and the length of time required to complete education and enter the workforce.

Recently, AHEC agreed to contribute \$40,000 to the Commission to support the survey of licensed nurses in the state. Additionally, the Commission will collaborate with AHEC to research the status of other allied health professions and complete a study of health education programs and "pipelines", including the full array of programs available in Delaware; the supply of nursing and health professional faculty at colleges and universities; and the length of time required for students to complete their education and enter the workforce.

The Commission will work closely with AHEC staff to maintain open dialogue and coordinate activities, recognizing that AHEC may require some state funding in the future.

### **2006 ACTION- Nursing Implementation Committee**

- 1. Maintain the Committee for the purpose of overseeing the survey of licensed nurses. The frequency of future meetings is to be determined.**
- 2. Collect survey responses from nurses in the state and oversee analysis of the data by Wesley College.**
- 3. The Committee will serve as a review board for any future nursing initiatives.**
- 4. Continue dialogue with AHEC and determine means of assuring coordination and communication between AHEC, DHCC, DIMER and DIDER.**

### **Health Professional Workforce Committee –**

In 2006 a new committee will be established to determine health professional workforce needs, collect data and provide resources to coordinate strategies to predict and prevent shortages. This new committee will help streamline the fragmented data collection systems that exist throughout the state today, creating a comprehensive and objective workforce data resource for stakeholders. Primary goals and functions may include:

- Centralize and coordinate information on health professions throughout the State
- Standardize the collection and analysis of state-wide data
- Forecast health workforce supply, demand, and demographics
- Evaluate the educational “pipelines” for health professionals in the State
- Fundraise and/or seek grants to support activities and research
- Create long-term solutions for the recruitment of workforce professionals

With regard to nursing, the shortage is already well documented. The Commission has acknowledged the nursing issues and will continue to monitor and “course correct”. Now the Commission needs to be more proactive in addressing and documenting issues with other allied health professions.

### **2006 ACTION- Health Professional Workforce Committee**

**1. With regard to nursing, continue to monitor and revise current activities.**

**2. Establish the Health Professional Workforce Committee to oversee the following activities:**

- **Determine the best means to coordinate activities and collaborate with other state institutions and entities with similar goals.**
- **Determine the best means to collect and update reliable, statewide data on nursing and allied health professions.**
- **Consider issues regarding the supply of nursing faculty and other educational resources for colleges and universities in Delaware.**
- **Identify and begin to promote action-oriented strategies.**
- **Seek outside funding (grants, etc.) to support data collection activities.**

**3. Execute the study of allied health professionals and educational pipeline issues in cooperation with the Delaware AHEC.**

# Research & Policy Development – Research Reports

In order to provide accurate and up-to-date information to policy and decision-makers, the Health Care Commission partners with the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware to perform ongoing research. Reports and findings are published annually and made available to the public.

## **Total Cost of Health Care**

This report documents how much money is spent annually on health care in Delaware. It also identifies trends in health care costs and spending and serves as a very valuable resource for policy-makers.

**Issues:** What methods are used to determine a new cost shift number each year? Is the analysis of the cost shift estimate rigorous enough?

### **2006 ACTION**

- 1. Continue to produce the report.**
- 2. Resolve the issues listed above.**

## **Delawareans Without Health Insurance**

This report analyzes and tracks the uninsured population in Delaware and their demographic characteristics. It is also a very valuable resource for policy makers and should be updated annually.

### **Issues:**

Multiple data sources are essential for optimal accuracy. The Census Bureau Current Population Survey data is insufficient and should not be used the sole basis for determining Delaware's numbers.

It is unfortunate that the *Delaware News Journal* published a story on the uninsured in Delaware based solely on a Census Bureau press release. The fact that the Commission was not contacted for comment indicates the need to raise awareness of our Uninsured Report and promote our methodology for generating the most accurate information.

### **2006 ACTION**

- 1. Continue to produce the report.**

## **Racial and Ethnic Disparities in Delaware**

### **2006 ACTION**

- 1. Determine whether resources exist to update the 2004 Health Disparities Report.**

# Research & Policy Development – Health Fund Advisory Committee

## HEALTH FUND ADVISORY COMMITTEE

The Health Fund Advisory Committee was established by the General Assembly to make recommendations on expenditures of the State's Tobacco Master Settlement Agreement revenue. The Commission has three representatives on the Committee, and is responsible for providing research and policy guidance to the Committee.

Meetings were conducted in fall 2005 and three Commission representatives, Joseph Lieberman, Dennis Rochford, and Vincent Meconi, attended.

The Committee finished work in December so that recommendations could be incorporated into Governor Minner's recommended budget for FY 2007.

### **Issues:**

The Commission should request additional funds to support the health promotion and disease management components of the CHAP program.

### **2006 ACTION- Health Fund Advisory Committee**

- 1. Continue Commission representation on the Committee and maintain support from Commission staff.**
- 2. Request additional funds to support the CHAP program based on the increased number of uninsured citizens in the target population and the addition of a health promotion and disease management component.**

# Specific Health Care Issues & Affiliated Groups

## Mental Health

Implementation of recommendations from the State's Mental Health Issues Committee is underway in collaboration with Division of Public Health and Division of Substance Abuse and Mental Health. Activities include a survey of practitioners, focus groups of consumers and practitioners, and mental health policy analysis. The University of Delaware is analyzing the surveys while Delaware State University is conducting the mental health policy analysis and identification of model programs.

### **Goals:**

Determine the supply of mental health providers and the demand for and access to mental health services in the state.

Obtain the federal designation as a Health Professional Shortage Area (HPSA) for mental health care providers, thereby making it easier to recruit mental health professionals to Delaware, particularly for Federally Qualified Health Centers and State Loan Repayment Program.

### **2006 ACTION- Mental Health**

- 1. Continue to provide staff support for data collection activities.**
- 2. Re-convene the Mental Health Committee to review the data being collected when appropriate.**

## Chronic Illness Task Force- House Joint Resolution 10

A report from this Task Force, administered by the Health Care Commission, was issued in June 2004. Follow-up is now required to determine if the recommendations have been implemented appropriately.

### **2006 ACTION- Chronic Illness**

- 1. Re-convene the Task Force members periodically to receive updates on steps being taken to implement the recommendations.**
- 2. Compile a list of current activities taking place to implement recommendations.**
- 3. Discuss the possibility of a symposium (one of the task force recommendations) with the Insurance Commissioner, Matthew Denn.**
- 4. Confer with the Task Force Chair, Representative Bethany Hall-Long, about next steps.**

### **Medical Liability Insurance Task Force – House Resolution 17**

This Task Force is assigned with following-up on the work of an earlier task force convened on this topic. To the extent possible, the resolution calls for all of the original members to serve on new task force. The DHCC Chairman, Lt. Governor John Carney, will serve as a member. Meetings have not yet been scheduled as of this printing.

#### **Issues:**

The Commission should review and understand proposals for legislation regarding medical liability that are currently under consideration.

Research will be conducted on legislative action being taken in other states and at the federal level.

#### **2006 ACTION- Medical Liability**

- 1. Compile a review of recent legislation in Delaware and other states.**
- 2. Commission will participate and contribute as necessary.**

### **Physical Activity & Education Task Force – House Concurrent Resolution 37**

This Task Force is assigned to review physical education programs in the State, research successful strategies in other states, and recommend strategies to improve physical education and physical activity in Delaware schools.

The Commission is represented by the Lt. Governor John Carney, and assists with staff support.

#### **2006 ACTION- Physical Activity**

- 1. Commission will participate and contribute as necessary.**

### **Healthcare Associated Infections Task Force – House Resolution 30**

This Task Force was created to examine issues surrounding healthcare associated infections and address approaches to address the problem.

Joe Lieberman represents DHCC on the task force, with Lois Studte as a back-up.

#### **2006 ACTION- Healthcare Associated Infections**

- 1. Commission will participate and contribute as necessary.**

## **Racial and Ethnic Health Disparities**

Subsequent to the publication of a Commission report and the coordination of a statewide conference in 2004, Governor Minner established a new Health Disparities Task Force. DHCC is represented on the Task Force by its Chairman, Lt. Governor John Carney.

The Governor's Task Force should be made aware of CHAP and its key findings so they may be considered within the scope of Task Force's work.

More comprehensive data is needed on the Hispanic population in Delaware.

### **2006 ACTION- Health Disparities**

- 1. Determine whether resources exist to update the 2004 Health Disparities Report.**
- 2. Monitor activities and provide data and support as needed.**

## **Health Resources Board (HRB)**

The HRB oversees the Certificate of Public Review (CPR) process for all new medical capital construction in the State. The Commission was previously represented by Herbert Nehrling and Robert Miller. Presently, new representation is needed.

HRB completed Sunset Review this year. A strengthened relationship and better coordination with DHCC were identified as issues that need to be addressed. Currently, HRB is required to:

- coordinate activities with DHCC, DHSS and other groups as appropriate
- develop a Health Resources Management Plan and submit to DHCC for review
- include continual care communities and other non-traditional long term care facilities in the scope of CPR, so long as the other facilities are identified by DHSS or DHCC

To date, most HRB activities have been project specific rather than policy oriented.

### **2006 ACTION- Health Resources Board**

- 1. DHCC and staff from the Bureau of Health Planning will discuss ways to better coordinate their activities.**
- 2. Designate a representative of the Commission to serve on the Board.**

# 2006 Action Steps: At-A-Glance

## 1. Uninsured Action Plan

### **Community Healthcare Access Program (CHAP)**

1. Continue CHAP for another year and implement proposed changes, including new health promotion and disease management components.
2. Refine cost and budget information.
3. Continue and enhance program evaluation.
4. Identify ways to close geographical gaps in the existing safety net.
5. Execute appropriate contracts to implement the items listed above.

### **Small Group Health Insurance Issues**

1. Review the report from Elliot Wicks of the Economic & Social Research Institute and secure recommendations from the Small Business Health Insurance Committee.
2. Continue the analysis of small group health insurance regulatory issues under contract with the Economic & Social Research Institute.
3. Continue to provide support for purchasing pool legislation presented by the Insurance Department and endorsed by the Commission in 2005.

### **Delaware First Healthy Choices**

1. Continue to monitor the development and implementation of this program and identify key policy implications.

### **S-CHIP Expansion**

1. Work with DHSS as necessary to obtain cost estimates and ensure accuracy of data and uniformity of methodologies.
2. In consultation with Delaware's Department of Health and Social Services staff, determine the best method of obtaining federal waivers and implementing the extension, using grant money to support.
3. Report findings to the Office of Management and Budget and the Controller General's Office.

### **Universal Coverage – Single Payer Analysis**

1. Complete and issue the RFP for Phase II.
2. Review RFP responses in consultation with the Universal Coverage Committee.
3. Receive Phase II report and recommendations.

**Websites-** [www.healthinsurancechecklist.com](http://www.healthinsurancechecklist.com) and [www.dhin.org](http://www.dhin.org)

1. Continue to support and maintain the websites.
2. Implement recommendations from the State Chamber of Commerce.

### **Community Health Center Marketing**

1. Enter into more specific discussions with staff and the Board of Henrietta Johnson Medical Center to determine the scope of a marketing initiative.
2. Explore alternative ways to close gaps in the safety net.

## **2. Information & Technology**

### **Delaware Health Information Network (DHIN)**

1. Support DHIN throughout the Technology Investment Council review process.
2. Support DHIN as an RFP is developed and vendor(s) are selected.
3. Recognize that state financial support may be required and pursue appropriate means to secure funds.
4. Facilitate communication at critical points as necessary, particularly with General Assembly.
5. Continue to receive updates on key topics at monthly Commission meetings.

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

### **Delaware Institute of Medical Education and Research (DIMER)**

1. Invite the AHEC Executive Director to meetings to continue dialogue and the coordination of activities.
2. Determine the best means of achieving organizational collaboration among DHCC, DIMER and AHEC.
3. Explore why some students who were accepted chose not to enroll at Jefferson.
4. Monitor trends in enrollments at both medical schools.
5. Determine how to increase and improve outreach efforts to recruit a more diverse pool of applicants.
6. Obtain more detailed information on applications, acceptances and matriculations from PCOM.

### **Delaware Institute for Dental Education and Research (DIDER)**

1. Support the DIDER request to pursue an agreement with Temple University School of Dentistry to reserve 6 slots for Delaware students each year.
2. Request funds to implement the agreement and provide a tuition supplement for participating students.

3. Explore the possibility of implementing an externship program for dental students at dental facilities in Delaware.
4. Once it is complete, receive and review the report from the Division of Public Health outlining the demographics and location of dentists throughout the state.

#### **State Loan Repayment Program**

1. Determine new award thresholds for mid-level health professionals.
2. Continue support of state efforts to secure the federal designation of a Health Professional Shortage Area (HPSA) for mental health professionals.
3. Focus on marketing and outreach for the program to generate more applications.

#### **Nursing Implementation Committee**

1. Maintain the Committee for the purpose of overseeing the survey of licensed nurses.
2. Collect survey responses from nurses in the state and oversee analysis of the data by Wesley College.
3. The Committee will serve as a review board for any future nursing initiatives.
4. Continue dialogue with AHEC and determine means of assuring coordination and communication between AHEC, DHCC, DIMER and DIDER.

#### **Health Professional Workforce Committee**

1. With regard to nursing, continue to monitor and revise current activities.
2. Establish the Health Professional Workforce Committee to oversee various activities related to data collection.
3. Execute the study of allied health professionals and educational pipeline issues in cooperation with the Delaware AHEC.

### **4. Research & Policy Development**

#### **Research Reports**

1. Continue to produce the “Total Cost of Health Care” and “Delawareans Without Health Insurance” reports.
2. Determine whether resources exist to update the 2004 Health Disparities Report.

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

1. Continue Commission representation on the Committee and maintain support from Commission staff.
2. Request additional funds to support the CHAP program based on the increased number of uninsured citizens in the target population and the addition of health promotion and disease management components.

## **5. Specific Health Care Issues & Affiliated Groups**

### **Mental Health**

1. Continue to provide staff support for data collection activities.
2. Re-convene the Mental Health Committee to review the data being collected when appropriate.

### **Chronic Illness Task Force**

1. Re-convene the Task Force members periodically to receive updates on steps being taken to implement the recommendations.
2. Compile a list of current activities taking place to implement recommendations.
3. Discuss the possibility of a symposium (one of the task force recommendations) with the Insurance Commissioner, Matthew Denn.
4. Confer with the Task Force Chair, Representative Bethany Hall-Long, about next steps.

### **Medical Liability Insurance Task Force**

1. Compile a review of recent legislation in Delaware and other states.
2. Commission will participate and contribute as necessary.

### **Physical Activity & Education Task Force**

1. Commission will participate and contribute as necessary.

### **Healthcare Associated Infections Task Force**

1. Commission will participate and contribute as necessary.

### **Racial and Ethnic Health Disparities Task Force**

1. Determine whether resources exist to update the 2004 Health Disparities Report.
2. Monitor activities and provide data and support as needed to the Governor's Task Force.

### **Health Resources Board**

1. DHCC and staff from the Bureau of Health Planning will discuss ways to better coordinate their activities.
2. Designate a representative of the Commission to serve on the Board.

# APPENDICIES

A) Delaware Health Care Commission: History and Background

B) Board and Committee Lists

Delaware Health Information Network (DHIN) Board of Directors

Delaware Institute of Medical Education & Research (DIMER) Board of Directors

Delaware Institute for Dental Education & Research (DIDER) Board of Directors

State Loan Repayment Committee

Nursing Implementation Committee

Universal Coverage Committee

Health Care Access Improvement Coalition (HCAIC)

C) DIMER Annual Report 2006

## Delaware Health Care Commission: 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 strives to alleviate specific health conditions that are particularly problematic. Currently, the Commission is involved with initiatives addressing chronic illness, mental health services, medical liability insurance, physical activity and education, healthcare associated infections, and racial and ethnic disparities.

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