Dialogue on Healthcare Reform Implementation in Delaware
February 1- 2, 2011
Newark, Delaware

The Delaware Public Policy Institute (DPPI) is a nonprofit, nonpartisan, nongovernmental public policy research organization. Its mission is to conduct research and encourage the study and discussion of public policy issues affecting the citizens of Delaware. The Institute identifies emerging issues that drive Delaware's future public policy agenda.

This report was prepared for DPPI by Brad Sperber and Johanna Raquet of The Keystone Center (www.keystone.org), a nonprofit that has been helping public, private, and civic-sector leaders solve complex problems and advance good public policy since 1975. Keystone relies on its independence, commitment to good science and skills in designing and leading consensus-building processes to establish new partnerships, reduce conflict, and produce policy agreements.

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Executive Summary

The Delaware Public Policy Institute (DPPI) convened a dialogue of leaders from the public, private and civic sectors to consider the implications of the Patient Protection and Affordable Care Act (PPACA – Public Law 111-148) for healthcare delivery in the State of Delaware.[1] Stakeholders representing a diversity of sectors, disciplines and perspectives gathered on February 1-2, 2011 at the University of Delaware to share information, exchange views, identify priorities, and formulate recommended strategies for implementation of the healthcare reform legislation.

The aims of the PPACA include increasing the accountability of insurance companies, lowering healthcare costs, providing more healthcare choices, and enhancing the quality of healthcare for all Americans. However, many details of how best to interpret and implement many key elements are left to the discretion of states, creating a need for coordination of efforts and interests among key stakeholders to ensure effective and efficient operationalization of the reform package.

The dialogue endeavored to ensure strong familiarity among key Delaware stakeholders with key elements of the legislation, assess how the State is currently positioned to implement those elements, consider how implementation should proceed in the context of healthcare delivery in Delaware, and consider whether and how healthcare delivery in the State can be transformed into a preventive model. The dialogue focused on the present content of the PPACA – the law as it currently exists and how it should be implemented in Delaware – rather than how it might have been configured or might evolve in the future.

Specifically, the dialogue addressed the following needs:

- Definition and implementation of the medical home concept
- Definition and implementation of Accountable Care Organizations in Delaware
- Consideration of the establishment of Healthcare Innovation Zones in Delaware
- Readiness for "meaningful use" of health information technology to share medical data and information among providers and with patients
- Assessment of the need for and barriers to development of the medical workforce.

The participants included medical professionals, executives of medical centers, patient advocates, educators, organized labor, representatives of special needs populations, employers (both large and small businesses), and state officials. The Attendee List accompanies this report as Appendix A.

This report, developed by the meeting's facilitators, summarizes the key discussion points from the dialogue. The document intends to accurately represent participating stakeholders' observations and joint recommendations, although participants were not asked to endorse this report as written.

[1] http://docs.house.gov/energycommerce/ppacacon.pdf.

Summary of Recommendations

Medical Homes

1) The Patient-Centered Medical Home (PCMH) Demonstration Project Guidelines developed by the Patient-Centered Primary Care Collaborative (PCPCC) should serve as a starting point for defining the medical home concept for purposes of implementation in Delaware. Further, the joint use principles for PCMH as defined by PCPCC should be adopted fully or in part for purposes of implementation in the State.

2) The Delaware Health Care Commission should convene a working group to determine in more detail how the medical home concept may be applied more broadly throughout the State, conducting evaluations and developing targeted legislation as appropriate. The group should be constituted to ensure that all essential stakeholders have a voice in the process. The working group should conduct an in-depth study of innovative approaches to establishing incentives, learning from the experiences of other states with circumstances similar to those of Delaware. This proposed working group should be convened by late spring 2011 and have developed a state plan by the end of 2011.

Accountable Care Organizations and Health Innovation Zones

1) Accountable Care Organizations (ACOs) should be driven by local hospitals or physician groups.

2) The healthcare delivery system needs to shift in emphasis from volume to value, with providers paid by the value of care provided rather than by volume of cases or tests.

3) Healthcare leaders in Delaware must develop a transparent, equitable means of distributing responsibility for the care of high-needs patients among ACOs. At the same time, ACOs must be incentivized to include high-needs population and patients eligible for Medicare and Medicaid.

4) Federal regulation must be amended to allow the collaboration among providers necessary for formation and successful functioning of ACOs.

5) Significant tort reform must occur to ensure a reasonable degree of immunity for caregivers who adhere to established evidence-based guidelines.

6) The Delaware Medical Society, the Delaware Nurses Association, and healthcare and hospital associations should collaborate to ensure that the best available data (including Medicaid claims information and population health data) are used to inform understanding of the biggest cost drivers in the care of special needs populations, as well as to identify opportunities to better serve those populations.

Meaningful Use of Health Information Technology

1) Implementation of the meaningful use concept in Delaware should be guided by the following statement:

   Healthcare providers in Delaware should be committed to fully adhering to and benefitting from the federal guidelines for meaningful use of health information technology. For implementation to be meaningful, all relevant stakeholders must be involved in using the technology in appropriate ways. Physicians, especially those in private practice, will require substantial support and adaptation of this principle to enable them to meet clinical responsibilities.

Medical Workforce Development

1) Current supply and distribution of the healthcare workforce should be measured, establishing benchmark data that can be used in projecting and future needs. (This information can be compiled largely by using existing data from the University of Delaware, supplemented by interviews of key hospital personnel.)

2) Additional state funding should be allocated to the Delaware State Loan Repayment Program by November 2011, and the program should be expanded to include medical residents.

3) An increase in residency training in Delaware should be pursued over the next two to four years as a means of building the workforce over time, since physicians tend to practice within fifty miles of where they completed their residency. Special attention must be paid to the downstate areas where practitioners are most needed.

4) Legislative action and leadership from the executive branch are needed to increase the scope of practice for nurse practitioners, physician assistants and other caregivers to meet the current and future healthcare needs of the State.

Delaware as a Center for Healthcare Innovation

1) Leaders in the public, private, and civic sectors in Delaware should collaborate to position the State as a regional and national center for healthcare innovation. The Delaware Health Care Commission should serve as an incubator and convenor for an ongoing series of initiatives aimed at integrating innovation into the process of healthcare reform, focusing on population-based approaches to preventive health that can improve the health profile of all Delawareans.

Introduction

Background

Healthcare spending in the United States (U.S.) is among the highest of all industrial countries, accounting for 16.2 % of the country's Gross Domestic Product. Costs have risen steadily for several years, from $253 billion in 1980 to $2.3 trillion in 2008, outpacing both inflation and the growth in national income.[2] Despite this investment, concerns persist about health outcomes and affordability of and access to quality care. A 2007 study by the National Association of Community Health Centers and the Robert Graham Center found that 56 million Americans – most of whom have health insurance – lack ready access to primary care.[3] Many Americans (at least half, according to some research) are not receiving the care they need, with a disproportionate burden borne by minorities and the poor.

On March 23, 2010, President Obama signed comprehensive national health reform into law in the form of the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148).[4] The aims of this legislation include:

- Increasing the accountability of insurance companies;
- Lowering healthcare costs;
- Providing more healthcare choices; and
- Enhancing the quality of healthcare for all Americans.

The Congressional Budget Office estimated that implementation of the PPACA (in tandem with the Health Care and Education Reconciliation Act of 2010 – H.R. 4872) will equate to significant cost savings. Their estimate included a reduction of the deficit by $143 billon over the first 10 years and by $1.2 trillion in the second. The reform package is also expected to reduce the number of uninsured by upwards of 32 million[5]

While the fundamental provisions of the legislation are mandatory, details of how best to interpret and implement many key elements are left to the discretion of states. To many stakeholders of the U.S. healthcare system, passage of the PPACA constitutes a paradigm shift in patient care (and in the delivery of that care) requiring thoughtful consideration of how to ensure full realization of the opportunities it affords, as well as how to navigate the complexities it presents. More narrowly and pragmatically, there is a need for coordination of efforts and interests to make efficient and effective use of Federal resources dedicated to implementation of the reform mandates.

[2] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Care Expenditures Data*, January 2010.
[3] National Association of Community Health Centers, The Robert Graham Center, and Health Link, *Access Granted: The Primary Care Payoff*, August 2007.
[4] http://docs.house.gov/energycommerce/ppacacon.pdf.
[5] http://www.cbo.gov/publications/collections/health.cfm, accessed on March 11, 2011.

The Dialogue

The Delaware Public Policy Institute (DPPI) convened a dialogue of leaders from the public, private and civic sectors to consider the implications of this recent legislation for the State of Delaware. Stakeholders gathered on February 1-2, 2011 at the University of Delaware to share information, exchange views, identify priorities, and begin development of promising strategies.

Objective and scope

The chief goal of this dialogue was to ascertain how healthcare delivery in Delaware should evolve in light of the PPACA. Specifically the dialogue aimed to:

- Ensure strong familiarity among key stakeholders with key elements of the national legislation, especially those pertaining to healthcare delivery;
- Assess how Delaware is currently positioned vis-à-vis implementation of the prescribed reform;
- Consider how implementation of reform should proceed in the context of healthcare delivery in Delaware; and
- Consider whether and how healthcare delivery in Delaware can be transformed into a preventive model.

Through pre-meeting discussions with stakeholders, the facilitators identified five substantive topics as priority areas of inquiry for the dialogue:

- Definition and implementation of the medical home concept
- Definition and implementation of Accountable Care Organizations in Delaware
- Consideration of the establishment of Healthcare Innovation Zones in Delaware
- Readiness for "meaningful use" of health information technology to share medical data and information among providers and with patients
- Assessment of the need for and barriers to development of the medical workforce.

The dialogue focused squarely on the present content of the PPACA – the law as it currently exists and how it should be implemented in Delaware. Questions of what the Federal legislation might or should have contained, as well as about whether and how the act might be amended going forward, were outside the purview of discussion.

Participants

DPPI assembled a robust group of participants, striving for diversity in professional sector and discipline, subject matter expertise, geographical location, and demographics, as well as the ability to characterize the interests of and be influential among key constituencies (e.g., professional peers, a region or community). The participants included medical professionals, executives of medical centers, patient advocates, educators, organized labor, representatives of special needs populations, employers (both large and small businesses), and state officials. Several other key stakeholders were invited to observe the dialogue but did not participate actively in plenary discussion. The Attendee List accompanies this report as Appendix A.

The Keystone Center (www.keystone.org) provided a facilitation team to assist with designing the agenda, moderating discussion in a fair and impartial manner, and to draft this report.

The dialogue process

The meeting commenced with presentations by Federal government representatives in order to provide participants with a shared foundation of knowledge regarding the implications of the PPACA for the State, and what potential opportunities are available as a result of the legislation. Dialogue participants were briefed by Joanne Corte Grossi, Regional Director, US Department of Health and Human Services, Region III, on key components of the legislation as it pertains to delivery of healthcare. Nancy O'Connor, Regional Administrator for the Centers for Medicare & Medicaid Services (CMS), provided an overview of the provisions of the Act that CMS is implementing and their status and potential impact on the states.

Following the background presentations, the dialogue group delved into extensive discussion – in plenary and small group settings – of the major issue areas noted above. In the course of deliberation, participating stakeholders also identified a need and opportunity for the State of Delaware to position itself more firmly as a regional and national leader in healthcare innovation.

Consensus (defined as the absence of significant dissent) was sought during the discussion, but was not considered essential to a successful outcome since differences in perspective, value or interpretation can also be important information for purposes of making policy and crafting public health strategy. However, the recommendations contained in this report are the product of consensus or, at minimum, enjoyed the support of a strong majority of participants.

The meeting agenda accompanies this report as Appendix B.

This report

Audiences for the recommendations contained in this report include (but are not limited to) the Delaware Department of Health and Social Services, the Delaware Health Care Commission, medical centers, doctors and other medical professionals, small and large employers (or state and local chambers of commerce), patient and consumer advocacy groups, and elected officials.

This report serves as a summary of discussion during the meeting, capturing key discussion points, major bodies of opinion, and agreements. The document does not attribute statements or viewpoints to specific individuals.

The report was developed by the meeting's facilitators. Meeting participants should be understood as important contributors to the discussion; the observations and recommendations presented in these pages are the product of their deliberation. However, participants have not been asked to endorse this report as written.

Recommendations

Medical Homes

The medical home is an approach to providing primary care services that is team-based, whole-person, comprehensive, ongoing and coordinated patient-centered care. The "patient-centered medical home" model establishes teams that comprehensively attend to multiple needs of patients, aiming to provide more coordinated care, promote prevention and reduce health care costs. The American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association have jointly defined the medical home as "a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians."[6][7]

Participants articulated a vision for comprehensive healthcare in Delaware in which all patients should have access to quality healthcare that is coordinated, comprehensive, integrated, preventive, interactive, and affordable both to the patient and to the community. Implementation of the medical home concept provides a means of realizing this overarching vision. The medical home constitutes an approach to providing organized healthcare that can improve quality and reduce cost by centering on the patient's needs. Participating stakeholders noted that such coordination of care will be beneficial to patients by reducing confusion and increasing access.

In order to qualify for funding opportunities that may be available or become available, the State needs to adopt a more comprehensive, coordinated approach to patient centered medical care. Coordinated care is the "wave of the future" and Delaware must prepare to be competitive in funding opportunities.

Participants recommended that the Patient Centered Medical Home (PCMH) Demonstration Project Guidelines (http://www.pcpcc.net/content/guidelines-patient-centered-medical-home-pcmh-demonstration-projects) developed by the Patient-Centered Primary Care Collaborative (PCPCC) (www.pcpcc.net) serve as a starting point for defining the medical home concept for purposes of implementation in Delaware. Participating stakeholders further recommended that the joint use principles for PCMH as defined by PCPCC be adopted fully or in part for purposes of implementation in the State.

The participant group expressed strong concern about the lack of an adequate workforce to provide the level of care needed in this new medical home model. Participants observed that existing professional boundaries need to be reorganized to better meet the needs of patients. The group also acknowledged the need for a patient's medical home to shift in many cases based on health status and on the current reality of a shortage of primary care practitioners.

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[6] Association of Maternal and Child Health Programs, *Health Reform: What's in it to Promote the Medical Home?* October 2010, www.amchp.org, accessed on March 14, 2011.

[7] http://www.pcpcc.net/, accessed on March 14, 2011.

The group also recommended that the Delaware Health Care Commission (DHCC) convene a working group to determine in more detail how the medical home concept may be applied more broadly throughout the State. The working group should be constituted to ensure that all relevant stakeholders have a voice in the process. The working group should conduct an in-depth study of innovative approaches to establishing incentives, conducting evaluations and developing targeted legislation. Special consideration should be given to models of medical homes in Vermont, Rhode Island, Maine, Maryland, Pennsylvania, and other states that may closely align with Delaware's unique circumstances.

The proposed working group should be convened by late spring 2011 and a state plan developed by the end of 2011. Many participants acknowledged the ambitious nature of this timeframe, and also noted challenges in financing a robust medical home system. Participants generally agreed, however, on the importance of proceeding expeditiously and in coordinated fashion.

Accountable Care Organizations and Healthcare Innovation Zones

Provisions for the creation of Accountable Care Organizations (ACOs) appears in Section 3022 of PPACA under "shared savings program" and authorizes the Center for Medicare and Medicaid Services (CMS) to create an ACO program no later than January 1, 2012. Though CMS has not announced an official definition of ACOs as of this writing, the concept is widely defined as "a group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get." Payment is tied to achieving health care quality goals and outcomes that result in cost savings.[8] The law provides for incentives for physicians to join ACOs. Such collaboratives intend to provide enhanced coordinated care by improving quality, preventing illness and disease, and reducing hospital admissions, thereby reducing costs in the healthcare system.

For purposes of implementation in Delaware, the group defined the ACO as an *organized collaborative of multiple providers assuming joint accountability for improving healthcare quality and slowing the growth of healthcare costs*. The ACO is a means of driving improvement in the coordination and efficient delivery of healthcare, while enhancing the quality of that care through joint responsibility. An ACO should encompass the full spectrum of care including acute care, well care and chronic care.

Roles, governance, and operations

Participants agreed that such a collaborative should be driven by local hospitals or physician groups, and typically organized by proximity. Each ACO should be responsible for establishing a system of governance to build, implement and maintain an appropriate business model, including by-laws, a fee structure, a payment structure, and a distribution system.

It is essential to establish the willingness of payors – both public and private – to participate in the shared savings system offered by the ACO concept. Start-up funding from payors would

[8] http://www.healthcare.gov/glossary/a/accountable, accessed on March 14, 2011; and Harold D. Miller, "How To Create an Accountable care Organization," Center for Healthcare Quality and Payment Reform, September 2009.

facilitate the initial formation and implementation of the collaboratives. Payor organizations will need to monitor and report out on the performance of ACOs to ensure that progress can be tracked and incentivized.

Patient-centered care

A variety of models are likely to emerge throughout the State of Delaware, but in all cases the well-being and safety of patients should serve as the highest goal of all member providers. The current healthcare delivery system needs to shift from volume to value, with providers paid by the value of care provided rather than by volume of cases or tests. In an ACO, providers should therefore be accountable for the patient's health outcomes. Payment structures should take patient satisfaction into account, with that satisfaction worded and weighted in a way that does not penalize those who care for high-risk populations.

Healthcare leaders in Delaware must devise a transparent means for distributing the responsibility for caring for high-needs patients among ACOs, to ensure that those patients receive the best care possible and to ensure that the responsibility for that care is shared equitably. Participants suggested development of a case mix index encompassing key medical and socioeconomic factors to inform such decisions.

A successfully structured and managed ACO should ensure patients receive the needed care in the appropriate setting. Shifting to a focus on outpatient care minimizes the degree to which patients enter (or re-enter) facility-based care prematurely, thereby making more efficient use of resources, fostering a sense of independence, and reducing exposure to healthcare-associated infections.

Legal and regulatory reform

Successful implementation of needed reforms in healthcare delivery in Delaware will require legal and regulatory changes, which must be pursued collaboratively by payors, providers, the business community, trial lawyers, and hospitals.

The number of ACOs that actually emerge in Delaware will depend in part on whether anti-trust restrictions can be redefined. Federal regulation must be amended to provide a "safe harbor" that allows more collaboration (for purposes of ACOs specifically) among providers. Such changes to the status quo are especially important given the size and market circumstances of Delaware; providers must be attracted from elsewhere. Without regulatory and legislative changes – which must be approved by CMS – ACOs either will not form or will not operate successfully, with the needed impacts.

Participants also noted significant tort reform as a high priority, while acknowledging that support for the needed changes must be cultivated over time. For the ACO concept to achieve the benefits envisioned, a legal framework must support immunity for caregivers that follow established evidence-based guidelines.

Healthcare Innovation Zones

The concept of the Healthcare Innovation Zone (HIZ) was developed by the Association of American Medical Colleges (AAMC) in recognition of the vital importance of healthcare education and research in the development of the culture of medical practice. HIZs combine change in the structure of healthcare delivery systems with an educational and research agenda designed to facilitate and sustain that change. Functionally, the group defined HIZs as Accountable Care Organizations which incorporate the education of healthcare professionals and research on the effectiveness of the ACO in serving the community.

The establishment of the Delaware Health Sciences Alliance (University of Delaware, Christiana Care Health System, AI DuPont/Nemours, and Thomas Jefferson University) together with the collegial relationships among healthcare providers in the State offers a unique opportunity to test the effectiveness of the HIZ concept. Several organizations in the State (i.e., BayHealth, Christiana Care) have been instrumental in the development of the concept.

As a point of focus, participants suggested implementation of HIZs should be utilized as an opportunity to foster care of high-needs populations or those eligible for Medicare and/or Medicaid. Available Federal funding should be pursued to incentivize ACOs to include such populations. At the same time, existing data (including Medicaid claims data and population health data) must be mined to improve understanding of the biggest cost drivers of special needs populations, identifying opportunities to better serve those populations.

Participating stakeholders recommended that the Delaware Medical Society, the Delaware Nurses Association, and healthcare and hospital associations collaborate to ensure that such data guides the strategy, leading to positive health outcomes.

Meaningful Use of Health Information Technology

As part of the American Recovery and Reinvestment Act of 2009, the Health Information Technology Economic and Clinical Health Act (HITECH) was enacted. This law authorized incentives payments for providers as well as funding to build national infrastructure for the adoption of the Electronic Medical Record (EMR), and established the goal of "meaningful use" of EMR. Together with the passage of the ACA, these measures are intended to facilitate better management healthcare costs, and improved quality resulting in improved patient health outcomes.[9]

The dialogue explored questions of how aggressively and legalistically meaningful use of Health Information Technology (HIT) should be pursued in Delaware. Participants shared the assumption that approximately 20% of practitioners in the State currently use Electronic Medical Records (EMR), and agreed that the use of EMR needs to increase statewide significantly.

[9] http://healthit.hhs.gov, accessed on March 15, 2011.

State officials expressed interest in the government serving as a partner to support the implementation and enhancement of HIT in the State. The State is coordinating the Delaware Health Information Network (DHIN), a communication system that is available to healthcare providers throughout Delaware. The DHIN will apply the latest technology with security practices to make it possible for physicians, hospitals, and laboratories to deliver and access critical healthcare for patients. The DHIN will aid the effort to achieve eventual development of a fully integrated system by saving time, improving care, enhancing privacy and reducing cost.

The group concluded that overall costs of healthcare delivery can be reduced with the implementation of meaningful use of health information technology throughout the State. However, the group stressed the importance of participation by all healthcare practitioners in all settings for this effort to be successful. Increased participation will result in more beneficial communication among practitioners and therefore more comprehensive care to patients. Barriers to participation include financing, although Federal funding is available to offset some of the cost of implementation. Physicians close to retirement age seem least likely to implement these changes because of the high upfront costs of implementation, including training.

Participants developed the following statement as guidance for implementation of the meaningful use concept in the State:

> *Healthcare providers in Delaware should be committed to fully adhering to and benefitting from the federal guidelines for meaningful use of health information technology. For implementation to be meaningful, all relevant stakeholders must be involved in using the technology in appropriate ways. Physicians, especially those in private practice, will require substantial support and adaptation of this principle to enable them to meet clinical responsibilities.*

While the statement stresses widespread use, its flexibility should allow for greater adaptation and therefore implementation.

Discussion focused on the need to communicate to practitioners – not only practical information about use of the DHIN, but also the business case for participation. It was acknowledged that different marketing tools may be needed for different medical settings and types of practitioners, to make the appeal for EMR and participation in the DHIN. Participants proposed that the Health Science Alliance add research on cost savings to its research agenda.

Medical Workforce Development

Participating stakeholders articulated a goal of assuring that a high-quality healthcare workforce exists to meet the needs of a diverse and changing population in Delaware. Ensuring a workforce of caregivers that is adequate in number – and sufficiently trained and resourced – must become a top priority of leaders in government, education, and the healthcare community.

Current supply and distribution of the healthcare workforce should be measured, thereby establishing benchmark data, and future needs must be projected. This information can be

compiled largely by using existing data from the University of Delaware, supplemented by interviews of key hospital personnel.

Recommended strategies for developing the needed workforce include expanding assistance with student debt, increasing residency training, redefining the scope of practice for some types of caregivers, identifying new ways of providing long-term care, and incentivizing students to enter primary care practice.

Student debt

Ensuring adequate financial support for the education of future caregivers is an essential step. The group recommended that additional state funding be secured for the Delaware State Loan Repayment Program, and that the program be expanded to include medical residents. Efforts should focus on targeted professional areas as part of a broader strategy to allow all practitioners (doctors, nurses, physician assistants, etc.) to work at the top of their skill level.

It is hoped that the State legislature and the governor will consider this need as a budget priority, with a goal of authorizing the needed funds. The Delaware Health Care Commission (HCC) should continue to provide oversight, and the Medical Society of Delaware should support and advocate for the needed changes.

Residency training

An increase in residency training in Delaware should be pursued over the next two to four years as a valuable means of building the workforce over time. (Physicians tend to practice within fifty miles of where they completed their residency.) Special attention must be paid to the downstate areas where practitioners are most needed.

Team and residency training need to be incorporated and applied to all healthcare professionals. Hospitals and the Health Sciences Alliance (HSA) can be leaders in promoting this development. The number of training and clinical positions must increase commensurately, as well as the administrative capabilities to handle the additional residents.

Scope of practice

It will be necessary to increase the scope of practice for nurse practitioners, physician assistants and other caregivers to meet the current and future healthcare needs of the State. This will require legislative action and leadership from the executive branch in order gain political momentum and eventual passage.

The issue of liability and patient privacy related to the role of volunteers in providing care will also need to be addressed.

Long-term care

The current number of long-term care providers in Delaware cannot meet the growing need within the system of healthcare delivery. Participants recommended the encouragement of alternatives to long-term care (such as home care) to help aid in the reduction of costs by avoiding multiple (and sometimes premature) hospital visits.

This demand obliges leaders in Delaware (policy-makers, medical professionals, employers, patient advocates, etc.) to consider new ways of practicing and providing patient care, such as telemedicine and tele-monitoring. A supplemental workforce may also become necessary. A supervised non-medical workforce can emerge as a new type of caregiver, although social stigmas must be addressed via public education in order for this strategy to be successful.

Pursuant to ensuring an adequate qualified workforce and considering alternative venues for and means of care, payment reform may be needed to support the needed transition. Involvement and action by the HCC, Delaware Department of Health and Social Services (DHSS) and advocacy groups such as the AARP will be vital to the success of advancing long-term care.

Incentives for primary care

The current system does not sufficiently incentivize medical students to select a professional focus on primary care. Recommended strategies for encouraging residents to enter primary care practice in Delaware include inclusion in loan repayment programs (as noted above), and better marketing of the quality of life and competitive pay that Delaware offers.

More significantly, the State should initiate a longer-term transition toward a preventive model of primary care – a shift involving private employers. Such a shift, requiring initial investment and a change in provider culture, should be supported and promoted by third party payors, provider organizations, and State government.

Delaware as a Center for Healthcare Innovation

Stakeholders expressed the need to articulate and build toward an expansive vision of the health of Delawareans in the future as the system of healthcare delivery evolves due to legislative reform and other drivers. Dialogue participants discussed the need to look beyond traditional pathways for providing care, fostering a state-wide culture of catalyzing innovative ideas to provide care to the next generation. Deliberations focused on developing Delaware as a regional and/or national leader in innovation. Given its compact size, diverse population, geographical proximity to major centers of education and policy (e.g., New York City, Philadelphia, and Washington, DC), collaborative nature, and well-developed relationships with the public sector, Delaware is uniquely positioned to become a showcase for innovation in healthcare.

The Delaware Health Care Commission could serve as an incubator and convenor for initiatives aimed at integrating innovation into the process of healthcare reform. Such efforts should focus on population-based approaches to preventive health, with an end goal of improving the health of all Delawareans. Topics to consider include obesity, clean air, and use of technology. Projects should learn from existing successful models for innovating and lowering costs, consider the potential roles of non-traditional caregivers (e.g., social workers, community-based organizations, and faith-based organizations), and showcase relevant research being conducted in Delaware. Increased collaboration among key stakeholders will be necessary to attract funding for such initiatives.

Proposed focus on reduction in chronic disease

As an example of such an initiative, participants proposed development of a comprehensive, population-based approach to reducing incidence of chronic disease – including obesity – prevalent in Delaware. A cross-sector focus on prevention would serve as an innovative approach to cost containment and reduction in the healthcare system. This program could foster the needed paradigm shift toward preventive, patient-centered care articulated in the PPACA, by providing support for individuals to assume greater personal responsibility for their health. The initiative could build on successes and incorporate lessons from various models within the State and around the country such as Farm to School programs and Florida's Healthy 100 program, which promote healthy eating and active living as part of obesity and chronic disease prevention.

Participants acknowledged that a "culture of health" needs to be created in the State and that cultural change takes time. The program should be piloted in the Medicaid population and then more widely implemented, with incentives to fully engage participants. A statewide marketing campaign will be needed to enlist all stakeholders in this effort at all levels and in all settings. Potential components could include:

- Financial incentives for healthy decision-making by patients/consumers
- Worksite wellness
- Community health coaches (provided to those who are high utilizers of the healthcare system)
- Campaign to "right-size" meals, addressing the problem of excessive portion size (especially in away-from-home settings)
- Effort to ensure affordability of healthy foods, especially for underserved populations

Funding sources for the program could include grants from private foundations, support from Federal agencies (such as the Centers for Medicare and Medicaid Services), and/or taxation of sugared beverages.

Next Steps

Participants considered how best to advance this body of recommendations. The Delaware Health Care Commission (www.dhss.delaware.gov/dhss/dhcc) is charged by the State General Assembly with developing a pathway to basic, affordable healthcare for all Delawareans, and

will continue its efforts to engage stakeholder in the implementation of the PPACA throughout the State pursuant to achieving comprehensive, patient-centered care. The Commission is uniquely positioned to engage interactively with stakeholders from all sectors while coordinating progress toward the needed action steps.

More broadly, participants in this dialogue, along with their counterparts throughout the State, must work together to catalyze the shift to a new model of healthcare delivery in Delaware that emphasizes quality over volume.

Appendix A: Attendee List

Dialogue on Healthcare Reform Implementation in Delaware
February 1- 2, 2011
Newark, Delaware

Attendee List

Participants

Ted Becker
The Inn at Canal Square
Delaware Health Care Commission

Dr. David Bercaw
President
Medical Society of Delaware

Bob Bird
Owner
Home Instead

Dr. Curt Blacklock

Tim Constantine
President and CEO
Blue Cross Blue Shield of Delaware

Robert Dayton
President
Delaware Bioscience Association

Mark DiMaio
Senior Director
Delaware Public Policy Institute

Richard Heffron
Senior Vice President
Delaware State Chamber of. Commerce

Bill Kirk
Vice President and General Counsel
Blue Cross Blue Shield of Delaware

Jim Lafferty
Executive Director
Mental Health Association of Delaware

Secretary Rita Landgraf
Delaware Department of Health and Social Services

Dr. Robert Laskowski
CEO
Christiana Care Health System

Lolita A. Lopez
President and CEO
Westside Family Healthcare.

Kathy Matt
Dean
College of Health Sciences
University of Delaware

Brian McGlinchey
Director, Government Affairs
Laborers International Union

Terrence M. Murphy
President and CEO
Bayhealth, Inc.

Bonnie Osgood
President
Delaware Nurses Association

Dr. Karyl Rattay
Director
Delaware Division of Public Health
Delaware Department of Health and Social Services

Bettina Riveros
Chair
Delaware Health Care Commission

Brian S. Olson
CEO
La Red Health Center

Steve Silver
Managing Member
Onix Group

John H. Taylor, Jr.
Executive Director
Delaware Public Policy Institute

Michelle Taylor
President and CEO
United Way of Delaware

Speakers

Joanne Grossi
Director
U.S. Department of Health and Human Services Region III

Nancy O'Connor
Regional Administrator
Centers for Medicare and Medicaid Services

Invited Observers

Sarah Carmody
Executive Director, Delaware Nurses Association

Karen Day
Executive Director
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Appendix B: Meeting Agenda

Dialogue on Healthcare Reform Implementation in Delaware
February 1- 2, 2011
Newark, Delaware

Agenda

Meeting objectives

The dialogue seeks to understand how healthcare delivery in Delaware should evolve in light of the Patient Protection and Affordable Care Act. Specifically, this meeting aims to:

A) Ensure strong familiarity with key elements of the national legislation, especially those pertaining to healthcare delivery;
B) Assess how Delaware is currently positioned vis-à-vis implementation of the prescribed reform;
C) Consider how implementation of reform should proceed in the context of healthcare delivery in Delaware; and
D) Consider whether and how healthcare delivery in Delaware can be transformed into a preventive model.

Day 1 – February 1st

8:15 a.m. **Room open, coffee available**

9:00 **Opening**

- Welcome and review of meeting objectives – *John Taylor, Executive Director, Delaware Public Policy Institute*
- Meeting overview – *Brad Sperber, Senior Associate, The Keystone Center*
  - Introductions
  - Review of agenda
  - Introduction of protocols for the meeting

9:45 **Overview of the Patient Protection and Affordable Care Act**

- Presentation of key components of healthcare reform legislation as it pertains to delivery of healthcare – *Joanne Grossi, Regional Director, U.S. Department of Health and Human Services Region 3*
- Q&A and discussion

10:30 **Break**

10:45 Continuation of legislation overview

11:30 Opportunities for federal funding to support reform implementation

- Presentation regarding current and future opportunities to secure federal resources for implementation efforts in Delaware – *Nancy O'Connor, Regional Administrator, Centers for Medicare and Medicaid Services*
- Q&A and discussion

12:15 p.m. Lunch

12:45 Medical homes

- Consideration of how best to define and implement the medical home concept

2:15 Accountable care in Delaware

- Consideration of how to define and implement "Accountable Care Organizations" in Delaware

3:45 Break

4:00 Healthcare innovation

- Consideration of how to define and implement Healthcare Innovation Zones in Delaware

5:15 Recap of Day 1, preview of Day 2

5:30 Adjourn

Day 2 – February 2nd

8:00 a.m. Room open; coffee available

8:30 Welcome, overview of the day

8:45 Meaningful use

- Readiness for "meaningful use" of health information technology to share medical data and information among providers and with patients

9:45 **Assessing the need for and barriers to development of the medical work force**

10:45 **Break**

11:00 **Breakout discussions**

- Small groups will form around the five substantive topic areas to identify priority strategies for implementation

12:30 p.m. **Lunch**

1:00 **Reports from breakout discussions**

- Brief reports from breakout groups
- Plenary discussion of priority strategies

2:15 **Closing**

- Follow-up to this meeting
- Identifying the contributions key stakeholders can make

3:00 **Adjourn**