

Delaware Health Care Commission

# Annual Report and Strategic Plan, 2010

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

Margaret O'Neil Building  
410 Federal Street  
Suite 7  
Dover, Delaware, 19901  
302-739-2730 - phone  
302-739-6927- fax  
<http://www.dhcc.delaware.gov/>

# Health Care Commission Members

## 2009 Membership

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

**Lisa C. Barkley, MD**  
*Appointed by the Governor*

**Theodore Becker**  
*Appointed by the Governor*

**Tom Cook**  
*Ex-Officio as Acting Secretary, Department of Finance*

**Karen Weldin Stewart**  
*Ex-Officio as Insurance Commissioner*

**A. Richard Heffron**  
*Appointed by the Governor*

**Rita Landgraf**  
*Ex-Officio as Secretary, Department of Health and Social Services*

**Janice E. Nevin, MD, MPH**  
*Appointed by the Governor*

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

**Vivian Rapposelli**  
*Ex-Officio as Secretary, Department of Services for Children, Youth and Their Families*

**Frederick A. Townsend**  
*Appointed by the Senate President Pro Tem*

# Commission Staff

**Paula K. Roy**  
*Executive Director*

**Leah A. Jones**  
*Director of Planning & Policy*

**Marlyn Marvel**  
*Community Relations Officer*

**Robin L. Lawrence**  
*Executive Secretary*

**Linda G. Johnson**  
*Administrative Specialist III*

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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.

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

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

# Introduction

The Delaware Health Care Commission respectfully submits the 2010 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 over the last year, the challenges that exist for both public and private stakeholders, trends in health care policy and a set framework for addressing these issues.

The FY2010 Budget Act administratively moved the Delaware Health Care Commission (DHCC) from the Office of Management and Budget into the Office of the Secretary, Department of Health & Social Services (DHSS). The move removed the Commission's operating budget, which had been in place since the Commission was established in 1990. However, it did not result in changes to the statute or its statutory authority and continued to appropriate operational funding to support the Commission's initiatives and programs, including that of the three advisory boards, which sit under the Commission:

- Delaware Institute of Medical Education & Research (DIMER)
- Delaware Institute of Dental Education & Research (DIDER)
- Delaware Health Information Network (DHIN)

It is important to note that while the administrative processes surrounding the Commission's administrative move to the Office of the Secretary, DHSS have been seamless and transparent to internal and external partners, the move has served as a catalyst for self-reflection. As a part of the Commission's strategic planning process, the DHCC took the opportunity to review its journey over the last 20 years and evaluated the Commission's current structure, role, function and purpose as it interacts and works with its affiliates, DIMER, DIDER and DHIN. Furthermore, the DHCC discussed ways to develop and establish a clear connection between the goals of the DHCC and DHSS. In addition, as a public and private multi-stakeholder policy setting body, the Commission embraces its role in developing a strategy that considers the implications of federal health care reform and will prepare recommendations for implementation at the state level.

Health Care Reform proposals circulating through Congress at the national level are stirring a great debate and may be reconciled in early 2010. Delawareans are bracing themselves in anticipation as there seems to be a sense of urgency to improve efficiencies in the health care system and to support families and employers with access to care and the burden of rising health care costs. Delaware must be ready to react because that's only the beginning of the reform process to the health care delivery system. The real work begins at the state and local level, which requires strategic leadership, open dialogue, and commitment from all key stakeholders to implement changes that make sense in Delaware, striving for improved quality care that is affordable and accessible. The Delaware Health Care Commission is well positioned to respond to health reform and is focused on post reform issues. The Commission plays a vital role in local and national health policy planning and development as the "convener" and as a policy setting body with a proven track record of building consensus around workable solutions. DHCC is ready to engage in dialogue and examine population and health outcomes, service delivery infrastructure, accessibility and utilization, financing and workforce development to support the implementation process.

There are some areas of agreement on policy across the health care reform proposals, which include the following:

- Individual mandates, subsidies to low-income individuals to make coverage more affordable, protecting lower income people from high out-of-pocket costs
- Medicaid coverage expansion
- Insurance market reforms (i.e. eliminating the practice of denying people coverage due to pre-existing conditions)
- National or regional exchanges for individuals and some small employers without other coverage options
- Coordination and integration by supporting “Advanced Primary Care” (based on the joint principles of the Patient Centered Medical Home (PCMH) model)<sup>1</sup> initiatives that promote the transformation of primary care practices; pay for performance
- Prevention and wellness programming, workforce recruitment and retention and
- Incentives to encourage the adoption of health information technology

These are common policy initiatives being explored to ensure access to quality health care for all citizens, but cost containment is still a concern. As Delaware struggles to finance existing programs (i.e. Medicaid), it will be a challenge to finance a reformed health system, which is truly a point of contention. Delaware and other states anticipate new financial responsibilities as a result of federal health reform, if resources are not made available to comply with new federal standards. Federal health reform may impose new taxes on “high benefit plans” and penalties on individuals and employers who violate mandates in order to provide a new revenue source.

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. In a most recent report issued by the Commonwealth Fund,<sup>2</sup> Delaware outperforms most states on access to care measures and related quality of care measures. This success can largely be attributed to the Commission-run Community Health Care Access Program (CHAP), which is specifically designed to link Delawareans who lack insurance to a medical home, or if eligible, with public coverage programs like Medicaid. Maintaining insurance coverage levels, particularly for small businesses still remains a concern due to rising premium costs. Other challenges include childhood and adult obesity rates, growing health disparities among diverse racial and ethnic populations, limited access to mental health services, and shortages of health professionals to care for the state’s growing and aging population.

As a result of the Health Care Commission’s 2010 Annual Strategic Planning process, this report offers key information about access to health care in Delaware, the cost of health care, and outlines the Commission’s comprehensive strategic plan with action steps detailing its path forward for the future. The report outlines the areas in need of the most attention and sets forth strategies to address them.

This report could not have been accomplished without the enthusiasm and support of the Delaware Health Care Commission (DHCC) members and leadership from the DIMER

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<sup>1</sup> Joint Principles of the Patient Centered Medical Home (February 2007).  
[http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf)

<sup>2</sup> *Aiming Higher for Health System Performance: A Profile of Seven States that Perform Well on the Commonwealth Fund’s 2009 State Scorecard.* (October 2009). The Commonwealth Fund.



Board, DIDER Board, DHIN, and staff, as well as public and private stakeholder input. Their dedication, time and willingness to have an open dialogue helps define and identify underlying questions and policy issues throughout the year and during the Commission's Annual Retreat 2009. They are greatly appreciated for their ongoing commitment, valuable health policy expertise, and willingness to provide assistance, comments and insights, which are critical to the Commission's success.

Paula K. Roy  
Executive Director  
Delaware Health Care Commission

Rita Landgraf  
Cabinet Secretary  
Delaware Health & Social Services

# Looking Back on Our Journey

The Delaware Health Care Commission, formed by the 135<sup>th</sup> Delaware General Assembly in 1990, was created to oversee the implementation of the recommendations put forward by the Indigent Health Care Task Force. Representatives and participants were assembled together including large and small businesses, the health insurance industry, health care providers, public representatives (DHSS, Insurance Commissioner), and economic specialists. The General Assembly recognized the need to ensure basic and affordable health care to all Delawareans. Also recognizing the complexities of the health care delivery system, the Health Care Commission's mission was established to recommend methods to provide basic, affordable, equal quality, and accessible health care to all Delawareans. The Health Care Commission has a long and successful history and has served as a focal point for reviewing public policy issues on healthcare in Delaware and responding to areas of unmet needs.

In 1993, the window of opportunity for major health care reform under President Clinton's administration was strongly believed to take shape by the federal government's initiative and states were preparing for implementation of a reformed U.S. health care system. The Commission's initial efforts (1991-1993) targeted areas most in need based on three segments of the uninsured population, which included children, the unemployed uninsured and the working uninsured. Of particular note and due to the Commission's steadfast policy focus, Medicaid expansions brought health care to children up to age 18 ( up to 100% fpl) and to pregnant women and their infants (up to 185% fpl). In addition, the Commission focused on pilot projects. For example, a pilot initiative was established in partnership with the Medical Society of Delaware, Voluntary Initiative Program (VIP), which linked Medicaid beneficiaries with a medical home and actively recruited primary care physicians to treat uninsured patients on a voluntary basis. This network of physicians remains strong as ever today with more than 500 private physicians participating and helps provide medical services to Community Health Care Access Program (CHAP) enrollees.

From 1993 -1994 the Commission focused on developing a comprehensive health care plan, due to the fact that federal health care reform seemed more imminent than in 1991. A Cost Containment Committee was established to investigate the factors of cost shift issues. A recommendation of the Committee was to strengthen the Certificate of Need (CON) process for the construction of new health care facilities, the development of new services and the purchase of major medical and technology equipment for containing health care costs in Delaware. This process is currently the Certificate of Public Review (CPR) with oversight from the Health Resources Board and sits in the Division of Public Health. In May 1994, the Commission issued a plan based on a managed competition model.

In the wake of the demise of national health care reform efforts in 1995, states watched the federal plan unravel, which was designed as a middle-of-the road compromise between the market-based and the regulation based reforms. One positive outcome of the failed health reform effort was a small scale coverage program initiative, the State Children's Health Insurance Program (S-CHIP), designed to cover uninsured children in families with incomes

that are modest but too high to qualify for Medicaid. States also re-focused their health reform efforts and began experimenting with state-level innovations in health care reform that included extending coverage to the uninsured and health care quality. In 1996, the Delaware Health Care Commission acknowledged the trend in the private sector system to consolidate plans, hospitals, and physicians, which were reforming the health care system in the state and in the nation. Employers saw managed care as a means to continue offering health insurance to their employees while containing rising health care costs. The health care industry responded by becoming more competitive, thus creating a whole new set of public policy issues. The fee for service system encouraged physicians to do too much, while the new system of cost savings in a managed care system put pressure to do too little. This produced some questions about whether the cost savings approach produced by managed care lowered quality to unacceptable levels.

Also in 1996, in response to the Joint Sunset Committee of the General Assembly, the Commission established a Primary Care Committee to conduct a review and make recommendations on the Delaware Institute of Medical Education and Research (DIMER). One outcome of the review was that DIMER place its administration under the auspices of the Delaware Health Care Commission and serve as an advisory board to the Commission, where it resides today. This expanded DIMER's mission to help the state meet its broader health care needs. As a result of the review, it was further concluded that DIMER focus its attention to the health care needs of rural and underserved areas of the state in collaboration with the Jefferson Medical College serving as Delaware's medical school.

At the onset of 1997, the Commission's vision was to provide Delawareans with timely, reliable and relevant health care information and as a result, formed the Delaware Health Information Network (DHIN) to accomplish this task. Legislation was signed by Governor Thomas R. Carper (currently, U.S. Senator Thomas R. Carper) creating DHIN as a public instrumentality of the state. This public-private partnership provides a statewide electronic network for data exchange of health care information. The purpose of DHIN is to promote more efficient communication among multiple health care providers; create additional efficiencies in cost by eliminating redundancy in data, storage and reducing administrative costs; enhance the ability of the state to monitor health status and provide reliable information to health care consumers and purchasers about the quality and cost effectiveness of health care services, plans and providers. At the time, DHIN's long-term objective was to increase the efficiency and quality of health care in Delaware, which still holds true today in 2009.

As the Health Care Commission hit the turn of the 21<sup>st</sup> Century, a similar period of self-reflection occurred with a "decade of focus", and a revisit of the Commission's mission statement and purpose, key initiatives and accomplishments. At the time, an exciting opportunity evolved to promote a healthier Delaware through the Delaware Health Fund, which was created to receive funding flowing to the state as a result of the Master Settlement Agreement, an agreement reached between the nation's attorney Generals and the tobacco industry. Today, the Commission is charged with advising the Health Fund Advisory Committee in providing research and guidance as decisions are made on the use of the fund.

The Commission's efforts to significantly reduce the number of uninsured and underinsured and strengthen the health care infrastructure for these populations are largely attributed to its Uninsured Action Plan. The State Planning Program, launched in 2001 after securing a federal grant, helped Delaware develop a plan for increasing the availability of affordable and meaningful coverage options for the uninsured and helped establish the Community Health Care Access Program (CHAP). CHAP, now in its ninth year, successfully connects low

income uninsured individuals with the ever-important health home, providing a full complement of primary care services. Over the course of the Planning Grant period the Commission rigorously reviewed and analyzed over twenty short-term and long-term health insurance coverage options for Delaware.

### ***DHCC has made a difference***

The Commission's work over the past twenty years has made a lasting impression on the First State. The combination of research, policy analysis, consensus building and managing new programs and the Commission's unique status in state government has made its success possible.

**DHIN** – Delaware boasts the nation's first (and of this writing, the only) statewide health information exchange, and DHIN is recognized as a national leader on organizing, developing and operating a successful HIE.

### **HEALTH PLANNING – CERTIFICATE OF PUBLIC REVIEW**

A thorough research project analyzing the impact of the Certificate of Need Program (CON) in 1996 resulted in phasing out CON and establishing the current Certificate of Public Review overseen by the Health Resources Board, which sits in the Division of Public Health.

### **HEALTH FUND EXPENDITURES**

The Commission provided the policy framework for the work of the current Health Fund Advisory Committee, which makes annual recommendations on how to spend funds flowing to Delaware as a result of the Master Settlement Agreement reached between the nation's attorneys general and the tobacco industry in 1999. Delaware continues to stand out as one of the few states that has spent the funds on health related programs and tobacco cessation.

### **SERVICES FOR THE UNINSURED**

A successful federal grant application paved the way for the Community Health Care Access Program (CHAP), which has provided medical homes focusing on primary care as well as access to specialty services, diagnostic services and linkage to other programs for which patients may be eligible. Over 22,000 low-income uninsured individuals have been served by CHAP. They are less likely to use the hospital emergency room, have shorter hospital lengths of stay and better health outcomes as a result.

### **ANNUAL TRACKING OF THE UNINSURED**

The Delawareans without Health Insurance Report issued annually is a valuable source of information for people wanting to learn about the uninsured in Delaware. The report is used to target programs aimed at expanding coverage or access to health care, and has been the basis for designing the S-CHIP program in Delaware, design Medicaid expansions, and implement insurance reforms.

### **COVERAGE OPTIONS**

The Commission's intense examination of coverage options to expand coverage for more Delawareans provides a wealth of information to inform the state's response to anticipated federal health reform.

## **POLICY FRAMEWORK FOR DELAWARE HEALTHY CHILDREN PROGRAM**

The Commission's series of public hearings following the creation of the State Children's Health Insurance Program (S-CHIP) at the federal level provided the framework for the design of the program in Delaware.

## **INSURANCE REFORMS**

The Commission's policy focus on insurance resulted in:

- Reforms in the small group market, designed to make it easier for small employers to purchase insurance.
- Creation of a Creenaght, a pilot insurance program aimed at small employers, based on a medical management model.

## **DIABETES**

As a result of a 1999 report of the Commission's Diabetes Task Force, a new diabetes program was created using tobacco settlement funds to inform Delawareans about diabetes risk factors and preventative measures. To fight diabetes, the Health Care Commission in collaboration with the state's Diabetes Prevention and Control Program (DPCP) launched a multi-faceted diabetes campaign. The program operated within the Commission until 2005, and now operates under the direction of the DPCP within the Delaware Division of Public Health. According to the 2009 Burden of Diabetes in Delaware report issued by DPH, it is estimated that 58,000 Delawareans over the age of 18 currently have diabetes. Obesity is a significant risk factor for the development of diabetes, and currently 37 percent of Delaware adults age 18 and older are overweight; an additional 28 percent are obese.

## **HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT**

The Commission has helped focus the importance of having an adequate supply and distribution of health professionals through the course of its existence, making several important contributions. They include:

DIMER – The Commission's review of DIMER in 1996, working in response to a request from the General Assembly's Joint Sunset Committee resulted in revamping the structure of DIMER, re-affirming the state's commitment to maintaining a relationship with Jefferson Medical College (and later to the Philadelphia College of Osteopathic Medicine) and giving DIMER an administrative home within the Commission. Maintaining reserved admission slots for Delawareans assures the opportunity to attend medical school without the financial investment of supporting a state medical school.

DIDER – A similar legislatively requested review of DIDER resulted in a similar commitment to dental education, administrative support for the organization and an affiliation with Temple University to provide opportunities for Delawareans to attend dental school.

## **NURSING**

The 2002 report *Solving the Nursing Shortage* paved the way for significant investment in state nursing education programs, creating more opportunities for Delawareans to attend nursing school.

## **STATE LOAN REPAYMENT PROGRAM**

The Commission instituted a Loan Repayment Program in 2000 in recognition that substantial educational debt creates a barrier for health professionals ready to enter the workforce. Through the loan repayment program a portion of debt is repaid in exchange for practicing in underserved areas of the state. To date, a total of 66 health professionals (42

physicians, 10 mid-level practitioners, and 14 dentists) have been placed in underserved areas of the state.

### ***DHCC: A PATH FORWARD***

During the 2009 Annual Retreat, the Health Care Commission highlighted some activities and accomplishments to date that measured its progress and success as they looked back on the journey over a 20 year period. In addition, the Commission clearly recognized its unique position, broad and diverse expertise, and its ability to respond to important emerging health policy issues and trends. The Commission is proactive based on evidenced based research and data and has the foresight to develop consensus that positively affects change in Delaware's health care delivery system.

It was concluded that the Health Care Commission should evaluate its organizational structure, which currently has oversight of three advisory boards (DIMER, DIDER and DHIN), examine its current administration and management of projects, review its mission statement and its enabling statute and make recommendations that consider the current environment. Furthermore, the Health Care Commission will re-focus its efforts on policy analysis and will develop a comprehensive plan to prepare for Federal health reform, taking a lead role, bringing together stakeholders with varying points of view to address implementation at the state level.

# Five Things You Should Know About Health Care in Delaware

## **About 11 percent of us are uninsured:**

- Approximately 101,000 Delawareans (11.2 percent of the population) are without health insurance.<sup>3</sup> About 28% percent, or 28,017 people who are uninsured are actually eligible for public coverage through either Medicaid (20% percent or 20,552 people) or the Delaware Healthy Children Program – S-CHIP (7% percent or 7,465 people). Another 20 percent (about 20,202 people) are eligible for CHAP, the Community Healthcare Access Program administered by the Health Care Commission.

## **Income and where we work are good predictors of health insurance coverage:**

- Today, the probability of being uninsured is linked to individuals' income levels, which are linked to their level of education and where they work. Small businesses and organizations are less likely to offer health insurance coverage to their employees, because of rising costs of health care services and insurance premiums. 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 poor, where most uninsured adults that are low to moderate income are not eligible for Medicaid or S-CHIP. Medicaid coverage is primarily available to low-income children, parents, pregnant women, people with disabilities, and the elderly. The average annual cost of employer-sponsored coverage for a family of four rose 5% in 2009 to \$13,000, with employees on average paying 17% of the total premium for single coverage and 27% for family coverage out of their paychecks to cover their share of the cost. The average annual premiums for single coverage rose by nearly 120% over the same period, to \$4,824 in 2009.<sup>4</sup> This has the greatest impact on lower income workers who cannot afford these plans without employer-based contributions.

## **We face significant, continued shortages of health professionals:**

- Delaware, like other states, faces a shortage of health professionals. Specifically, Kent County, Sussex County, and parts of the City of Wilmington have been federally designated as health professional shortage areas. There are particular shortages among primary care physicians, dentists, nurses and mental health professionals. These shortages threaten the ability of health care facilities in Delaware to provide timely access to quality care.

## **Racial and ethnic disparities persist:**

- 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. Black infant mortality rates are higher than white rates in all three Delaware counties, according to

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<sup>3</sup> Delawareans without Health Insurance (2008). Center for Applied Demography and Survey Research, University of Delaware. Edward C. Ratledge.

<sup>4</sup> 2009 *Employer Health Benefits Study*. Kaiser Family Foundation.

Delaware's Health Statistics Center 2001-2005.<sup>5</sup> Overall, the rate in DE was 17.1 percent for Black, compared to 6.8 percent for whites, and 7.2 percent for Hispanics. According to the *2008 National Healthcare Disparities Report*, issued by the Agency for Healthcare Research & Quality, for Blacks, Asians, American Indians/Alaska Natives (AI/ANs), Hispanics, and poor people, at least 60% of measures of quality of care are not improving (either stayed the same or worsened). 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 (i.e. smoking, poor nutrition, lack of physical activity).

### **We spend slightly more, but health care is a major provider of jobs:**

- Overall, \$6.5 billion was spent on personal health care (about \$7,485 per person) in Delaware in 2008, compared to \$5 billion in 2003 and \$5.9 billion in 2006.<sup>6</sup> The annual rate of growth averages about 5 percent per year. The largest share of spending is on hospital care (39%), physicians (25.4%), and prescription drugs (14.8%). The health care sector is a significant source of employment for the Delaware economy, accounting for 12% of the total workforce and 11% of all reportable wages. Today, 54,000 people are employed in the health care industry (Health sciences), compared to just 29,000 in 1990. The Delaware Department of Labor statistics show that healthcare occupations comprise 12 of the 20 fastest growing occupations for the projected period between 2006-2016. According to a recent study released by the Delaware Healthcare Association, Delaware's hospitals estimate that they will need to fill a total of 1,400 new nursing positions and 363 new allied health positions through 2014, a 27% growth in the nursing workforce and a 16% growth in the allied health professional work force.<sup>7</sup> This number jumps significantly when retirements and other terminations are included in the forecast, to a total of 7,900 employees in the nursing and allied health profession.

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<sup>5</sup> *2008 Delaware Racial and Ethnic Disparities Health Status Report Card*. Delaware Health and Social Services, Division of Public Health.

<sup>6</sup> *Total Cost of Health Care in Delaware*. (2008). Amirah Ellis and Edward C. Ratledge. CADSR, University of Delaware

<sup>7</sup> *Delaware Acute Care Hospitals and Health Systems Workforce Needs 2008-2114*. (December 2009) Delaware Healthcare Association.



# Executive Summary

The 2010 Annual Report summarizes the extent to which the Commission's mission and goals have been met over the last year, the challenges that exist for both public and private stakeholders, trends in health care policy and a set framework for addressing these issues.

The FY2010 Budget Act administratively moved the Delaware Health Care Commission (DHCC) from the Office of Management and Budget into the Office of the Secretary, Department of Health & Social Services (DHSS). The move removed the Commission's operating budget, which had been in place since the Commission was established in 1990. However, it did not result in changes to the statute or its statutory authority and continued to appropriate operational funding to support the Commission's initiatives and programs, including that of the three advisory boards, which sit under the Commission:

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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** – exploring strategies to preserve and expand health insurance coverage through the *State Planning Program* and linking uninsured citizens with reliable health homes and affordable care through the *Community Healthcare Access Program (CHAP)*.
- 2. Information & Technology** – developing a statewide clinical health information exchange through the *Delaware Health Information Network (DHIN)*.
- 3. Health Professional Workforce Development** – assuring an adequate supply and distribution of health care professionals through the *State Loan Repayment Program* and the *Health Workforce Development 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**

### ***State Planning Program***

The State Planning Program, launched in 2001, permits continued identification and analysis of both short-term and long-term health coverage options for Delaware. Over the last decade the Commission has reviewed and analyzed over twenty options. After extensive consideration, two approaches were identified as the most appropriate for Delaware. The Commission has adopted a two-pronged strategy to preserve existing insurance coverage (targeting small group employers) and to expand coverage to all uninsured Delawareans (targeting low-income residents).

The second part of the two-pronged, short-term strategy is the expansion of insurance coverage. Strategies are being considered to aggressively enroll children that are eligible but not yet enrolled in S-CHIP, a coverage initiative under the Delaware Healthy Children Program. A marketing study of how and why consumers use community health centers was expanded in 2008 to include additional federally qualified health centers (i.e. Delmarva Rural Ministries and La Red Health Center), and based on the key findings, marketing strategies will be developed to promote the use of these facilities. Studies that examine the impact of Community Health Centers (CHCs) on healthcare spending and utilization have found that the use of these centers help reduce health care spending and help patients, especially those with chronic conditions, to avoid unnecessary complications and acute care. Many studies attribute the reduction in health spending, in part, to fewer emergency room (ER) visits, fewer inpatient hospital admissions or shorter inpatient length of stay. In 2010, strengthening the network of federally qualified health centers will be important to the Commission.

The Commission's long-term coverage strategy is the analysis of universal insurance coverage systems for Delaware. Two models in particular were thoroughly researched to achieve universal coverage: traditional single-payer and a "building blocks" model, which makes use of existing systems based on reforms enacted in the state of Massachusetts. In 2009, a micro-simulation analysis of the cost of implementing these approaches was completed and will be very valuable in 2010 if health reform comes to fruition.

### **2010 ACTION - State Planning**

1. **DHCC is uniquely positioned to take the lead role to help DE prepare and respond to federal health reform**
2. **DHCC contribution to policy development has been extensive**

- **Commissioners possess the expertise needed to lead on comprehensive planning for health care reform**

### **3. Anticipated federal health reform will necessitate closer collaboration with the Health Resources Board (HRB)**

- **Examine opportunities to coordinate and support Health Resources Board**

### **4. The Commission will engage in dialogue with stakeholders on coverage expansions**

- **No planning or implementation of reforms can occur in a vacuum**

### ***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 medical services provided through community hospitals, community health centers, and a network of 521 private physicians who participate in the Voluntary Initiative Program (VIP). The target population for CHAP is comprised of approximately 20 percent of the state’s uninsured population, about 20,202 adults. Since the inception of the program in 2001, and as of the writing of this report, CHAP has served 22,241 uninsured patients and enrolled 3,624 in other state and federal medical assistance programs such as Medicaid and the Veteran’s Administration.

When CHAP was launched in June 2001, an evaluation component was incorporated as part of the program structure. Over the past eight years evaluation activities have focused on operational processes, health outcomes, chronic disease management, utilization and penetration of outreach activities in designated geographical areas of the state. Each variation of evaluation activities consistently point to the same conclusions. CHAP patients show improvements in health outcomes, improved rates of screenings, fewer hospital emergency department visits and improved control of chronic disease.

As the Commission looks ahead to a decade of services to the uninsured through CHAP, and prepares itself for the real possibility that some health reforms will be enacted at the federal level, 2010 presents the opportunity to turn attention away from continuing to measure program outcomes, and focus on a more global perspective on how CHAP can play a meaningful role in the overall delivery of health care, both in Delaware and in a reformed health care system. The existing CHAP infrastructure and service delivery of primary care suggest it could play a key role in how federal reforms are implemented in Delaware.

### **2010 ACTION - Community Healthcare Access Program (CHAP)**

#### **1. Implement the Evaluation Plan of the CHAP Workgroup**

- **Examine the safety net and determine how it will look in a reformed system**
- **Scenario planning – what is the impact of health reform on CHAP?**

- **Prioritize and assess workforce needs and increased demand post health reform**
  - **Redefine the role of outreach in the event that coverage is mandated**
- 2. Infrastructure and service delivery applicability for coverage expansion in a reformed system**
- **Continue to examine ways to expand primary care and prevention by building on the CHAP network**
  - **Analysis of existing programs targeting similar populations**
  - **Continue to examine opportunities for collaboration with the Health Resources Board (i.e. Charity Care Policy)**
  - **Analysis of financial value of services rendered (screening and eligibility, outreach and enrollment)**
- 3. Strengthen the Network of Federally Qualified Health Centers**
- **Examine key findings from the Delaware Federally Qualified Health Center (FQHC) Research Study and analysis conducted by John Snow, Inc. (JSI) (i.e. targeted marketing strategies; operational and performance improvement efforts; improve access/reduce barriers to care)**
  - **Explore the feasibility of the FQHC network with State oversight and opportunities for greater efficiencies**

## **2. INFORMATION & TECHNOLOGY**

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

Delaware boasts the nation's first statewide health information exchange and DHIN is recognized as a leader. The use of information and technology in the health care system has emerged as a national priority. In 2008, DHIN was the first Health Information Exchange (HIE) to successfully connect with the federal government (Federal CONNECT) and successfully secure a connection with another HIE (CareSpark). The intent of DHIN is to further enhance patient safety and quality of care by providing a patient centric historical record from multiple healthcare providers (i.e. hospitals, physicians, laboratories, pharmacies, etc.) at the time and place of care, including medication history, hospitalizations, clinical reports, and test results. Ultimately, this exchange network will help improve clinical decision-making and reduce time and financial costs resulting from unnecessary duplication of diagnostic tests and procedures performed in the absence of data and patient information.

In 2010, DHIN is expected to spin off as a separate operating entity. The DHIN is closely nearing the end of its capital phase and looks forward to a more mature operations and long-term financing model. Up until now, the Health Care Commission served as a good home and "incubator". Both the DHIN and the Commission will be supporting recommendations arising from the Sustainability and Financing work, incorporating the same public private partnership purview, which has attributed to its success to date. While change is desired, the Commission recognizes that it is critical to keep the status quo until details are developed and solidified. DHIN's stakeholders are also committed to working through a strategic

process to develop a consensus based approach to governance and financing, which will meet the needs of DHIN users as well as the patients whose care is enhanced by the DHIN.

Implementation of Phase 1 of DHIN, secure results delivery, was successfully completed in March 2007. As of 2009, DHIN provides a streamlined results distribution system that delivers approximately 80 percent of lab tests and hospital admissions to approximately 1,260 providers in 144 practices that are trained and actively using the system. Another 59 practices are in the process of enrolling/being trained.

- Practices Enrolled:

- 144 Practices enrolled
  - 59 In pipeline (to be scheduled/trained)
  - 203 Total Practices

- Total DHIN Providers by County:

- 64% New Castle County
  - 24% Kent County
  - 21% Sussex County

- Percentage of Providers Utilizing Each Delivery Method

- 20% Electronic Medical Record (EMR)
  - 60% Inbox
  - 11% Auto-print
  - 6% Search only

In 2009, DHIN implemented Phase 2: patient centric record search function, including clinical results and reports. Additional planned functions to be rolled out in 2010 :

- eOrder Entry - electronic order entry sent from providers' electronic medical record (EMR) will be received electronically by LabCorp and Quest Diagnostics.
- Transcribed Reports - Transcribed reports include; history and physical, operative notes, radiology reports, discharge summaries, etc.
- EMR Primer – The primer will help providers implement technology to support “meaningful use” in order to draw down federal incentive funding.
- Medication History Pilot - Medication History will be a history of “filled” prescriptions, derived from a third party aggregator that consolidates history of pharmacy data from multiple sources. It is anticipated that medication history will be available for about 85% of all prescriptions filled in Delaware. Pilot sites will include emergency departments, which first must be trained and comfortable with using DHIN. The pilot is expected to roll-out the first quarter of 2010.

DHIN is recognized as a leader in advancing health information technology (HIT) and is receiving a significant amount of attention. Due to DHIN's success, there is increased scrutiny and focus nationally, regionally, as well as at the state level. At the state level, DHIN was selected as one of six entities for Sunset review in Fiscal Year 2010, a process that is established in State law by the Sunset Act. The purpose of the review is to determine

whether or not there is a public need for the service the agency being reviewed provides and, if so, determine if it is effectively performing to meet those needs as statutorily created. DHCC staff and DHIN staff are responding diligently to requests for information, which is reviewed by the JSC when the General Assembly resumes session in January 2010. In addition, DHIN is undergoing an audit by the State Auditor's Office, which is reviewing DHIN financing, administrative operations and governmental oversight over the life of the project.

The Sunset and the State Audit process is taking place simultaneously with DHIN's self-assessment and review of a new governance model and long-term sustainability structure. Two workgroups have been formed for the purpose of exploring options for a new governance and sustainability structure; Governance and Finance. Appointments have been made and each has broad stakeholder representation. Both workgroups will continue to meet through the end of the 2009 calendar year for the purpose of developing and presenting recommendations to the DHIN Board, the Commission and to the General Assembly.

The project is supported financially with State funds, private contributions, and federal contracts with the U.S. Agency for Healthcare Research and Quality (AHRQ) and the National Health Information Network (NHIN). In 2009, DHIN applied for American Recovery and Reinvestment Act (ARRA) funds, which established the State Health Information Exchange Cooperative Agreement Program, to enhance DHIN's current health information exchange infrastructure and functionality.

The Commission will continue to promote and expand provider enrollment and usage of the network, provide staff support, and facilitate communication between DHIN and the General Assembly.

### **2010 ACTION - Delaware Health Information Network (DHIN)**

- 1. Support DHIN development and implementation and legislation to spin off into its own entity.**
- 2. Support continued State funding FY11.**
- 3. Provide administrative support for DHIN and maintain status quo in the short-term until a new entity is established and operational.**
- 4. Engage in development of long-term sustainability model; Despite DHIN's anticipated move into a separate organization, there will continue to be a policy relationship between the two agencies. This will be developed and defined as part of the process.**

### **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.

The Delaware General Assembly created DIMER in 1969, primarily as an alternative to a state medical school. At the time there was a general shortage of physicians throughout the country, and states were moving to address this problem by establishing their own medical school. Because of Delaware's small size, such an undertaking was not financially feasible at the time. Instead, Delaware created a public/private Board to develop legal agreements and organize a cooperative arrangement to reserve admission slots for Delaware residents at Jefferson Medical College (JMC) and later in 2000, entered into an agreement with Philadelphia College of Osteopathic Medicine (PCOM), both located in Philadelphia, PA. Scholarships and tuition supplements are also available for the students. The General Assembly also tasked DIMER with *"initiating and promoting incentives for qualified personnel in the health and health-related professions to practice in Delaware."* As such, one of the tools for fulfilling this role is the Delaware State Loan Repayment Program, which resides as a line item in the DIMER budget. The DHCC is responsible for the administration of DIMER, which serves as an advisory body to the Commission. At the annual retreat, the Commission concluded that there is some confusion and misunderstanding that continues to exist over DIMER.

In 2010, it is imperative that the Commission re-tell the DIMER story to show the entire breadth of the program, examine its relationship to DHCC, demonstrate the value of the strong relationship with Jefferson and PCOM, and the benefits derived from these affiliations. This will be particularly important in light of the recently established Delaware Health Sciences Alliance, a formalized partnership and coalition between Jefferson Medical College, the University of Delaware, Christiana Care Health Services, and the Nemours Foundation. The alliance is expected to boost and strengthen the state and regional capacity in biomedical research, technology and personnel, and improve health care delivery in Delaware by creating health professional jobs and business opportunities; this clearly aligns with the DIMER mission and purpose.

### **2010 ACTION - Delaware Institute of Medical Education and Research (DIMER)**

- 1. Continue to demonstrate the critical value that the DIMER affiliation with Jefferson Medical College (JMC) and the Philadelphia College of Osteopathic Medicine (PCOM) provides and the benefits derived from the relationship to help recruit more providers to train and practice medicine in Delaware.**
- 2. Identify and support enhanced opportunity for Delaware through the new Delaware Health Sciences Alliance: UD, JMC, CCHS, and Nemours**
- 3. Effectively communicate the DIMER story and increase awareness to show the entire breadth of the program purpose, which is educational and broader than the issue of mandating students return to the DE to practice medicine**
- 4. Report on the relationship with the Commission including the events that resulted in DIMER's operational move to DHCC**
- 5. Identify how to streamline administration of DIMER programs and activities**
- 6. Revisit the State Loan Repayment Program three-tiered review and approval process**
- 7. Health Reform and workforce needs – Assess DIMER's role in the future of "advanced primary care" and MD/DO recruitment and retention**

The Delaware General Assembly created DIDER in 1981 primarily to support the general practice residency program for dentistry in Delaware. This is viewed as important because Delaware is relatively unique to require a one-year residency as a condition of licensure. DIDER was moved under the administration of the Commission in 2001, and given the additional tasks of *“strengthening of the factors favoring the decision of qualified dental personnel to practice in Delaware, including, but not limited to, tools such as loan repayment programs, and promoting the dental needs of the community at large and particularly those who do not have ready access to dental care.”* DIDER has also developed a legal agreement and organized a cooperative arrangement to reserve admission slots for Delaware students at the Maurice H. Kornberg School of Dentistry at Temple University in Philadelphia, PA.

In 2010, the Commission recognizes that the agreement between DIDER and the Maurice H. Kornberg School of Dentistry at Temple University in Philadelphia, Pennsylvania is critical to providing educational opportunities and attracting dentists to practice in Delaware. Through this partnership, financial support is provided to Temple in exchange for reserved admission slots, providing Delaware residents that meet academic admissions requirements with an opportunity to receive training at a highly regarded regional dental school. The partnership also promotes opportunities for participating dental students to complete externship and residency training programs at facilities in Delaware.

#### **2010 ACTION - Delaware Institute for Dental Education and Research (DIDER)**

- 1. Continue support of DIDER and relationship with the Maurice H. Kornberg School of Dentistry at Temple University.**
- 2. Assure that workforce issues are a strategic priority by continuing to recruit dental providers and promote a climate that makes it conducive to practice in Delaware; target high need areas (i.e. Kent/Sussex)**
- 3. Continue to support and aggressively promote the State Loan Repayment Program as a means to recruit dentists and hygienists to Delaware.**
- 4. Continue to support the general practice dental residency program based at the Wilmington Hospital at CCHS.**
- 5. Support activities of the Oral Health Workforce planning and implementation grant from the US Health Resources and Services Administration (HRSA) to expand access to dental care in Sussex County.**
- 6. Monitor and support emerging agreement between the University of Delaware and the Temple University School of Dentistry, which plans to establish an accelerated degree in dental education.**

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

The State Loan Repayment program is almost nine years old since its inception, and has proven to be essential in helping the state meet its health care recruitment and retention needs. 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. When the program was first established, DHCC held a series of informal interviews with critical access hospitals and other providers to discern recruitment needs in Kent and Sussex counties. Feedback from these interviews helped establish the list of eligible specialties for the loan repayment program. Up until now,



the program has closely mirrored the federal program guidelines. Over the life of the program, common issues and themes have been identified by the State Loan Repayment Program (SLRP) Review Committee, the DIMER and DIDER Boards, which produced some approved changes to the program in 2006.

Since the program's inception in 2001, the following health practitioners have been placed in underserved areas of the state:

- fourteen dentists,
- forty-two physicians,
- four certified nurse midwives,
- five certified nurse practitioners and
- one physician assistant

Of the total 66 participants, 22 were placed in New Castle County, 17 in Kent County, and 27 in Sussex County.

In 2009, a series of site visits were scheduled over the summer with community health centers, critical access hospitals, clinics, etc. to discuss and address key issues that the provider community is facing related to health care workforce recruitment and retention efforts. The informal interviews clearly engaged community providers and offered them the opportunity to make sure that the program is meeting its goal of placing health care professionals in underserved areas of the state and meet its individual community health care needs. In addition, during the interview, hospital representatives were offered the opportunity to confirm whether or not the program policy acknowledges and responds to a changing practice environment. To support the long-term sustainability of the program, DHCC continues to seek and leverage state/federal funding. For example, Delaware applied competitively for the 2009 American Recovery and Reinvestment Act funded State Loan Repayment federal grant and was awarded in the amount of \$100,000 for a two year project period (September 20, 2009 through September 29, 2011).

As we continue to evaluate the program's outcomes in 2010, members of the SLRP Review Committee will coordinate on an ongoing basis with the Division of Public Health. Coordination among these two agencies will help obtain feedback on the publication of key reports, such as healthcare provider capacity in Delaware (i.e. primary care physicians, dentists, OB-GYNs, mental health professionals, etc.), medically vulnerable populations, and an analysis of the uninsured, which are prepared for the two agencies. These reports and other studies help the Commission re-evaluate the designated shortage areas, identify recruitment and retention strategies and examine access to primary care to discern if progress has been made as well as to create an opportunity to make programmatic changes, if warranted.

In 2010, the Health Care Commission will continue to support the program, recognizing that the State Loan Repayment Program is a valuable workforce recruitment tool, placing health professionals in underserved areas of the state.

### ***Addressing Shortages in the Health Workforce***

The Health Workforce Development Committee is tasked with identifying needs for health workforce information, collecting data and providing resources to coordinate strategies to predict and prevent shortages. This committee uses existing data collected statewide and other national data to make recommendations to improve the supply, distribution and diversity of our health professional workforce to ensure that Delaware meets its future needs.

In 2008, the Health Workforce Development Committee completed a comprehensive study designed to assess the supply and distribution of allied health professionals and pharmacists, providing valuable information about estimated shortages among these members of the health workforce. The committee laid the foundation and groundwork for future health workforce activities and examined policy areas for implementation. Specifically, the work of the committee examined the following:

- Aging population
- Address mental health services as an essential component to overall health
- Increased diversity of the population
- Aging workforce
- Barriers to the workplace
- Increased burden of chronic disease
- Regional workforce and training issues
- Innovative financing for implementation strategies

Delaware anticipates a greater demand on our health workforce and service delivery infrastructure as a result of health reform and grappling with the issues involved (i.e. understanding its current state and capacity and predicting needs, evaluating the emerging health care needs of individuals and their families, and the skills and competencies of the workforce) are not easy, but are very important. The Commission may consider reconvening the Workforce committee in 2010 or a similar advisory body to continue its work. This working committee would be charged with the responsibility of evaluating Delaware's pressing health workforce issues and priorities, engage in dialogue with other agencies and the medical community to identify expectations and propose policy recommendations post health care reform.

### **2010 ACTION - Health Professional Workforce Development**

#### **1. Engage Workforce Committee – anticipated greater demand post health care reform**

- **Continue the public/private sector collaboration to develop strategies to predict and prevent workforce shortages.**
- **Prioritize and assess the pressing health workforce issues, and propose policy recommendations to improve supply, distribution and diversity of our health professional workforce. Recommendations will consider the following:**
  - **Aging population**
  - **Address mental health services as an essential component to overall health**
  - **Increased diversity of the population**
  - **Aging workforce**
  - **Barriers to the workplace**

- Increased burden of chronic disease
- Regional workforce and training issues
- Innovative financing for implementation strategies
- Engage in dialogue with other agencies and the medical community and identify expectations

**2. Support activities of the Oral Health Workforce planning and implementation grant from the US Health Resources and Services Administration (HRSA) to expand access to dental care in Sussex County (See page 55).**

#### **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. DHCC is uniquely qualified and positioned to provide analysis of the social climate related to health and key issues pertaining to health reform. In 2010, the Commission will produce the “*Delawareans Without Health Insurance*” report and the “*Total Cost of Health Care in Delaware*” report.

##### **2010 ACTION: Research Reports & Data**

- 1. DHCC is uniquely qualified and positioned to provide analysis of social climate related to health indicators and key issues pertaining to health care reform**
- 2. Outstanding issue for consideration: Continue to publish both the *Total Cost of Health Care in Delaware* and *Delawareans Without Health Insurance* reports annually**

##### **2010 ACTION: Policy Development**

- 1. Develop consensus building strategies**
  - Organize health care policy forums, convene committees and workgroups to bring stakeholders to the table on comprehensive planning for emerging issues and implementation strategies
  - DHCC’s role is to serve as a convener, systemic advisory body and change agent
- 2. Serve as a Change Agent**
  - Continue to be flexible to change and be on the cutting edge of policy issues and health care reform
  - Recognize when to disengage from projects
  - Identify appropriate agencies to take on issues and to carry out projects to full fruition
  - Review current DHCC enabling legislation and statute related to the Health Care Commission’s mission, function and purpose
- 3. Evaluate organizational structure – policy and operations**

- **Identify the physical/personnel capacity of the organization, discretionary resources available to the organization**
- **Establish a commitment to the DHCC vision, mission and common purpose**
- **Develop a communication plan which include benchmarks to measure performance and define success**

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

Occasionally, specific health care conditions are so prevalent in Delaware that they warrant special attention. In 2010, the Commission will continue to focus attention on the following issues: mental health, chronic illness, racial & ethnic health disparities, and obesity prevention and wellness. In addition, the Commission is often assigned to cooperate with various bodies created by the General Assembly.

DHCC statute stipulates that the Commission coordinate efforts with the Health Resources Board (formerly the Health Resources Management Council), which is responsible for overall health planning and the State's Certificate of Need program, to ensure that Delaware has a balanced approach to access, quality and costs of health care. DHCC's renewed focus on policy analysis and health care reform will necessitate a closer working relationship with the Health Resources Board. DHCC staff will participate and a representative of the Commission will be designated to serve on the *Health Resources Board (HRB)*, which operates with staff support provided by the Bureau of Health Planning and Resources Management within the Division of Public Health, reviewing applications for a Certificate of Public Review. The Certificate of Public Review process assures that there is public scrutiny of new health-related capital construction projects in the State.

In 2010, the Commission will coordinate activities with the Health Resources Board, with particular attention on the CHAP program and the HRB's charity care policy to examine whether opportunities exist to ensure that the two programs are more seamless. CHAP is a good source of recruitment to the VIP Network, and is a mechanism to meet charity care requirements.

Additionally, Commission representatives continue 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.

### **2010 ACTION - Health Resources Board (HRB)**

- 1. Continue coordination between DHCC and HRB staff; work to collaborate between CHAP and HRB's charity care policy.**

### **2010 ACTION: Health Fund Advisory Committee**

- 1. Continue the current arrangement with Commission representation on the Committee and support from Commission staff.**

### **2010 ACTION - Nutrition, Physical Activity, and Obesity Prevention Coalition/Network**

1. Support the development of a statewide coalition and participate as a collaborative partner to create a new comprehensive state plan with recommendations, objectives and action steps.
2. Continue support and participation as necessary.

### **2010 ACTION- Mental Health Issues**

1. Continue to support the Committee's implementation planning as a result of the *Supply and Demand of Mental Health Services in DE (2006)* report and recommendations.
2. Coordinate with the Division of Public Health (DPH) and the Division of Substance Abuse and Mental Health (DSAMH) on the new federally designated Health Professional Shortage Areas (HPSA) for mental health care providers, to improve recruitment and retention, particularly for Federally Qualified Health Centers and the State Loan Repayment Program.

### **2010 ACTION - Chronic Illness**

1. Examine opportunities to address these issues over the next year.
2. Continue coordination and support as necessary.
3. Support the planning and development activities as a key collaborative partner of the Primary Care Partnerships to Prevent Heart Disease in Women, a three year grant awarded to DE from the U.S. Office on Women's Health.

### **DHCC - PATH FORWARD**

During the 2009 Annual Retreat, the Health Care Commission highlighted some activities and accomplishments to date that measured its progress and success as they looked back on the journey over a 20 year period. In addition, the Commission clearly recognized its unique position, broad and diverse expertise, and its ability to respond to important emerging health policy issues and trends.

It was concluded that the Health Care Commission should evaluate its organizational structure, which currently has oversight of three advisory boards (DIMER, DIDER and DHIN), examine its current administration and management of projects, review its mission statement and its enabling statute and make recommendations that consider the current environment. Furthermore, the Health Care Commission will re-focus its efforts on policy analysis and will develop a comprehensive plan to prepare for Federal health reform, taking a lead role, bringing together stakeholders with varying points of view to address implementation at the state level.

## **2010 ACTION – Path Forward**

- 1. Form a Committee that will examine DHCC function, role, and purpose and propose updates to the statute that reflect new reality and vision; include representatives from DIMER & DIDER**
  - **Form a sub work group with DIMER & DIDER to examine streamlined administration and relationship to DHCC (i.e. State Loan Repayment Program)**
  - **Form a sub work group to address Workforce Development issues**
- 2. “Drill down” and revisit key issues raised at the 2009 Annual Retreat <sup>8</sup>**
- 3. Closely follow and analyze federal health reform; DHCC plays a vital role going forward**
- 4. DHIN – Identify future relationship with the DHCC**
- 5. Coordination with CHAP Evaluation planning**

The current activities and action items summarized in this report, clearly demonstrate the commitment, the level of activity and the depth of partnerships in Delaware surrounding access to affordable and quality health care. Many of these initiatives have included the Delaware Health Care Commission as a key partner or lead convener, which has been instrumental to the small, but effective steps and progress made to expand and preserve coverage and move towards comprehensive health care reform.

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<sup>8</sup> 2010 DHCC planning and policy issues are captured throughout the Annual Report.

# 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  
Disparities

# Health Care – Access

Access to health care is measured by two indicators:

1. Access to health insurance coverage
2. Supply and capacity of health professional workforce

## **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>9</sup> Additionally, a person without insurance is more likely than their insured counterparts to use the emergency department, the most costly and often inefficient source of health care services.

### **Uninsured in Delaware**

Over the past five years, the percentage of Delawareans who are uninsured has risen from 9.9% to 11.2%. Currently, 101,000 Delawareans are estimated to be without health insurance.<sup>10</sup> In the US Census Bureau report, “*Income, Poverty, and Health Insurance Coverage in the United States: 2007*,” Delaware fairs better than the nation who respectively had an uninsured rate of 15.4% and better than states in the region at a rate of 12.7% (MD; NY; NJ).<sup>11</sup>

➤ *Who are the uninsured in Delaware?*

<b>23% are under the age of 19</b>	<b>56% are working adults</b>
<b>54% are male</b>	<b>69% are White</b>
<b>22% are Hispanic</b>	<b>21% live alone</b>
<b>34% with household income over \$50,000</b>	<b>59% own or are buying their home</b>
<b>9% are self-employed</b>	<b>21% are non-citizens</b>
<b>80% are above the poverty line</b>	

<sup>9</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>10</sup> *Delawareans without Health Insurance*. (2008). Center for Applied Demography and Survey Research, University of Delaware. Edward C. Ratledge.

<sup>11</sup> *Income, Poverty, and Health Insurance Coverage in the U.S.: 2007*. (August 2008). US Census Bureau.



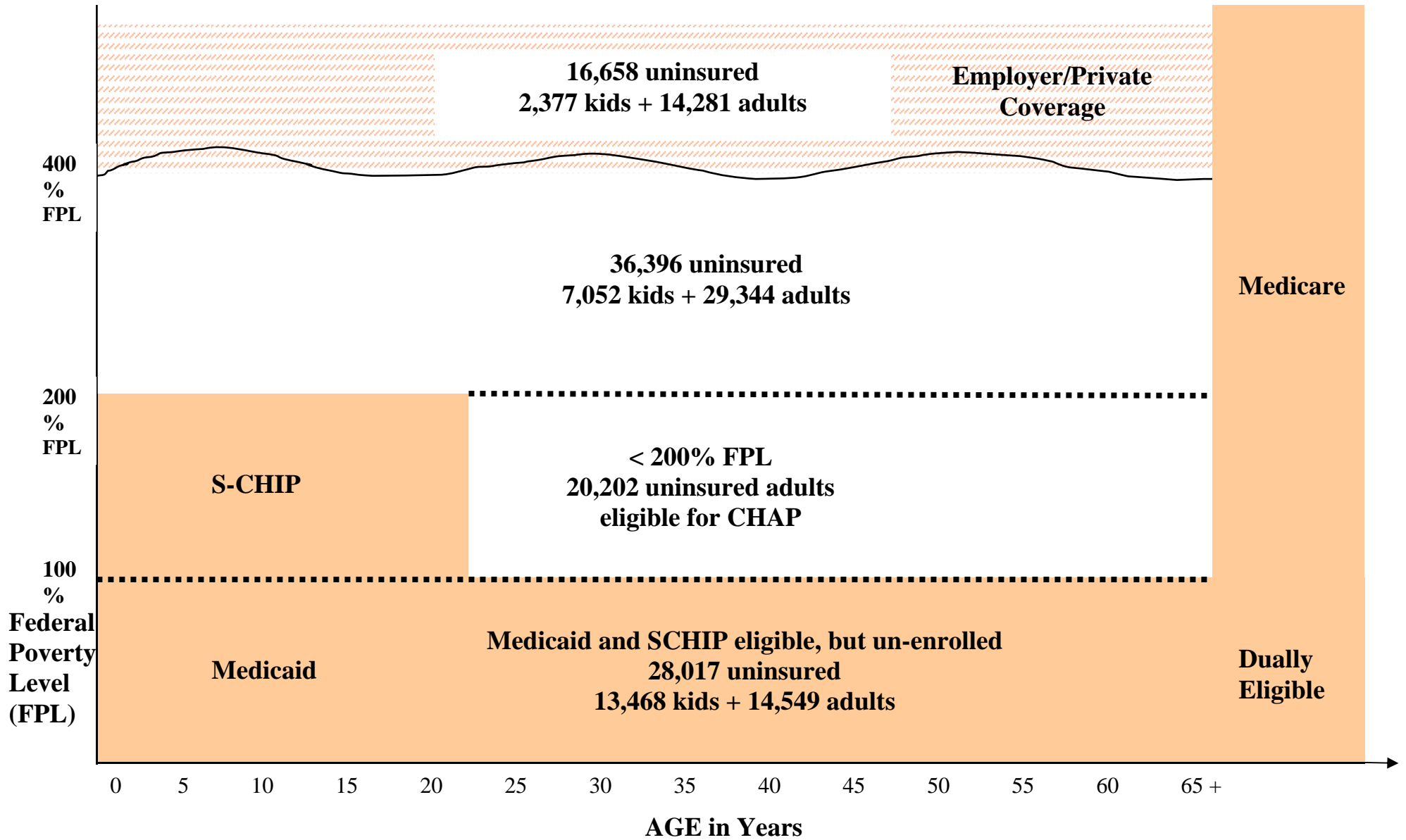
In developing policies and programs to reduce the number of uninsured in Delaware, one way to examine the population is by income level and insurance coverage eligibility.

Consider the following:

- Nearly 27 percent of the uninsured population, approximately 27,667 people, are eligible for existing public coverage but are not enrolled. This includes about 14,549 adults and 6,003 children in families with incomes below 100 percent of the federal poverty level (FPL), which is \$22,050 for a family of four. Most of this group is eligible for Medicaid. Additionally, 7,465 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). Strategies for addressing this group include outreach, education and identification and reduction of barriers to enrollment.
- About 20,202 people, or 20 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 52.5 percent, or 53,054 uninsured people in Delaware have family incomes above 200 percent FPL. This includes 9,429 children and 43,625 adults. This group includes many people who are self-employed or work for small businesses/non-profit organizations 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. Long-term, comprehensive reform strategies will include this group in addition to the other two.

# Who are the Uninsured by Poverty Level?

Source: *Delawareans without Health Insurance*. (2007). Center for Applied Demography & Survey Research, University of Delaware  
 US Bureau of Census, Current Population Survey, March 2006-2008. Table 3-1 and Table 4-3.



**Uninsured in Delaware by Age and Poverty Level-**  
(3-year average 2006-2008)<sup>12</sup>

<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 (2009)<sup>13</sup></b>
<100 FPL	6,003*	14,549*	20,552	\$22,050 @ 100%
100-199% FPL	7,465 <sup>#</sup>	20,202 <sup>^</sup>	27,667	\$44,100 @ 200%
200-299% FPL	4,205	18,466	22,671	\$66,150 @ 300%
300-399% FPL	2,847	10,878	13,725	\$88,200 @ 400%
400-499% FPL	1,404	4,602	6,006	\$110,250 @ 500%
500+ FPL	973	9,679	10,652	>\$110,250

\* Income eligible for Medicaid.

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

<sup>^</sup> Income eligible for the Delaware Community Healthcare 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. Nearly 23 percent of Delawareans that work for firms with fewer than 25 employees and 13 percent of those that work for firms with 25-100 employees are uninsured. This is up from 20 percent and 12 percent respectively in 2003, serving as an indicator that small businesses are having greater difficulty providing coverage for their employees. In terms of industry, construction workers have the highest rates of uninsurance (32 percent) followed by people in the trade industry (13.5 percent) and service industry (14 percent). Those who are self employed are more likely to be uninsured (24 percent) compared to 12 percent of private sector workers and 5 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 2009, compared with 66 percent in 2003 and 69 percent in 2000.<sup>14</sup> The latest trend in employer health benefits is offering employees a range of wellness programs including weight loss programs, gym membership discounts, smoking

<sup>12</sup> *Federal Register*, Vol. 74, No. 14, January 23, 2009,. Page 4199-4201.

<sup>13</sup> Source: *Delawareans without Health Insurance*. (2008). Center for Applied Demography & Survey Research, University of Delaware. US Bureau of Census, Current Population Survey, 2006-2008. Table 3-1.

<sup>14</sup> Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits- 2009 Summary of Findings. <http://ehbs.kff.org/pdf/2009/7937.pdf>

cessation programs, a personal health coach, and classes in nutrition or web-based resources on healthy living. Health and wellness programs are proven prevention strategies that give people the tools needed to live healthier lifestyles and self-manage chronic diseases.

**County Residence**

People who live in Sussex County are more likely to be uninsured (16 percent) than people who reside in Kent County (13 percent) and New Castle County (10 percent). However, although the rate of un-insurance is lowest in New Castle County, the actual number of uninsured people is higher there than the other counties. Almost 51% of the uninsured reside in New Castle County. Approximately 51,100 people who live in New Castle County are without health insurance compared to Kent County where 21,900 people are uninsured and to Sussex County where 28,300 people are uninsured. Notably, rates of un-insurance are growing most rapidly in Kent and Sussex Counties.

**Household Composition**

Two-person and four-person households are the least likely to report lacking health coverage (9.4 and 9 percent respectively), while single person households are the most likely to report being uninsured (15.3 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	11.3%
5-17 years	9.9%
18-29 years	20.7%
30-64 years	12.6%
65+ years	Not measured due to Medicare coverage

**Race and Ethnicity**

Delawareans who classify their race as black have nearly a 17 percent higher risk of being without health insurance coverage as those that report being white. In terms of ethnicity, 37 percent of Hispanics are uninsured (a significant increase from 25 percent in 2003), compared to 10 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/nonprofit 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 to care requires a sufficient number and distribution of health care professionals throughout Delaware to provide services. There are pockets within the state that are underserved. For example, the federal Health Resources and Services Administration (HRSA) has designated significant sections of Wilmington (New Castle County) and all of Kent and Sussex Counties as health professional shortage areas for primary care physicians and dental care providers. Most recently, Delaware was granted approval for federal shortage area designations for mental health professionals.

Throughout Delaware there are shortages of primary care physicians<sup>15</sup> and mental health providers,<sup>16</sup> particularly downstate in Kent and Sussex Counties. The shortage of psychiatrists and other mental health professionals that treat children is particularly significant in Sussex County. There is also a well documented, statewide shortage of nurses that is expected to worsen over the next decade, due in part to shortages of teaching faculty at colleges and universities in Delaware.<sup>17</sup> Based on projections, 1,400 new nursing positions and 363 new allied health professionals need to be recruited to Delaware's hospitals through 2014 to meet the needs of Delaware's growing and aging population.<sup>18</sup>

Additionally, critical shortages among radiological technicians, laboratory technicians, pharmacists, and other allied health professionals are reported among practitioners "in the field". In 2008, the Allied Health Professionals study was completed. The study was designed to assess the supply and distribution of allied health professionals and pharmacists in the state and was completed in partnership between the Health Care Commission, Division of Public Health and the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware. The study surveyed almost 5,000 allied health professionals, including pharmacists, paramedics, physical therapists, physical therapists assistants, physician assistants, respiratory practitioners, speech/language pathologists, therapeutic optometrists and radiologic specialists. Four key areas were highlighted in the study: current supply and distribution, education, diversity, and barriers to the workplace.

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<sup>15</sup> Primary Care Physicians in Delaware 2008, prepared for the Delaware Division of Public Health by Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

<sup>16</sup> Mental Health Professionals in Delaware 2005, prepared by Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

<sup>17</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>18</sup> "Delaware Acute Care Hospitals and Health Systems Workforce Needs 2008-2014." December 2009.

To help recruit health care providers and ensure an adequate supply and distribution of a health professional workforce, the Commission administers a number of programs such as the State Loan Repayment Program (see Page 56).

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 or dental education and help recruit qualified clinicians to practice in the state (See Page 52).

## Health Care – Cost

Overall, \$6.5 billion was spent on personal health care (about \$7,485 per person) in Delaware in 2008, compared to \$5 billion in 2003 and \$5.9 billion in 2006.<sup>19</sup> Comparatively, the United States spends \$ 6,566 per person on health care.<sup>20</sup> Delaware is generally in the mainstream among states with regard to personal spending, but is expected to see growth in consumption of services as the population increases and ages. While medical prices (the cost of services) are inflating at 4 percent per year, the total cost of care in Delaware has risen about 5 percent per year since 2001. The total cost of care is affected by three variables: population size, price of services, and utilization.

Health care spending in the U.S. and Delaware is poised to increase, largely due to a growing population and the aging Baby Boomer generation, but also fueled by advances in technology and greater consumption of services and treatments, such as prescription drugs. As the number of people in the state increases, the total cost of care will also increase. Since 1990, more than 206,000 people have joined Delaware's population (a growth rate of 31 percent). Collectively, they will increase total health expenditures by almost \$1 billion annually.

Utilization increases are largely driven by the relaxation of tight managed care restrictions, which held overall spending down in the mid 1990's. Now, hospitals, physicians, and other specialists are experiencing rising patient demand, which is a driver in rising health care expenditures. Also, the drug sector is rapidly expanding and the outlook for expenditures is strong continued growth.

As a share of total health care expenditures, 37 percent is spent on hospital care and 30 percent on physicians and other health professionals. Most of the remainder is comprised of drugs (14%), nursing home care (7%), home health (2%) and dental care (5%). The study also found that 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.

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<sup>19</sup> *Total Cost of Health Care in Delaware*. (2008). Amirah Ellis and Edward C. Ratledge. CADSR, University of Delaware.

<sup>20</sup> National Health Expenditures, Forecast summary and selected tables, Office of the Actuary in the Centers for Medicare & Medicaid Services, 2008. Accessed March 20, 2008.

## **Economic Impact**

While the U.S. devotes 16 percent of gross domestic product to health care and Delaware only 11 percent, health care remains an increasing portion of the total output in both the state and the nation. This is expected to increase between now and 2030. Between 2010 and 2030, the 45-54 year age group is projected to actually decline by about 15,000 while the over-65 year group will increase by over 100,000. This will place increased demands on the health care sector and contribute to its consuming a greater portion of the state Gross Domestic Product (GDP).

The health care industry serves as an engine for job growth in Delaware. A large proportion of the state's workforce is in the health care sector, with 12 percent of the workforce and 11 percent of reportable wages. Today, a little over 50,000 people are employed in the health care industry, compared to 29,000 people in 1990. The growth of employment in the health services industry is accelerating and projections show that employment in the industry will continue to grow. In 2008, hospital employment, by far the largest segment of medical services employment, accounted for 33 percent of the state's health care industry.

The expansion of health care providers in the state will place further demands on an already undersupplied work force. The Delaware Department of Labor forecasts that Health Care and Social Assistance will account for 17 percent of total job growth between 2006 and 2016, just passing the current largest industry Retail Trade. Over the next decade, almost one out of every five new jobs in Delaware will be created in the Health Care and Social Assistance Industry. Of the 20 fastest growing occupations in Delaware (2006-2016), 12 are health-related. Medical assistants, massage therapists, physician's assistants, physical therapy assistants, and pharmacy technicians are all expected to be in high demand.

### **Delaware Average Annual Salary of Selected Health Occupations**

<b>Occupation</b>	<b>Average Annual Wages</b>
Licensed Practical Nurse (LPN)	\$44,328
Registered Nurse (RN)	\$61,295
Dental Hygienist	\$60,820
Radiologic Technologists & Technicians	\$46,464
Pharmacists	\$90,697
Optometrist	\$147,510
General Practitioner/Physician	\$145,960

**Source: Delaware 2016 Occupation & Industry Projections, 2006 Average Annual Wages, Office of Occupational and Labor Market Information, Delaware Department of Labor.**

## **Cost Shift**<sup>21</sup>

Cost shifting is defined as the process by which health care providers recover the unpaid or underpaid costs of care delivered to one patient population by collecting above cost revenues from another patient population. The process is a common dynamic in the health care marketplace and occurs in different contexts and settings. In the case of hospitals and physicians, cost shifting has been attributed to two factors: below-cost reimbursement rates

<sup>21</sup> *Total Cost of Health Care in Delaware*. (2008). Amirah Ellis and Edward C. Ratledge. CADSR, University of Delaware.



paid by public programs such as Medicare and Medicaid, and uncompensated care losses due to bad debt or charity care.

National markup of charges over costs continues to grow and now stands at more than twice their costs. Private payer payment-to-cost ratio is also on the rise. In 2005, private payer payment-to-cost ratio was 1.24 - the highest it has been in 10 years. Hospital margins in the nation and neighboring states are 5-10 percent. The national hospital margin figure is the highest. Delaware's hospital margin measure exhibits some volatility. If averaged, the measure is comparable to the state's peers. Uncompensated care is one driver of cost shift. Nationally uncompensated care as a percentage of total expenses is 5-6 percent, and has been since 2000. In dollar terms, however, uncompensated care costs continue to rise and now stand at almost \$35 billion.

### **Aging Population**

Demand for health services will continue to grow rapidly as the "Baby Boomer" generation moves into retirement later this decade, placing further strain on health care providers and available resources. The Delaware Population Consortium (2007) projects an increase in the 65-plus population by 123,000 people or 106% between 2005-2030. By 2030, almost 238,000 people will be 65 and older and the population of the "oldest of the old", age 85 and older, will more than double to almost 31,000 people. Not only will there be more older people, but with advancements in health care, people are also living longer. The aging of the Delaware population fosters greater demand for health care services in the future, and is consistent with rising health care expenditures forecast over the next twenty years.

### **Prescription Drugs**

The drug sector is the fastest growing source of spending on health care and shows no sign of abating. Nationally, increases in prescription drug expenditures were responsible for almost half (44%) of total health care expenditure increases in 1999 and 27% in 2000. Furthermore, prescription drug costs are the most rapidly increasing expense for employer-based insurance, representing 40% of the premium increase from 1998-1999.

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**

### *Delaware Vital Statistics Annual Report (DVSAR) 2006*

One way to monitor health care quality in Delaware is through public health indicators. According to Delaware Vital Statistics Annual Report (DVSAR) 2006 (the latest year available at time of printing), the first and second leading causes of death continue to be heart disease and cancer, at 26 percent and 25 percent respectively, accounting for more than half of all deaths. Chronic respiratory disease accounts for 5 percent, followed by stroke (5 percent), accidents (4.5 percent) and diabetes (3 percent). The “all other causes” category represents the remaining almost 32 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, the United Health Foundation’s America’s Health Rankings (2009) statistics show a very slight decline in the infant mortality rate of 8.6 infant deaths per 1,000 births, but still significantly higher than the U.S. rate of 6.7. For the same time period, Delaware’s age adjusted cancer mortality and infectious disease rate were significantly higher than the U.S. rate.

### ***America’s Health: State Health Rankings – 2009 Edition***

Overall, according to *America’s Health: State Health Rankings - 2009 Edition* Delaware ranks 32<sup>nd</sup>; it was 35<sup>th</sup> in 2008. The report, 20<sup>th</sup> anniversary edition, is produced by the United Health Foundation in partnership with the American Public Health Association and the Partnership for Prevention. The study methodology weighs the contributions of various factors, including a number of risk factors -- such as the presence of health insurance and the prevalence of smoking, obesity, children in poverty, access to care-- and health outcomes, such as cancer deaths and deaths due to heart disease.

According to the report, Delaware’s strengths include a low rate of uninsured population at 11% and few poor mental health days per month (3 days in the previous 30 days), and a low percentage of children in poverty at 13.6 percent. Delaware is ranked 15<sup>th</sup> in the nation in per capita public health funding at \$94 per person.

Challenges include a high violent crime rate (703 offenses per 100,000 population), a high incidence of infectious disease (23.6 cases per 100,000), high levels of air pollution, a high infant mortality rate (8.6 deaths per 1,000 live births) that ranks DE 45<sup>th</sup> in the nation, a high rate of cancer deaths, and a high prevalence of binge drinking at 18.3 percent of the population.

Another challenge is the rising rate of obesity: in the past year, the prevalence of obesity increased from 26 percent in 2007 to 28 percent of the population in 2009. Based on research, it is estimated that the direct healthcare cost of obesity for the state of Delaware is \$222 million and is expected to reach \$975 million by 2018.<sup>22</sup>

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<sup>22</sup> *America’s Health Rankings- Economic Cost of Obesity.* (2009). United Health Foundation, the American Public Health Association and Partnership for Prevention.

### **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 2006 Report,<sup>23</sup> life expectancy rates for babies born in 2006 exemplify the fact that health disparities exist in Delaware:

White males, 76.4 years	Black males, 71.4 years
White females, 81.7 years	Black females 77.8 years

The differences in life expectancy are directly related to differences in mortality for a wide range of diseases. For example, black Delawareans are about 20 percent more likely than whites to die from heart disease and twice as likely to die of complications from diabetes as white Delawareans.

HIV/AIDS mortality has also disproportionately affected Delaware's black population. The 2002-2006 mortality rate of 30.74 deaths per 100,000 was seventeen times higher than the rates for whites. In the 2002-2006 time period blacks accounted for 77 percent of all deaths due to HIV/AIDS. According to the 2008 Delaware Racial and Ethnic Disparities Health Status Report Card, location also appears to be an issue: 72 percent of HIV cases are found in New Castle County and 44.4 percent of HIV cases are in the areas that tend to be linked to the city of Wilmington.

Another clear example of disparities is found in the infant mortality rates in Delaware from 2002-2006. Overall, the rate in DE for blacks was 16.1 percent, compared to 6.4 percent for whites and 7 percent for Hispanics. Delaware also performs worse than the nation on infant mortality rates: 13.9 percent for blacks in the U.S. compared to 5.7 percent for whites.

The prevalence of obesity is also disproportionately affecting the non-Hispanic black population at 40.2 percent than non-Hispanic whites at 25.5 percent and Hispanics at 28.2 percent. Obesity is now recognized and described as the fastest growing public health issue the US has ever faced and is attributed to inadequate physical activity, unhealthy eating habits, and changing food alternatives.

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<sup>23</sup> Due to data limitations, statistics in the DAVSR 2006 are only presented for black and white populations.

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

## 2010 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 – State Planning Program

**Purpose-** the State Planning Program, 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 rigorously reviewed and analyzed over twenty short term and long term options. In 2007, Planning Grant funds expired, but after extensive consideration, two strategies have been analyzed and the Commission concluded that these were most appropriate for Delaware moving forward:

### **Preserve and Expand Coverage-**

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

In 2006 a report prepared by Elliott Wicks, PhD, of the Economic and Social Research Institute, was submitted to the Small Business Health Insurance Committee for consideration. The Committee reviewed the materials and presented recommendations to the Health Care Commission, adopted in May 2006, that seek to reform current small group insurance regulations in Chapter 72, Title 18. The goal is to achieve better stability, predictability and enforcement of insurance premiums in the small group market, primarily affecting small businesses and small not-for-profit organizations. Legislation based on the Commission's recommendations (i.e. reduced rating factors to age, health status and group size, compress the allowable rate variation, implement mechanism to make rates for stable) was adopted in 2009.

### Universal Coverage:

The Commission's long-term coverage strategy is the analysis of universal insurance coverage systems for Delaware. In June 2007 the Health Care Commission released a Request for Proposals to conduct econometric simulation and analysis of options to achieve universal health insurance coverage in Delaware to understand the financial impacts of the respective strategies, *single payer* and *building block* approaches. Results from this study were submitted to the Commission and will require further discussion and refinement of the findings in 2010.

**SINGLE PAYER APPROACH** - This long-term coverage strategy includes an examination of the feasibility of implementing a single-payer health care financing system in Delaware to achieve universal coverage. A Phase I study focused on feasibility was completed in 2007. It included a framework of basic system design, which will be used as a basis for modeling the financing of such a system. A detailed analysis of design and implementation strategies for a single payer system was completed.

**BUILDING BLOCK APPROACH** - This strategy toward achieving universal coverage would build upon and make use of existing systems and coverage programs in Delaware, such as Medicaid, S-CHIP, CHAP, etc. A specific review and analysis of other state health reforms such as those adopted in Vermont and Massachusetts and proposed in California were included in the project.

## **2010 ACTION- State Planning**

- 1. DHCC is uniquely positioned to take the lead role to help DE prepare and respond to federal health reform**
- 2. DHCC contribution to policy development has been extensive**
  - **Commissioners possess the expertise needed to lead on comprehensive planning for health care reform**
- 3. Anticipated federal health reform will necessitate closer collaboration with the Health Resources Board (HRB)**
  - **Examine opportunities to coordinate and support Health Resources Board**
- 4. The Commission will engage in dialogue with stakeholders on coverage expansions**
  - **No planning or implementation of reforms can occur in a vacuum**

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

The Community Healthcare Access Program (CHAP) helps find low-cost medical homes for uninsured people with incomes below 200 percent of the federal poverty level (= \$44,100 for a family of four). A network of community care coordinators links uninsured people with health homes or, if eligible, with public coverage programs like Medicaid. The program is overseen by a CHAP Workgroup, comprised of Commissioners and also includes representation from agencies with similar missions such as the Division of Medicaid and Medical Assistance (DMMA) and the Division of Public Health (DPH).

Medical services for CHAP enrollees are provided through community hospitals, community health centers, and a network of 521 private physicians who participate in the Voluntary Initiative Program (VIP). CHAP, which began enrolling patients in June 2001, was initially funded through a federal grant from the Health Resources and Services Administration (HRSA). Today, the program is funded entirely by revenue from the state's Master Tobacco Settlement Agreement, distributed by the Delaware Health Fund Advisory Committee.

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

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

### **CHAP Goals-**

- 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 with a health risk assessment and disease management component that identifies and focuses on high-risk and high-need patients

According to the most recent report of the uninsured in Delaware, about 20,202 people (18 percent of the uninsured population) are eligible for CHAP and make up the program's target population. Since the program's inception, a total of 31,536 applications for initial enrollment were received and 22,241 people were enrolled at some point in CHAP. An additional 3,624 applicants were identified as eligible for Medicaid and 107 were referred to the Veteran's Administration (VA). As of the writing of this report, 6,802 people are actively enrolled and receiving services through the program.

A total of 7,539 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. 3,624 of them were eligible for Medicaid).

Currently, CHAP eligibility is limited to uninsured Delawareans at or below 200 percent of the Federal Poverty Level (FPL). However, opportunities for CHAP to possibly expand eligibility to promote coordination with the Delaware Health Resources Board (HRB) charity care policy implementation and enforcement are being explored. Currently, the HRB defines "charity" as 350 percent FPL.

### Outreach

Currently CHAP has two types of outreach partners; hospitals and non-profit organizations that can reach the target population. Hospitals have the unique means to identify potential CHAP enrollees through direct daily operation and community programming. Similarly, some non-profit organizations can help find and assist CHAP enrollees. A challenge in 2008 was to evaluate the effectiveness of the program's outreach strategies by focusing on enrollment increases of eligible participants in targeted areas. While the community outreach vendors are broadly disseminating information about CHAP, the resulting program enrollees do not necessarily know the outreach vendor by name to credit for raising their awareness and/or evoking their application. A strategy was implemented in 2008-09 to improve outreach evaluation by consolidating contracts, establishing performance measures, standardizing activities and providing CHAP with documentation of outcomes.

### Evaluation

When CHAP was launched in June 2001, an evaluation component was incorporated as part of the program structure. Over the past eight years evaluation activities have focused on operational processes, health outcomes, chronic disease management, utilization and penetration of outreach activities in designated geographical areas of the state. Each variation of evaluation activities consistently point to the same conclusions. CHAP patients show improvements in health outcomes, improved rates of screenings, fewer hospital emergency department visits and improved control of chronic disease.

### 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, such as mammograms, pap smears, cholesterol tests and flu shots.

Emergency department visits have been reduced.

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

Uninsured people with medical homes have increased.

- In 2009, almost 20,497 uninsured patients have been enrolled and received care at a participating health home or private practitioner since the program's inception.

The number of volunteer physicians participating in VIP is increasing:

- Fall 2003 – 334 physicians (20 percent of practicing physicians)
- Fall 2007 – 500 physicians (28 percent of practicing physicians)
- Fall 2008 – 511 physicians (29 percent of practicing physicians)
- Fall 2009 – 521 physicians (30 percent of practicing physicians)

In FY 2009, 95 – 97% of requests for prescription assistance were filled resulting in a total annual savings for patients of \$472,000.

As the Commission looks ahead to a decade of services to the uninsured through CHAP, and prepares itself for the real possibility that some health reforms will be enacted at the federal level, 2010 presents the opportunity to turn attention away from continuing to measure program outcomes, and focus on a more global perspective on how CHAP can play a meaningful role in the overall delivery of health care, both in Delaware and in a reformed health care system. The existing CHAP infrastructure and service delivery of primary care suggest it could play a key role in how federal reforms are implemented in Delaware.

### **Strengthen Network of Federally Qualified Health Centers:**

The Community Healthcare Access Program (CHAP) and the State Planning Program compliment one another as ways to support the state safety net, improve access to care and provide seamless coverage to Delawareans. In 2006, a need was identified to assist some of the state's community health centers in attaining their outreach goals and operating at full capacity.

In 2007, an analysis was conducted by John Snow, Inc. (JSI) to determine how and why various populations access health services, particularly in community health centers. Initial efforts focused on the Henrietta Johnson Medical Center (HJMC) in Wilmington. The primary goal was to understand the perceptions, attitudes, level of satisfaction/awareness of individuals who: 1) currently receive health care services at a federally qualified health center (FQHC); 2) have received services in the past; and 3) who have never received services at a FQHC. The final deliverable from JSI included a report and a "tool kit" that would allow other sites to replicate the study.



In 2008, through the Mid Atlantic-Association of Community Health Centers (MACHC) two other FQHC's in Delaware, La Red Health Center and Delmarva Rural Ministries, replicated the HJMC study. In order to preserve credibility of the process and similarity of the data, the Commission arranged for JSI to train the FQHC's on how to conduct the study. Subsequently, the FQHC's submitted their raw data to JSI for analysis. The costs for the data analysis were shared between the Commission and the Division of Public Health.

In 2010, strengthening the network of federally qualified health centers will be important to the Commission. Community health centers play an integral part in maintaining the success of CHAP and informing program designs as well as serving patients in underserved areas of the state. Studies that examine the impact of Community Health Centers (CHCs) on healthcare spending and utilization have found that the use of these centers help reduce health care spending and help patients, especially those with chronic conditions, to avoid unnecessary complications and acute care. Many studies attribute the reduction in health spending, in part, to fewer emergency room (ER) visits, fewer inpatient hospital admissions or shorter inpatient length of stay.

### **2010 ACTION - Community Healthcare Access Program (CHAP)**

#### **1. Implement the Evaluation Plan of the CHAP Workgroup**

- **Examine the safety net and determine how it will look in a reformed system**
- **Scenario planning – what is the impact of health reform on CHAP?**
- **Prioritize and assess workforce needs and increased demand post health reform**
- **Redefine the role of outreach in the event that coverage is mandated**

#### **2. Infrastructure and service delivery applicability for coverage expansion in a reformed system**

- **Continue to examine ways to expand primary care and prevention by building on the CHAP network.**
- **Analysis of existing programs targeting similar populations**
- **Continue to examine opportunities for collaboration with the Health Resources Board (i.e. Charity Care Policy).**
- **Analysis of financial value of services rendered (screening and eligibility, outreach and enrollment)**

#### **3. Strengthen the Network of Federally Qualified Health Centers**

- **Examine key findings from the Delaware Federally Qualified Health Center (FQHC) Research Study and analysis conducted by John Snow, Inc. (JSI) (i.e. targeted marketing strategies; operational and performance improvement efforts; improve access/reduce barriers to care).**
- **Explore the feasibility of the FQHC network with State oversight and opportunities for greater efficiencies**

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

The implementation of health information technology has emerged as a national priority, and Delaware is the leader in the development of a statewide clinical information exchange. 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 intent of the DHIN is to provide secure, fast, and reliable exchange of health information among the many health care providers treating patients in the State of Delaware. The DHIN will improve the quality of care in Delaware and reduce costs associated with a reduction in medical errors. DHIN continues to enjoy strong support from key stakeholders, including Delaware's federal Congressional delegation.

### **DHIN Purpose**

The organizational structure for the Delaware Health Information Network (DHIN) was established by the Delaware General Assembly in 1997 as a public instrumentality of the State, which currently functions under the direction of the Health Care Commission. The DHIN was designed as a public-private partnership, which provides the organizational infrastructure to support the implementation of a clinical information sharing network. The DHIN has served as the incubator organization for the health information exchange project since its inception. While DHIN operates under the auspices of the Health Care Commission, it is guided by the DHIN Board of Directors, Executive Committee, Consumer Advisory Committee, Project Management Committee, Health Information Management Systems (HIMS) Committee and a Clinical Advisory Group. The DHIN statutory purpose includes:

- Advance the 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

### **DHIN Project:**

DHIN is a secure, reliable communication system that is available to healthcare providers throughout Delaware. Through a combination of the latest technology and well-designed security practices, this system makes it possible for physicians, hospitals and labs to deliver and access critical health information to ensure better healthcare for patients in Delaware. The beneficiaries of DHIN include patients, health care providers, insurers/health plans, and employers.

DHIN adheres to national standards for data reporting and security. DHIN receives data from four hospital systems, encompassing six hospitals throughout the State (Bayhealth Medical Center, Beebe Medical Center and Christiana Care Health System), a full service pathology lab and the two major nationwide laboratories (LabCorp and Quest Diagnostics). Additional (small) laboratories have expressed interest in participating with DHIN and those negotiations continue. Conversations are also being pursued with three of the State's largest non-hospital radiology facilities and DHIN anticipates connectivity with them beginning in 2010.

### **DHIN Planning**

In May 2005, DHIN began a planning process to define the system requirements for a clinical health information exchange network. An environmental analysis provided the basis for understanding the current technical capabilities of stakeholder organizations as well as their functional needs for DHIN.

In addition to the technical and functional requirements of the system, a cost-benefit analysis was conducted to better understand the cost of building the system and the benefits to the stakeholder groups, including: hospitals and health systems, health plans, employers and State government (through Medicaid and state employee's health plan savings as well as streamlined bioterrorism and public health reporting).

In February 2006, a Request for Proposals (RFP) including all requirements for the DHIN was completed. In March 2006, the RFP was published to solicit bids from a qualified contractor to design, develop and implement a clinical information exchange network in Delaware. Six bidders responded to the RFP. After careful review by a stakeholder-wide evaluation committee as well as live test demonstrations from the top three bidders, DHIN negotiated and signed a contract with Medicity, Inc. to implement the system.

In June 2006, an RFP for Quality Assurance Monitoring was released and John Snow, Inc (JSI) was selected as the vendor. The purpose of this contract is to help ensure the DHIN project comes in on-time, on-budget and within scope.

DHIN submitted an Evaluation RFP in the spring 2009 to understand the clinical, environmental, and financial value of the health information exchange for its stakeholders. The sole responder was John Snow, Inc. (JSI), who has provided Quality Assurance oversight to DHIN since September 2006. The project plan is segmented into three separate phases. Phase I of this project has been completed, which is to design and develop an Evaluation Plan including the following:

- Create evaluation questions and issues via collaborative meetings
- Develop relevant tasks and activities
- Develop project timelines
- Identify JSI and DHIN participant roles
- Identify necessary metrics

## **DHIN Partners**

Data senders - those organizations that provide diagnostic testing, radiology and/or in-patient services based on practitioner orders - include: Bayhealth Medical Center, Beebe Medical Center, Christiana Care Health System, LabCorp, Quest Diagnostics, and Doctors Pathology Services. In 2010, DHIN anticipates connecting additional data senders. Data receivers – those who order diagnostic tests, radiology and/or admit patients for in-patient care – DHIN enrollment has increased by 56% in the past 12 months; from 64 live and active practices in November 2008 to 144 live and active practices in November 2009. As of November 30, 2009, 59 additional practices/provider locations statewide are currently in the pipeline (i.e. various stages of enrollment and training; varying size, specialties, and levels of technical sophistication). . Other key partners include Blue Cross Blue Shield of Delaware and Delaware Physicians Care, Inc. (Medicaid Managed Care).

## **Phase 1: Results Delivery**

The first phase of the project was successfully implemented in March 2007. Currently DHIN provides a streamlined results distribution system that delivers approximately 80 percent of lab tests and hospital admissions in the state. Health care providers receive lab, radiology and other test results via fax, in-box, auto-print, electronic medical record (EMR), and in some cases through a web portal that the provider must sign into and query for his/her patient's test results. DHIN allows the provider to decide in what format he/she wants to receive all test results and delivers those results to the provider in real-time based on their chosen method. Providers also receive alerts when a result is outside normal limits. In most cases, there is little to no added investment to the provider and the result is a more efficient, cost-effective and streamlined process for the practice. The provider must have high speed internet. Those practices that have Internet access may choose to have results delivered to a secure mailbox where they can track their patients' test results and make referrals to other providers using the DHIN. Practices with electronic medical records can have results delivered directly to the patient's electronic record in a secure manner.

## **Where does the information go?**

All of the clinical results sent by each sending organization are stored in a segregated database where only the sender, the recipient, and certified DHIN database administrators are authorized to access it. The benefits to this approach include:

1. The provider can simply query DHIN to get another copy if he/she cannot locate the original rather than having to call the sender to request another report.
2. It permits the patient's physician to view all test results in one location to provide historical context if the information in the paper file is not conveniently available.
3. It permits the patient's physician to authorize access to a specialist at the time of referral.

## **Phase 2: Patient Record Inquiry**

In Phase 2, which was implemented in June 2009, participating providers are able to query the DHIN for patient record history once an authorized patient-provider relationship has been

established in the system. (This process will likely require patient consent based on policies to be developed in collaboration with the DHIN Consumer Advisory Committee). For example, when a patient is new to a practice, the provider may query the DHIN to better understand the patient's history and therefore provide more informed treatment. Information which may be available on a patient could include medications, allergies, test results, and hospitalizations. In another scenario, if a patient presents in the emergency room, providers there would be able to learn about the person's health history to provide better treatment. Should the patient not be able to speak for him/herself or remember important details in a traumatic situation (e.g., medications and allergies); information obtained from the DHIN may be the difference between life and death. Phase 2 is set to go-live in 2009 and will also include a patient centric record history, public health reporting, transcribed reports, consumer participation via a patient portal, electronic order entry and the addition of new data senders and electronic medical record (EMR) users.

### **Current Functionality**

The function of DHIN is to move the practice of medicine into today's technology arena. Currently, DHIN functionality includes:

- Sends results to clinicians on lab tests, radiology tests, pathology tests, and hospital admission and discharge information.
- Allows authorized physicians to look up information about the tests their patients have taken
- Allows emergency room physicians to have more complete medical information about a patient prior to treating them, resulting in better clinical decision-making and patient care.
- Sends reportable public health information directly to the Division of Public Health. This benefits the citizens of Delaware by providing public health experts with patient symptoms and test results immediately, rather than relying on manual reporting, which can be delayed by several days. As a result, outbreaks such as food-borne illnesses or infectious diseases can be identified quickly and mitigated.

### **Funding**

In October 2004, DHIN was awarded \$700,000 through the Federal budget. These funds are administered through a contract with the U.S. Agency for Healthcare Research and Quality (AHRQ). With support from Delaware's Congressional Delegation and through a successful RFP response, DHIN was able to leverage an additional \$4.0 million from AHRQ totaling \$4.7 million over a five year period (ending September 2010).

DHIN has received Bond Budget appropriations from FY2007 to FY2010. DHIN originally requested \$9M over a three year period to support the capital infrastructure development phase of the project. Due to enhanced federal funding and sound fiscal management, DHIN has spent funding at a lesser rate than anticipated. Therefore, the \$9M has been spread over 5 years, with funding requests from the Bond Budget. In FY07 and FY08, DHIN was awarded \$2.0 million and \$3.0 million respectively from the Delaware General Assembly through the Bond and Capital Improvements budget ("Bond Bill"). It is the basis on which DHIN leverages federal and private funding to develop and implement phases of the system as it works toward an operational/sustainability plan. In FY09 and FY10, \$1.5M was appropriated in the Bond and Capital Improvement Act. DHIN is requesting \$1 million in the capital budget for FY11, which is the amount needed to implement the final year of new functionality. These funds will be matched (and will likely be exceeded) by private sector

funding; but nonetheless, are vitally important to moving DHIN toward its sustainability model.

In 2007, DHIN responded to a Request for Proposals (RFP) from the U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology for the National Health Information Network (NHIN) entitled *Nationwide Health Information Network Trial Implementation*. DHIN was one of nine states selected to implement NHIN use cases statewide and connect with other NHIN prototype sites. In 2008, work began to implement two use cases and demonstrate interoperability with other NHIN sites. Use cases currently under negotiation with NHIN are: biosurveillance/public health reporting, medication management, emergency responders, and lab reporting. NHIN funding is helping to support real time delivery of reportable disease data from hospital labs to the Division of Public Health through the DHIN, a valuable tool to monitor and manage potential disease outbreaks in Delaware. Without DHIN, these outbreaks might be identified in weeks; with DHIN, these outbreaks are identified in days or even hours and can result in reduced illness and days of work lost.

### **Privacy and Security are Paramount**

All access beyond the initial ordering physician will be subject to rigorous debate before permission will be granted. DHIN has state of the art security and disaster recovery protocols. Every transaction is logged and all access through patient record inquiry will be audited, including who viewed a given patient's information and when. The secure databases are systematically scanned for quality control purposes and are fully HIPAA compliant. Security protocols require users to be authorized with regular password reset intervals.

### **Project Status & Future Functionality**

DHIN will add onto the functionality in Phases 1 and 2 based on available funding and stakeholder interest. Added functionality may include: electronic order entry, electronic prescribing, a patient portal with personal health record access, secure provider-patient electronic communication, benefits eligibility verification, population health, disease management, and electronic claims submission.

DHIN will continue to recruit and enroll additional physician users throughout the state. DHIN provides a streamlined results distribution system that delivers approximately 80 percent of lab tests and hospital admissions to approximately 144 practices that are trained and actively using the system. Another 59 practices are in the process of enrolling/being trained. Delaware's four federally qualified health centers (La Red Health Center, Westside Health Services, Delmarva Rural Ministries and Henrietta Johnson Medical Center) are also connected to DHIN.

DHIN sustainability planning is critical to transition from building functionality (the capital phase) to its self-sustaining model (operational phase). This model is based on the premise that those who benefit from the system pay for the system.

In 2009, per the approval of the Commission, the DHIN Board of Directors made recommendations for the formation of two workgroups; Governance and Finance:

- 1) Governance – charged with considering governance options and to make recommendations to the DHIN Board of Directors regarding the most appropriate direction for governance and oversight of the DHIN. The Workgroup will consider the political, operational, technical, and market climates to ensure that the governance model is able to meet the needs of all stakeholders and constituencies.
- 2) Finance – charged with providing guidance and oversight for the work of the Finance Manager. The Finance Workgroup will consider several options for establishing a long-term revenue and operational structure. Some options may include: user fees, subscriptions, usage charges, and/or volume-based charges. These options and others will be explored by the Workgroup for recommendation to the Governance Workgroup and current DHIN leadership.

The DHIN is closely nearing the end of its capital phase and looks forward to a more mature operations and long-term financing model. Up until now, the Health Care Commission served as a good home and “incubator”. Both the DHIN and the Commission will be supporting recommendations arising from the Sustainability and Financing work, incorporating the same public private partnership purview, which has attributed to its success to date. While change is desired, the Commission recognizes that it is critical to keep the status quo until details are developed and solidified. DHIN’s stakeholders are also committed to working through a strategic process to develop a consensus based approach to governance and financing, which will meet the needs of DHIN users as well as the patients whose care is enhanced by the DHIN.

DHIN is currently in negotiations with the State of Pennsylvania to discuss a potential collaborative partnership to obtain health information exchange services through DHIN’s state contract. If an agreement is entered, PA will have the ability to leverage and accelerate the implementation of HIE functionality, positioning them for federal HIT incentive funds through the 2009 American Recovery and Reinvestment Act. As a national leader, DHIN is a valuable resource to health information exchanges in other states, and thus, providing consulting services is a potential source of revenue. On the state front, DHIN will consider pursuing a discussion with the largest health plans and other key stakeholders in the state to develop a financing model that includes long-term participation and support of current and future functionality.

Another exciting development on the national front is the American Recovery and Reinvestment Act of 2009 (ARRA), which established the State Health Information Exchange Cooperative Agreement Program, Title XIII – Health Information Technology, Subtitle B- Incentives for the Use of Health Information Technology. On August 20, 2009, the U.S. Department of Health and Human Services released the State Health Information Exchange Cooperative Agreement grant guidance.

Governor Markell specifically named DHIN as the “State Designated Entity” for the State of Delaware, making the DHIN the authorized applicant for the State Health Information Exchange Cooperative Agreement Program grant. The grant application was submitted in October 2009 and an award is expected in January 2010.

The DHIN has already implemented some of the required functions of this grant; as such, DHIN is “shovel ready”. The grant funding will allow DHIN to enhance the current health information exchange infrastructure and functionality, which it has successfully provided to Delaware’s health care community since 2007. Requirements under the grant include 7 key

functions that need to be implemented in the next two years with all functionality completed by 2014.

Under this agreement, the following deliverables are required and must be met over the next four years:

- Electronic clinical laboratory ordering and results delivery - *Results delivery has been live with DHIN since 2007; DHIN is currently implementing eOrders, to be piloted by the end of the year*
- Electronic eligibility and claims transactions – *This functionality does not exist in DHIN today, however, it has been on its planning roadmap.*
- Electronic prescribing and refill requests - *DHIN will meet this requirement through Electronic Health Record (EHR) Primer*
- Electronic public health reporting (i.e. immunizations, notifiable laboratory results)- *DHIN is currently reporting emergency room chief complaint and lab results for reportable diseases to the Division of Public Health in a real time, standardized format. Connectivity to the immunizations registry will be developed under the grant.*
- Quality reporting – *For DHIN, the data is available to support quality reporting, however, the capability will need to be developed under the grant.*
- Prescription fill status and/or medication fill history – *This capacity is ready, the pilot will be implemented in emergency department, nursing homes, health centers, and pain management facilities in order to assess the value and cost of the service.*
- Clinical summary exchange for care coordination and patient engagement – *DHIN's technology vendor has built the capability to exchange a clinical summary document; DHIN will deploy the capability under the grant.*

### **2010 ACTION- Delaware Health Information Network (DHIN)**

- 1. Support DHIN development and implementation and legislation to spin off into its own entity.**
- 2. Support continued State funding FY11.**
- 3. Provide administrative support for DHIN and maintain status quo in the short-term until a new entity is established and operational.**
- 4. Engage in development of long-term sustainability model; Despite DHIN's anticipated move into a separate organization, there will continue to be a policy relationship between the two agencies. This will be developed and defined as part of the process.**



# Health Professional Workforce Development –

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

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, twenty at JMC and five at PCOM annually. 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 thrive and Delaware derives significant benefits from the relationships. Both schools have consistently accepted the requisite number of Delaware students, more some years, 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 being accepted, without a cooperative agreement such as DIMER, are about one in 50. PCOM matriculations are on target – 15 students were accepted and 11 students matriculated. At JMC, 34 Delaware applicants were accepted and of those, 29 students matriculated.

Since JMC and PCOM are private colleges, the high tuition rates may be a deterrent to some students. Tuition and fees for the 2009-10 academic school year for a non-resident is \$47,902 at JMC and \$38,100 at PCOM.<sup>24</sup> Although DIMER provides some funding through scholarships and tuition stipends, the high tuition and corresponding prospect of having significant education debt upon graduation are regarded as barriers to recruiting key target populations.

The average medical student in the U.S. graduated \$154,607 in debt in 2008.<sup>25</sup> Over the last two decades, state and federal funding to support medical education have been reduced significantly and as a result, medical school tuition and fees have increased by 165 percent among private schools and by almost 300% for public schools. The cost of medical school education and the enormous burden of student loan debt may deter many young people from pursuing careers in medicine, which is why the tuition stipends have been very helpful to students who attend these private schools.

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 apply than residents of more urban New Castle County. It is an ongoing

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<sup>24</sup> Association of American Medical Colleges (AAMC); American Association of Colleges of Osteopathic Medicine. Average Annual Tuition and Fees at Private Medical Schools. 2009-2010

<sup>25</sup> Medical Student Debt: A Primary Concern. (Fall 2008). Bruce Auerbach, MD '78. Temple Medicine Bulletin.

challenge to recruit students of color (particularly black and Hispanic) and rural residents to medical school.

In 2010, the DIMER Board is particularly interested in pursuing discussions about the overall pending shortage of primary care physicians in Delaware and the nation, and the future role of “advanced primary care” or a patient centered medical home (i.e. coordinated care, increase number of primary care physicians and health professionals, team based approach to service delivery, and new payment structures and incentives for providing primary care). DIMER also identified a low number of applications and matriculations on the part of African Americans and Hispanics in medical school. Some areas that the Board will explore in more depth include:

- Establishing a medical scholars program at Delaware State University, similar to the program at UD.
- Developing initiatives that aim to diversify enrollment of residents entering medical school by encouraging the under-represented to take the right courses to get into college and medical school and additional strategies to provide support once students enter school, to sustain their interest.

Notably, DIMER financial support to Jefferson Medical College has remained level (\$1.0 million per year) over the last twenty years despite rising costs incurred by the college. The cost of medical education has risen significantly over the past decades. For example, total JMC expenditures in 1991 were \$76 million, compared to \$309.8 million in 2009. In 2000, PCOM’s budget was \$52M and today, its total budget is \$89.7M. DIMER remains the most economical alternative to Delaware having its own medical school. As our population grows and ages, the DIMER Program is a long-term approach that helps meet the future health care workforce needs of the State of Delaware. According to the Association of American Medical Colleges, the US will be at least 100,000 doctors short by 2025. There is far more benefit to the relationship with these two schools than just the reserved admission slots (see more information in attached DIMER Annual Report).

The DIMER Board is also closely watching an enhanced opportunity through the Delaware Health Sciences Alliance, which will certainly boost and strengthen the state and regional capacity in biomedical research, technology and personnel, and improve health care delivery in Delaware by creating health professional jobs and business opportunities. The recently established Delaware Health Sciences Alliance, a formalized partnership and coalition between Jefferson Medical College, the University of Delaware, Christiana Care Health Services, and the Nemours Foundation has resulted in the strategic vision and planning to develop a Campus for Healthcare Education in Delaware, which would be a satellite campus of Thomas Jefferson University. The new campus would house classrooms, a new residential facility for 150 medical and allied health professional students, and expand offerings in family and community medicine, surgery and its subspecialties, obstetrics, and gynecology, internal medicine and pediatrics. All of these health care disciplines are much needed to address Delaware’s health workforce shortages. One of the identified sites, an agreement which recently solidified the acquisition of 272 acres to the University of Delaware, is the former Chrysler auto plant, expanding the opportunity for Delawareans to pursue a medical education. Health care education is one of the alliances top priorities and is clearly aligned with DIMER’s purpose and mission.

## **2010 ACTION- Delaware Institute of Medical Education and Research (DIMER)**

**1. Continue to demonstrate the critical value that the DIMER affiliation with Jefferson Medical College (JMC) and the Philadelphia College of Osteopathic Medicine (PCOM) provides and the**

**benefits derived from the relationship to help recruit more providers to train and practice medicine in Delaware.**

**2. Identify and support enhanced opportunity for Delaware through the new Delaware Health Sciences Alliance: UD, JMC, CCHS, and Nemours**

**3. Effectively communicate the DIMER story and increase awareness to show the entire breadth of the program purpose, which is educational and broader than the issue of mandating students return to the DE to practice medicine**

**4. Report on the relationship with the Commission including the events that resulted in DIMER's operational move to DHCC**

**5. Identify how to streamline administration of DIMER programs and activities**

**6. Revisit the State Loan Repayment Program three-tiered review and approval process**

**7. Health Reform and workforce needs – Assess DIMER's role in the future of “advanced primary care” and MD/DO recruitment and retention**

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

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. A report on the supply and distribution of dentists was completed in 2006 and 2008, which reemphasized the need to educate and recruit dental professionals to Delaware. Since its inception in 2001, the State Loan Repayment Program has successfully recruited 14 dentists to practice in underserved areas of Delaware. Efforts are being made to also begin recruiting dental hygienists to help make use of DIDER loan repayment funds.

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 and Temple University emerged as the ideal partner. In 2006, DIDER signed an agreement with the Maurice H. Kornberg School of Dentistry at Temple University which guarantees admission to six qualified students from Delaware in each entering class of dental students. This provides Delaware residents with an opportunity to receive quality education and training at a highly regarded regional dental school. The partnership also promotes opportunities for participating dental students to complete externship and residency training programs at facilities in Delaware.

Delaware residents are eligible to participate regardless of the location of their undergraduate educational institution. Students must meet Temple University's academic requirements and this program does not guarantee admittance. All Delawareans who are accepted and choose to attend

Temple will be automatically admitted to the DIDER program; they are not required to fill out any additional applications. The Temple program was launched in state fiscal year 2007 (July 1, 2006 – June 30, 2007) when six slots were opened for incoming freshman. Due to budget reductions in FY10, the program was reduced from six slots to five, culminating with 23 slots in state fiscal year 2010. This partnership helps promote opportunities for dental students to complete externship and residency training programs at facilities in Delaware.

Additionally, since tuition and fees at Temple (\$48,902 for the 2008-09 school year) is slightly higher than tuition at JMC and PCOM, and through the generosity of the Delaware State General Assembly, DIDER provided \$75,000 for 2007 and 2008 academic years for tuition stipends to be divided among the Delaware residents who attend Temple. Originally, each student received, at a minimum, a tuition stipend of \$5,000 per year and the remaining funds were allocated based on financial need. Due to budget reductions in Fiscal Year 2010, the stipend was reduced to \$1,000 per student and the remaining funds are allocated based on financial need– to be determined using Temple’s financial aid formulas.

Another sound partnership and agreement is emerging between the University of Delaware and the Temple University’s School of Dentistry, which will establish an accelerated three year program for UD students who aspire to pursue post graduate dental education at Temple. The DIDER Board and the Commission will support and closely monitor this emerging agreement.

#### Oral Health Workforce Planning Grant

In 2008, the Commission and the Division of Public Health entered a collaborative partnership as a means to submit an Oral Health Workforce Development planning grant. Delaware was awarded \$200,000 in federal funding by the Health Resources and Services Administration, Bureau of Health Professionals an agency of the U.S. Department of Health and Human Services. The goal of the grant activities is to expand access to dental health care services and improve oral health outcomes in underserved areas of Delaware. The planning activities, including a feasibility study of three high-impact strategies, and a review of best practices will assist with the development of a defined implementation plan with action steps that address dental access needs, particularly in Sussex County. The three target initiatives include:

1. Creation of a case management program to develop a dental home for children in Medicaid and S-CHIP, to improve oral health status of the underserved.
2. Enhancement of dental education opportunities for dental hygienists and dental residents in southern DE, to strengthen the dental workforce.
3. Establishment of a multi-purpose dental clinic and training facility in Sussex County, to improve access to dental care and expand training opportunities.

A final report is expected by the vendor, John Snow, Inc. (JSI) in December 2009.

#### Oral Health Workforce Activities Grant

The Division of Public Health has also been awarded an implementation grant for \$440,000 each year for three years, which will run from September 1, 2009 through September 1, 2012. A component of the grant includes financial support to La Red Health Center (LRHC), a federally qualified health center in Sussex County, to jump start and expand their services to include oral health services. In addition, funding is also budgeted to support the implementation of activities and recommendations in the feasibility study. Grant funds in Year 2 and Year 3 could also be re-directed for additional oral health activities based on the final report and recommendations from JSI (for example, funding a position for a downstate dental residency program director). The grant will also support a part-time dentist for the mobile dentistry van, which will be up and running by the Division of Public Health in 2010.

The DIDER Board fully supports the grant activities and will provide input as necessary with recommendations to the Health Care Commission in early 2010.

**2010 ACTION- Delaware Institute for Dental Education and Research (DIDER)**

- 1. Continue support of DIDER and relationship with the Maurice H. Kornberg School of Dentistry at Temple University.**
- 2. Assure that workforce issues are a strategic priority by continuing to recruit dental providers and promote a climate that makes it conducive to practice in Delaware; target high need areas (i.e. Kent/Sussex)**
- 3. Continue to support and aggressively promote the State Loan Repayment Program as a means to recruit dentists and hygienists to Delaware.**
- 4. Continue to support the general practice dental residency program based at the Wilmington Hospital at CCHS.**
- 5. Support activities of the Oral Health Workforce planning and implementation grant from the US Health Resources and Services Administration (HRSA) to expand access to dental care in Sussex County.**
- 6. Monitor and support emerging agreement between the University of Delaware and the Temple University School of Dentistry, which plans to establish an accelerated degree in dental education.**

**State Loan Repayment Program (SLRP)**

The loan repayment program 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, for a minimum of two years. Practice sites may include public or private non-profit settings and private practices (solo or group).

The Delaware Health Care Commission (DHCC), in cooperation with the Delaware Higher Education Commission, administers the SLRP and is authorized to make awards for repayment of outstanding government and commercial loans incurred during undergraduate or graduate education (i.e. principal, interest and related expenses for tuition and educational costs).

**Funding**

There are two funding streams that support the State Loan Repayment Program: federal funding through the U.S. Health Resources and Services Administration (HRSA) Bureau of Health Professions, and State General Funds. Federal funding can only be used for full-time professionals practicing in federally designated Health Professional Shortage Areas (HPSAs) and a dollar for dollar match of non-federal money is required. State funds for the program appear as line items in the budgets for DIMER (\$150,000) and DIDER (\$100,000), both of which are advisory boards to the Health Care Commission. In August 2007, the DHCC competitively applied for and was awarded \$100,000 in federal funds annually for a three year project period through the U.S. Health Resources and Services Administration. Level funding was appropriated in FY10, even with the current state budget climate, which shows the strong support for the program. In 2009, Delaware applied competitively for the American Recovery and Reinvestment Act funded State Loan Repayment federal

grant and was awarded in the amount of \$100,000 for a two year project period (September 30, 2009 through September 29, 2011).

The SLRP provides educational loan repayment assistance to clinicians who agree to work at an eligible practice site in Delaware, which must be located in an area identified by the DHCC as being medically underserved. Health professionals participating in this program must provide services full-time (a minimum of 40 hours per week, not including on-call or travel time) for a minimum of two (2) years. Participants may re-apply for contract extensions in one-year increments, not to exceed a total of four (4) years of loan repayment. Extensions are granted at the discretion of the Loan Repayment Committee and are contingent upon the availability of funds. Priority is given to new applicants.

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 facility or a federally qualified health center. 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. Specific geographic locations in Delaware were recently federally designated as mental health HPSAs, which will increase the program’s ability to place clinicians at sites that meet federal guidelines and qualify for the federal matching funds. 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.

Private, public, federal loans for undergraduate or graduate education (i.e. principal, interest and related expenses for tuition and educational costs) qualify for loan repayment. In some cases, loan repayment funds may also be awarded to assist with capital loans (i.e. bank loans) for equipment expenditures to establish a practice in an area of high need. These awards are granted at the discretion of the Loan Repayment Committee and are contingent upon the availability of funds. In October 2006 official policies and procedures for capital expenditures were adopted by the Health Care Commission, which could potentially assist with loans for capital/equipment expenditures to establish a new practice in an area of high need.

**Eligible health professionals include:**

<b>Advanced-degree Practitioners</b>	<b>Mid-level Practitioners</b>
Primary Care Physicians (MD and DO)	Registered Clinical Dental Hygienists
<ul style="list-style-type: none"> <li>• Family Medicine</li> </ul>	Primary Care Certified Nurse Practitioners
<ul style="list-style-type: none"> <li>• Osteopathic Practitioners</li> </ul>	Certified Nurse Midwives
<ul style="list-style-type: none"> <li>• Internal Medicine</li> </ul>	Primary Care Physicians Assistants
<ul style="list-style-type: none"> <li>• Pediatrics</li> </ul>	Clinical or Counseling Psychologists
<ul style="list-style-type: none"> <li>• Obstetrics &amp; Gynecology</li> </ul>	Psychiatric Nurse Specialists
<ul style="list-style-type: none"> <li>• General Psychiatry</li> </ul>	Licensed Clinical Social Workers
Medical Oncologists	Mental Health Counselors
Pediatric Psychiatrists	Licensed Professional Counselors
General Practice Dentists (DDS and DMD)	Marriage & Family Therapists

Since 2006, new award thresholds have also been established for mid-level practitioners.

- *Advanced-degree Practitioners* may be granted up to \$70,000 total for a two (2) year commitment, or \$105,000 for a three (3) year contract.\*
- *Mid-level Practitioners* may be granted up to \$35,000 total for a two (2) year commitment, or \$52,500 maximum for a three (3) year contract.\*

\*Note that these figures represent the **maximum** award possible over 3 years; they are **not** guaranteed amounts, nor are they representative of recent awards. All awards are paid on a graduated scale.

Applications are accepted on a rolling basis. In 2007, the application review schedule for SLRP Committee, DIMER, DIDER meetings was re-arranged to reduce the length of the review and approval process to one-month. The SLRP Committee reviews and ranks applications in priority order. This is based on the objective review of data (including public health indicators, the number and spatial distribution of providers practicing in Delaware, hospital needs assessments when applicable), the availability of funding, practice sites and (when applicable) the outcome of face-to-face interviews with selected applicants.

To-date, the following loan repayment placements have been made:

TOTAL PARTICIPANTS BY FISCAL YEAR											
	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10*	Total
<b>Physicians Approved:</b>	2	2	3	2	3	4	5	7	6	8	42
<b>Mid-Level Approved:</b>	n/a	n/a	n/a	n/a	n/a	0	2	4	4	0	10
<b>Dentists Approved:</b>	0	2	1	1	0	1	2	2	5	0	14
<b>Total By Year:</b>	2	4	4	3	3	5	9	13	15	8	66

\*FY10 statistics as of December 2009

Gender	
Female	44
Male	22

County	
New Castle	22
Kent	17
Sussex	27

<b>Race/Ethnicity:</b>	
White	35
Black	9
Hispanic	1
Asian	8
Indian	3
Korean	2
Pakistani	1
Cuban	1
Vietnamese	1
Not reported	3

<b>Languages Spoken:</b>	
Spanish	11
Chinese Mandarin	2
French	2
Indian (Hindi, Telugu, Tamil)	3
Korean	1
African (Urdu, Gujarati)	2
Vietnamese	1
Italian	1

**Issues:**

A recognized disparity between DIMER and DIDER expenditures exists, due in part because DIMER has more eligible professions under its auspices and the funds are spent more quickly. Consideration will be given to explore non-federal funding (i.e. private match from community hospitals) for increased funding for DIMER. There is also need to re-visit whether priority should be given to primary care physicians over other eligible professionals. In 2009, a State Loan Repayment Program workgroup was empanelled to evaluate the current parameters of the program, identify and address outstanding policy issues and assess opportunities to improve the program. The workgroup developed a framework and set of policy recommendations for DIMER & DIDER Boards, and will require final approval by the Commission.

<b>Health Professional Workforce Development Committee</b>
--

The Commission's Health Professional Workforce Development Committee (HWDC) is a public/private sector collaborative partnership to develop strategies to predict and prevent health workforce shortages. This Committee works to streamline the fragmented data collection systems that exist throughout the state today, examines the level of skill, education and training for a competent workforce, and will propose the development of sustainable policy recommendations to improve the supply, distribution and diversity of our health professional workforce. Primary goals and functions include:

- Centralize and coordinate a public/private sector collaborative partnership to develop strategies to predict and prevent workforce shortages
- Maintain a basic set of state-wide health personnel data that is standardized
- Diversify the health care workforce
- Evaluate education and training pipeline issues
- Explore recruitment and retention efforts
- Identify resources (financial and non-financial incentives) to support policy recommendations and where they come from
- Identify legislative priorities
- Identify competencies in the workforce that address health care needs



In 2007, a comprehensive study was completed 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. For the purpose of this study, a total of 111 health education programs were identified at 23 educational institutions in Delaware, representing all of the known health training programs in the state. Of those 111 programs, 104 were found to be active programs with current student enrollments. A total of 89 responses to the survey were received, a response rate of 86 percent. A summary of findings can be found in the report, available in the online resource library at [www.dhin.org](http://www.dhin.org).

In 2008, a study designed to assess the supply and distribution of allied health professionals and pharmacists in the state was completed in partnership between the Health Care Commission, Division of Public Health and the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware. In 2007 surveys were distributed to over 5,000 health professionals in Delaware, including pharmacists, physical therapists, physician assistants, paramedics, speech/language pathologists, and radiologic technicians. The Commission was instrumental in shaping the design of the Allied Health Professionals capacity study and will determine next steps based on the key findings. The final report was released in the fall of 2008.

The Health Care Commission is the ideal agency to help facilitate the various planning activities to develop strategies to predict and prevent workforce shortages. At the 2009 Annual Retreat, the Commission discussed engaging the Workforce Committee as it anticipates greater demand placed on our health professional workforce, post health care reform.

## **2010 ACTION- Health Professional Workforce Development**

### **1. Engage Workforce Committee – anticipated greater demand post health care reform**

- **Continue the public/private sector collaboration to develop strategies to predict and prevent workforce shortages.**
- **Prioritize and assess the pressing health workforce issues, and propose policy recommendations to improve supply, distribution and diversity of our health professional workforce. Recommendations will consider the following:**
  - **Aging population**
  - **Address mental health services as an essential component to overall health**
  - **Increased diversity of the population**
  - **Aging workforce**
  - **Barriers to the workplace**
  - **Increased burden of chronic disease**
  - **Regional workforce and training issues**
  - **Innovative financing for implementation strategies**
- **Engage in dialogue with other agencies and the medical community and identify expectations**

**2. Support activities of the Oral Health Workforce planning and implementation grant from the US Health Resources and Services Administration (HRSA) to expand access to dental care in Sussex County (See page 53).**

# Research & Policy Development – Research Reports

In order to provide accurate and up-to-date information to policy and decision-makers, the Health Care Commission contracts 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.

## ***Research Reports and Data Collection***

The *Total Cost of Health Care in Delaware* report documents how much money is spent annually on health care in Delaware. It also identifies trends in health care costs and spending and impact on the state economy and labor market. A full replication and update of the original report will require the collection of additional data, including outpatient discharge data.

The *Delawareans Without Health Insurance* report analyzes and tracks the uninsured population in Delaware and their demographic characteristics. It is a very valuable resource for policy-makers and is updated annually.

## **2010 ACTION: Research Reports & Data**

- 1. DHCC is uniquely qualified and positioned to provide analysis of social climate related to health indicators and key issues pertaining to health care reform**
- 2. Outstanding issue for consideration: Continue to publish both the *Total Cost of Health Care in Delaware* and *Delawareans Without Health Insurance* reports annually**

## **POLICY DEVELOPMENT**

As Delaware considers comprehensive health care reform, advocates, stakeholders and policymakers will need to take on a lead role, ask the tough questions, and facilitate discussion to find solutions that are applicable to Delaware. In addition, the Commission and stakeholders will need to address cost containment and implement methods to control rising health care costs. While the costs of expanding coverage are significant, sustainable funding and shared responsibility will be necessary to support health care reform.

## **2010 ACTION: Policy Development**

- 1. Develop consensus building strategies**
  - Organize health care policy forums, convene committees and workgroups to bring stakeholders to the table on comprehensive planning for emerging issues and implementation strategies**
  - DHCC's role is to serve as a convener, systemic advisory body and change agent**

**2. Serve as a Change Agent**

- **Continue to be flexible to change and be on the cutting edge of policy issues and health care reform**
- **Recognize when to disengage from projects**
- **Identify appropriate agencies to take on issues and to carry out projects to full fruition**
- **Review current DHCC enabling legislation and statute related to the Health Care Commission's mission, function and purpose**

**3. Evaluate organizational structure – policy and operations**

- **Identify the physical/personnel capacity of the organization, discretionary resources available to the organization**
- **Establish a commitment to the DHCC vision, mission and common purpose**
- **Develop a communication plan which include benchmarks to measure performance and define success**

<b>HEALTH FUND ADVISORY COMMITTEE</b>
---------------------------------------

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

The Committee meets throughout the fall and finishes its work in December 2009 so that recommendations can be incorporated into Governor Markell's recommended budget for FY 2011.

**2010 ACTION: Health Fund Advisory Committee**

- 1. Continue the current arrangement with Commission representation on the Committee and support from Commission staff.**

# Specific Health Care Issues & Affiliated Groups

## Health Resources Board

The Health Resources Board (HRB) oversees the Certificate of Public Review (CPR) process for all new medical capital construction and the acquisition of major medical equipment in the State.

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

Recent policy changes have created opportunities for more interaction between the Commission and the HRB. The Certificate of Public Review process includes requirements for charity care, currently set at 2 percent of a facility's total gross revenue. Per the Health Resources Management Plan, free standing surgery centers that are subject to a CPR review are required to accept charity care up to 350% fpl. Policy and enforcement procedures were passed and signed into law in 2009, which granted the HRB authority to enforce the charity care requirement. Opportunities for HRB to coordinate with DHCC and the CHAP program for charity care policy implementation and enforcement are being explored. Currently, HRB defines "charity" as 350 % of the federal poverty level (FPL), while CHAP limits participation to 200% FPL.

DHCC statute stipulates that the Commission coordinate efforts with the Health Resources Board (formerly the Health Resources Management Council), which is responsible for overall health planning and the State's Certificate of Need program, to ensure that Delaware has a balanced approach to access, quality and costs of health care. In 2010, DHCC's renewed focus on policy analysis and health care reform will necessitate a closer working relationship with the Health Resources Board.

### **2010 ACTION - Health Resources Board**

**1. Continue coordination between DHCC and HRB staff; work to collaborate between CHAP and HRB's charity care policy.**

## Nutrition, Physical Activity, and Obesity Prevention Coalition/Network

In 2008, the Division of Public Health convened a summit inviting key stakeholders to discuss the development of a statewide Nutrition, Physical Activity, and Obesity Prevention Coalition. As a follow-up to the June summit planning session, a series of quarterly meetings of the workgroups or "Settings" for the planning process will be scheduled throughout the year. The settings will work to develop a strategic planning framework and strategies with objectives, responsibilities and a timetable. This combined effort culminated in the creation of a comprehensive plan in June 2009. Settings include:

- Healthcare
- Worksites
- Families in Communities
- Environment and policy
- Schools
- Social Marketing and Communications

In October 2008, the first quarterly meeting was held and convened the six settings to assist with the development of a 5 Year Comprehensive Plan for the Nutrition, Physical Activity, and Obesity Prevention Project sponsored by the Division of Public Health. The name of the planning effort was formerly established as the Delaware Partnership to Promote Healthy Eating and Active Living (DE HEAL). Throughout 2009, work continues on the development of recommendations from the settings and an inventory of existing efforts as well as a gap analysis.

In 2010, Commission staff will support the comprehensive planning process and provide input as necessary.

**2010 ACTION - Nutrition, Physical Activity, and Obesity Prevention Coalition/Network**

1. **Support the development of a statewide coalition and participate as a collaborative partner to create a new comprehensive state plan with recommendations, objectives and action steps.**
2. **Continue support and participation as necessary.**

<b>Mental Health Issues</b>
-----------------------------

Data gathering activities on the supply and demand of mental health services, including a survey of practitioners, focus groups of consumers and practitioners, and identification of best practices, is now complete. A comprehensive report was issued during the fall of 2006. Implementation of the recommendations is now underway in collaboration with Division of Public Health and Division of Substance Abuse & Mental Health. Staff will continue work on a plan for implementation with other key stakeholders.

Specific geographic locations in the state have been approved and federally designated as Health Professional Shortage Areas (HPSA) for mental health care providers, thereby supporting recruitment of mental health professionals to Delaware, particularly for Federally Qualified Health Centers and the State Loan Repayment Program.

**2010 ACTION- Mental Health Issues**

1. **Continue to support the Committee’s implementation planning as a result of the *Supply and Demand of Mental Health Services in DE (2006)* report and recommendations.**
2. **Coordinate with the Division of Public Health (DPH) and the Division of Substance Abuse and Mental Health (DSAMH) on the new federally designated Health Professional Shortage Areas (HPSA) for mental health care providers, to improve**

**recruitment and retention, particularly for Federally Qualified Health Centers and the State Loan Repayment Program.**

**Chronic Illness**

In 2006, in response to a request by several members of the General Assembly, the Commission convened a Stroke Task Force, a sub-committee of the Commission's Chronic Illness Task Force in partnership with the American Heart Association / Stroke Association. The Task Force was charged with exploring the current stroke care environment, identifying potential areas of excellence as well as gaps in the stroke care system, and if warranted, making recommendations to develop and improve Delaware's statewide system of care.

The Stroke Task Force included experts in various related fields from all three counties to draw upon their knowledge and experience working together to improve Delaware's response to stroke. The scope of this analysis covered the entire continuum of stroke care including: prevention, emergency response, acute/sub-acute treatment, rehabilitation, and continuous quality improvement. The report includes a summary of data relating to stroke incidence and death rates, data on risk factors affecting stroke, a description of current stroke care systems in Delaware and recommendations for improvement. The Stroke report and recommendations were presented to the Chronic Illness Task Force in 2007.

Further support and attention on the increased burden of chronic illness will be critical in 2010. The total cost of health care (\$6.5 B) is increasing at a rate of 5 percent annually, and much of this expenditure can be attributed to the diagnosis and treatment of chronic diseases and conditions, including cardiovascular disease (primarily heart disease and stroke). Specifically, one of the most recent health care initiatives that the Commission has joined as a key strategic partner, in addition to several other community based organizations, is the development of planning activities initiated by the Primary Care Partnerships to Prevent Heart Disease in Women, which is supported by a three year grant awarded to Delaware from the US Office on Women's Health.

**2010 ACTION - Chronic Illness**

- 1. Examine opportunities to address these issues over the next year.**
- 2. Continue coordination and support as necessary.**
- 3. Support the planning and development activities as a key collaborative partner of the Primary Care Partnerships to Prevent Heart Disease in Women, a three year grant awarded to DE from the U.S. Office on Women's Health.**

## DHCC - Path Forward

During the 2009 Annual Retreat, the Health Care Commission highlighted some activities and accomplishments to date that measured its progress and success as they looked back on the journey over a 20 year period. In addition, the Commission clearly recognized its unique position, broad and diverse expertise, and its ability to respond to important emerging health policy issues and trends.

It was concluded that the Health Care Commission should evaluate its organizational structure, which currently has oversight of three advisory boards (DIMER, DIDER and DHIN), examine its current administration and management of projects, review its mission statement and its enabling statute and make recommendations that consider the current environment. Furthermore, the Health Care Commission will re-focus its efforts on policy analysis and will develop a comprehensive plan to prepare for Federal health reform, taking a lead role, bringing together stakeholders with varying points of view to address implementation at the state level.

### **2010 ACTION – Path Forward**

**1. Form a Committee that will examine DHCC function, role, and purpose and propose updates to the statute that reflect new reality and vision; include representatives from DIMER & DIDER**

- **Form a sub work group with DIMER & DIDER to examine streamlined administration and relationship to DHCC (i.e. State Loan Repayment Program)**
- **Form a sub work group to address Workforce Development issues**

**2. “Drill down” and revisit key issues raised at the 2009 Annual Retreat <sup>26</sup>**

**3. Closely follow and analyze federal health reform; DHCC plays a vital role going forward**

**4. DHIN – Identify future relationship with the DHCC**

**5. Coordination with CHAP Evaluation planning**

The current activities and action items summarized in this report, clearly demonstrate the commitment, the level of activity and the depth of partnerships in Delaware surrounding access to affordable and quality health care. Many of these initiatives have included the Delaware Health Care Commission as a key partner or lead convener, which has been instrumental to the small, but effective steps and progress made to expand and preserve coverage and move towards comprehensive health care reform.

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<sup>26</sup> 2010 DHCC planning and policy issues are captured throughout the Annual Report.



# APPENDICIES

## A) Board and Committee Lists

Delaware Health Information Network (DHIN) Board of Directors

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

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

Health Workforce Development Committee

State Loan Repayment Committee

## B) DIMER Annual Report 2010

# Delaware Health Information Network (DHIN) Board of Directors

## CHAIR

**Robert J. White\***

*Delaware Physicians Care, Inc.*

## VICE-CHAIR

**Edward Ratledge\***

*Center for Applied Demography and Survey Research  
University of Delaware*

## SECRETARY

**William E. Kirk, III, Esq.\***

*Blue Cross Blue Shield of Delaware*

## BOARD MEMBERS

**Meaghan Brennan**

*Ex-Officio Budget Director Designee*

**Theodore W. Becker, Jr.**

*DHCC Representative*

**Terry Feinour**

*Bayhealth Medical Center*

**Mark Meister\***

*Medical Society of Delaware*

**Stephen Groff**

*Ex-Officio Health & Social Services Designee*

**Randeep S. Kahlon, MD**

*First State Orthopaedics*

**Joann Hasse\***

*Pubic Representative*

**Linda Nemes**

*Ex-Officio Insurance Commissioner Designee*

**A. Richard Heffron\***

*Delaware State Chamber of Commerce*

**Marcy Parykaza**

*Ex-Officio Public Health Director Designee*

**Terri Steinberg, MD, MBA\***

*Christiana Care Health System*

**Roberto Scaffidi, MD**

*Cardiology Consultants, PA*

**James H. Sills, III**

*Ex-Officio Secretary, Department of  
Technology & Information*

**Barbara Vugrinec**

*Beebe Medical Center*

(\* Indicates Executive Committee Membership)

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

**CHAIR**

**Louis Rafetto, DMD**  
*Delaware State Dental Society*

**BOARD MEMBERS**

**James C. Baker, DDS**  
*Christiana Care Health System*

**Ryan C. Barnhart, DDS**  
*Delaware State Dental Society*

**Lisa Goss, RDH, BS**  
*Delaware Dental Hygienist Association*

**Brian S. McAllister, DDS**  
*Higher Education Commission*

**Neil McAneny, DDS**  
*Delaware State Board of Dental Examiners*

**Gregory McClure, DMD, MPH**  
*Ex-Officio State Dental Director*

**Ray S. Rafetto, DMD**  
*Delaware State Dental Society*

**Wanda Gardiner Smith, DDS**  
*Public Representative*

**Vacant**  
*Delaware Health Care Commission*

**Maurice H. Kornberg School of Dentistry at Temple University Liaison**

**Lisa Deem, DMD, Esq.**  
*Associate Dean for Admissions and Student Affairs*

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## BOARD MEMBERS

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Division of Public Health

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**Vacant**  
*Delaware Health Care Commission*

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*David Paskin, MD*

## Philadelphia College of Osteopathic Medicine Liaison

*Carol A. Fox*

# Health Workforce Development Committee

## CO-CHAIRS

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*Delaware Health Care Commission*

**Janice E. Nevin, MD, MPH**

*Delaware Health Care Commission*

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*DE Economic Development Office*

**Joan Barnwell**

*Division of Public Health*

**Judith A. Chaconas**

*Division of Public Health*

**Kathy Collison**

*Division of Public Health*

**Wendy Gainor**

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**Maureen Laffey**

*Higher Education Commission*

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*Division of Professional Regulation*

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*Medical Society of Delaware*

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*Christiana Care Health System*

**Wayne A. Smith**

*Delaware Healthcare Association*

**Tibor Toth**

*CADSR, University of Delaware*

**Sherman Townsend**

*DIMER*

# State Loan Repayment Program Committee

## COMMITTEE MEMBERS

**Theodore Becker**

*Delaware Health Care Commission*

**Judith A. Chaconas**

*Delaware Department of Health & Social Services  
Division of Public Health*

**John A. Forest, Jr. MD**

*Delaware Institute of Medical Education & Research  
Board of Directors*

**Gregory McClure, DMD, MPH**

*Delaware State Dental Director  
Delaware Institute for Dental Education & Research  
Board of Directors*

**James C. Baker, DDS**

*Delaware Institute for Dental Education & Research  
Board of Directors*

**Carylin Brinkley**

*Delaware Higher Education Commission*

**Gerard Gallucci, M.D., M.H.S.**

*Delaware Department of Health & Social Services  
Medical Director, Division of Substance Abuse & Mental Health*

**STATE OF DELAWARE**

**Delaware Health Care Commission**

**Delaware Institute of Medical Education and Research**

**Annual Report**

**January 2010**

**State of Delaware  
Jack A. Markell, Governor**

**Delaware Health Care Commission  
John C. Carney, Jr., Chair**

**Delaware Institute of Medical Education and Research  
Sherman L. Townsend, Chair**

**Brian M. Aboff, MD, FACP**

**Michael Alexander, MD**

**Anthony D. Alfieri, DO**

**Lisa C. Barkley, MD**

**David A. Barlow, PhD**

**David Bercaw, MD**

**John A. J. Forest, Jr., MD**

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**Brian W. Little, MD, PhD**

**Vincent Lobo, Jr., DO**

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**Steven J. Stanhope, PhD \***

**Carl Turner, MD**

**Jefferson Medical College Liaison**

**David Paskin, MD**

**Philadelphia College of Osteopathic Medicine Liaison**

**Carol A. Fox**

\* Kathleen S. Matt, PhD – began term September 18, 2009

\* Steven J. Stanhope, PhD – January 20, 2009 through September 18, 2009





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## **Introduction**

On behalf of the Delaware Institute of Medical Education and Research and its volunteer members, I am pleased to submit this Annual Report. It is evident from this report that DIMER has fully embraced its dual purposes of (1) providing educational opportunities for Delaware residents to pursue careers as Doctors of Medicine and Doctors of Osteopathy and (2) helping the state meet its health care needs.

Because Delaware does not have a state-supported medical school, the state through DIMER secures at least 20 admission slots for Delaware residents at Jefferson Medical College in Philadelphia, Pennsylvania and at least 5 admission slots at the Philadelphia College of Osteopathic Medicine (PCOM). DIMER also encourages Delaware residents who attend Jefferson and PCOM to return to Delaware to practice medicine.

DIMER provides Delaware residents admitted to Jefferson Medical College and PCOM with tuition supplements and an opportunity to compete for need based scholarships.

I am pleased to announce that 51 health care clinicians have been successfully recruited to underserved areas of the State as a result of the Delaware State Loan Repayment Program. Under the program, health care professionals are eligible to apply for funds to offset their outstanding medical education debt. In exchange, they must practice for a minimum of two years in an underserved area of the state, as identified by the Delaware Health Care Commission. This program should allow us to identify and eliminate our current provider shortages more quickly, while providing the flexibility we need to stay in step with our provider workforce needs as they change over time.

DIMER is committed to improving health care in Delaware. The members of the DIMER Board of Directors give freely of their time and without hesitation share their knowledge about medical education and the practice of medicine in our state. They are to be commended for their hard work and dedication to our state.

Sherman Townsend, Chair  
DIMER Board of Directors

## **History and Background**

The Delaware General Assembly in 1969 created the Delaware Institute of Medical Education and Research as an alternative to a state medical school. At that time there was a general shortage of physicians throughout the country, and states were moving to address this problem by establishing their own medical schools. In Delaware, however, there was a concern that such an undertaking was not financially feasible. Instead, Delaware created a public/private board to develop legal agreements, organize cooperative arrangements and disburse appropriated State funds to resolve this and other problems relative to medical education in Delaware.

The plan was to reserve seats for Delaware students in a major nearby medical school. At issue was the fact that most medical schools receive financial support from their home state, and in return accept a preponderance of students from that state. As such, Delaware residents were always “out of state” applicants and not given admission preferences usually extended to in-state residents.

The DIMER Board, on behalf of the State of Delaware, in 1970 established an agreement between DIMER, Wilmington Medical Center (now Christiana Care Health Services), the University of Delaware and Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania. Jefferson Medical College agreed to accept at least 20 Delaware residents each year who met the same academic requirements as other students, resulting in Jefferson functioning as Delaware’s medical school. Premedical programs at the University of Delaware were strengthened to prepare aspiring medical students for medical school admission.

During the early 1990s, the Delaware General Assembly asked DIMER to create incentives to encourage students attending Jefferson through DIMER to return to Delaware to practice primary care medicine. In Fiscal Year 1993, the loan program was converted from a need-based program to one based on service repayment. Under the program, students admitted to the DIMER program who were interested in returning to Delaware to practice primary care medicine applied for funding assistance. The loans were repaid with one year of medical practice in a designated primary care field for each year the funds were accepted.

In 1995, the Delaware General Assembly Joint Sunset Committee asked the Delaware Health Care Commission to conduct the first comprehensive review of DIMER since its creation. The General Assembly asked the Commission to review DIMER’s purpose as it relates to the health care needs of all Delawareans, examine current training and higher education needs, consider ways such needs might be more effectively met and consider DIMER’s activities in light of state needs and priorities.

The Commission, through a Primary Care Committee, conducted the review and in 1996 submitted its findings and recommendations to the Joint Sunset Committee. The report concluded that the original purpose of DIMER as an alternative to a state-sponsored medical school was sound. While some of its original purposes continued to reflect recommended activities for the future, the report noted that others no longer had practical application. The review and recommendations resulted in enactment of Senate Bill 418.

The statute reaffirmed the original purpose of DIMER as an alternative to a state-sponsored medical school and expanded the Board to reflect its statewide responsibilities.

One of the new opportunities presented by the statute was for the new Board to work with the Commission to identify state health care needs and craft programs or make recommendations to address them. The Board also has the authority to develop recruitment programs to attract medical school applications from minorities, residents of rural and under-served areas, and pre-medical students interested in practicing community and rural medicine.

DIMER also was charged with establishing a standing *Committee on Rural Health* to ensure the unique health care needs of rural Delaware are addressed in DIMER activities. The Committee released its first report and recommendations in 1999.

Placing the administration of DIMER in the offices of the Delaware Health Care Commission recognized the similar missions of the two agencies with regard to the state's efforts to meet its health care needs. It also addressed DIMER's need for a state agency "home" and accompanying resources such as staff and funding for supplies.

In 1999, new language in the budget epilogue called on DIMER to enter into discussions with the Philadelphia College of Osteopathic Medicine (PCOM) to allow the school to function as Delaware's school of osteopathic medicine. In 2000, this goal was accomplished. The measure also, for the first time, allocated funds for DIMER to recruit physicians, either medical doctors or doctors of osteopathic medicine. Recruitment tools include loan repayments. The first physicians were recruited to Delaware through the new State Loan Repayment Program in 2001. The program is discussed in more detail on page 9 of this report.

In 2001, the budget epilogue called on DIMER to restructure the grant/loan program in effect since 1993 into either a scholarship program or a loan program with more favorable tax consequences than the previous program. As a result, the former grant/loan program was phased out. A new program was implemented that provides Delaware residents admitted to Jefferson Medical College and PCOM with tuition supplements and an opportunity to compete for need based scholarships.

DIMER occasionally receives private donations. In 2002, it used the donations to provide one-time funding for two new programs: 1) A Summer Research Program to stimulate interest in pursuing a health related career; and 2) A Health Care Workforce Development Scholarship Program to create an incentive for people to re-enter the health care work force or pursue a new career in health care.

Two college students participated in the Summer Research Program and found it to be a rewarding experience. One student researched the effectiveness of the Flex-Guide ET Tube Introducer as an airway adjunct to decrease surgical cricothyroidotomy (surgically placing a hole in the patient's neck). The Associate Chair of Emergency Medicine at Christiana Care Health Services served as her mentor. The second student researched and defined the role of a Cancer Care Concierge. The Senior Vice President of Medical Affairs at Nanticoke Memorial Hospital served as his mentor. The findings were submitted as an article to the Delaware Medical Journal in August 2003.

There was an overwhelming response to the Health Care Workforce Development Scholarship Program. A total of 92 applications for the scholarship were received, clearly demonstrating the need for scholarship assistance for adults to enter health care fields.

A total of 17 scholarships were awarded to 5 males and 12 females; 10 New Castle County residents, 5 Kent County residents, and 2 Sussex County residents. The scholarships were distributed as follows:

- 2 - \$1700 each for radiologic technology at Delaware Technical & Community College
- 1 - \$1700 for a physical therapist assistant at Delaware Technical & Community College
- 1 - \$3600 for nursing at Beebe Nursing School
- 2 - \$3600 each for nursing at Delaware State University
- 1 - \$540 for the nursing refresher course at the University of Delaware
- 10 - \$3600 each for the accelerated nursing degree program at the University of Delaware

## **Delaware Institute of Medical Education and Research 2009 Accomplishments**

While continuing its mission of providing Delaware students an enhanced opportunity to pursue a medical education, DIMER also focused on the broader health care needs of the state.

### Admissions to Jefferson Medical College

Through DIMER, Jefferson Medical College accepted 34 Delaware applicants in its 2009 entering class. Of those, 29 matriculated.

### Admissions to Philadelphia College of Osteopathic Medicine

Through DIMER, the Philadelphia College of Osteopathic Medicine accepted 15 Delaware applicants in its 2009 entering class. Of those, 11 matriculated.

### DIMER Grant/Loan Program

In 2001, the DIMER Board of Directors evaluated the Grant/Loan Program in its entirety. The evaluation was in response to a number of concerns, including the potential tax liability of the forgiven loan, the attrition rate and the inability to predict what our health care workforce needs would be at the time the loans were forgiven. As a result, the former grant/loan program was phased out. A new program was implemented that provides Delaware residents admitted to Jefferson Medical College and PCOM with tuition supplements and an opportunity to compete for need based scholarships.

### Need Based Scholarship and Tuition Supplement Program

For the 2009-2010 academic year 85 tuition supplements were awarded to all four classes at Jefferson Medical College. Need-based scholarships were awarded to 13 freshmen, 11 sophomores, 12 juniors and 11 seniors for a total of 47 scholarships.

For the 2009-2010 academic year, 29 tuition supplements were awarded to all four classes at PCOM. Need-based scholarships were awarded to 9 freshmen, 3 sophomores, 5 juniors, and 4 seniors for a total of 21 scholarships.

### DIMER Loan Repayment Program

A State Loan Repayment Program was designed and launched to meet Delaware's more immediate recruitment needs. The program is administered by the Delaware Health Care Commission and DIMER in cooperation with the Delaware Division of Public Health and Delaware Higher Education Commission. Forty-one physicians, four certified nurse midwives, five certified nurse practitioners, and one physician's assistant have been successfully placed in underserved areas as a result of the program.

### DIMER Committee on Rural Health

Several of the 1999 recommendations of the DIMER Committee on Rural Health were implemented, including those pertaining to the establishment of a Loan Repayment Program, monitoring Delaware's provider workforce capacity, developing a better understanding of the J-1 visa waiver program for international medical graduates, considering the importance of mental health in meeting the state's provider workforce needs, and continued support of the Downstate Residency Rotation Pilot Project.

### DIMER Dinners

DIMER traditionally holds an annual dinner for Freshmen and Sophomores at Jefferson Medical College to reinforce the relationship of the DIMER program to their attendance at Jefferson Medical College. The dinner is an opportunity to connect with Delawareans attending medical school and remind them of the state's desire that they consider returning to Delaware upon completion of their training. Along with the students, those who attend the dinner include members of the DIMER Board, and officials from Delaware's hospitals.

A second dinner targets Juniors and Seniors and is held in a restaurant off campus with the goal of recruiting them to Delaware for their residency training.

Each dinner is intended to foster conversation between students and hospital representatives about opportunities to enter residency training and practice in Delaware upon graduation. Both dinners are generally well attended, and considered successful by students, Jefferson Medical College, DIMER Board members and hospital representatives.

DIMER plans to continue the tradition of two separate dinners with Jefferson Medical College students.

In 2006 a new tradition began with a dinner with students at Philadelphia College of Osteopathic Medicine. The dinners have been very well attended and successful. DIMER plans to continue the tradition of an annual dinner with Philadelphia College of Osteopathic Medicine Students.



## **2010 Agenda**

For 2010, the DIMER Board plans the following projects:

Assure that at least 20 students are accepted by Jefferson Medical College.

Assure that at least 5 students are accepted by the Philadelphia School of Osteopathic Medicine.

Administer the Loan Repayment Program to health care professionals to underserved areas.

Monitor the relationship between DIMER students and Medical Scholars students from the University of Delaware who enter Jefferson to assure that an appropriate number of admission slots are available to both Medical Scholars and other Delaware students.

Continue the tuition supplement and need-based scholarship program.

Monitor Delaware's workforce needs to assure current and future DIMER activities reflect Delaware's needs.

Maintain a data bank of DIMER graduates to include their site of residency training and specialty of practice as a tool to assist in recruitment efforts.

## **DIMER Board: Composition**

The DIMER Board includes:

3 University of Delaware representatives, including 1 from the School of Nursing (now College of Health Sciences)

3 Medical Center of Delaware representatives (now Christiana Care Health System)

1 Delaware State University representative

6 representatives appointed by the governor, one from each of the state's three counties, one from the city of Wilmington, and two from medical residency programs other than those operated by the Medical Center of Delaware (now Christiana Care Health System)

1 representative appointed by the Association of Delaware Hospitals (now Delaware Healthcare Association)

1 representative appointed by the Higher Education Commission

1 representative appointed by the Delaware Health Care Commission

1 ex officio member, director, Public Health

## **DIMER Board: Purposes**

The purpose of the DIMER Board is to initiate, encourage and promote:

- The relationship with Jefferson Medical College as Delaware's medical school and ensure the admission of at least 20 Delawareans into Jefferson Medical College annually.
- Expansion of opportunities for Delawareans to receive training in the health and health-related professions when such Delawareans commit to practice in Delaware.
- Incentives for health and health-related professions to practice in Delaware.
- Continued development of a coordinated program of premedical, medical and graduate education among state public institutions, Delaware hospitals and Jefferson Medical College.
- Support of graduate and post-graduate medical and health training programs, with emphasis on those programs designed to meet Delaware's health care needs.
- Education and training programs in health fields and research in health and health-related fields, both basic and applied, including public health education, community health planning and health care costs.

## **ADVANTAGES DIMER PROVIDES TO DELAWAREANS**

DIMER provides a significant opportunity for the most qualified residents of Delaware to gain admission to medical school. The relationship Delaware has with Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, through DIMER results in Jefferson reserving at least 20 admissions each year for Delaware residents.

Through the DIMER program, the odds of a Delaware resident getting accepted into Jefferson are about one out of three. The odds of someone from another state getting accepted, without a cooperative agreement such as DIMER, are about one in 50.

DIMER also has a relationship with the Philadelphia College of Osteopathic Medicine, which results in PCOM reserving at least 5 admissions each year for Delaware residents.

DIMER clearly creates a significant educational opportunity for Delaware residents who wish to pursue a medical education. It remains the most economical alternative to Delaware having its own medical school.

Another less visible impact of DIMER on health care in Delaware is the fact that Jefferson Medical College and PCOM are a source of residents for Christiana Care Health Services. About 75% of Christiana Care family practice physicians and 45% of Christiana Care internal medicine residents establish practice within 50 miles of their residency training experience.

## STATE LOAN REPAYMENT PROGRAM

The State Loan Repayment Program is administered by the Delaware Health Care Commission and DIMER in cooperation with the Delaware Division of Public Health and Delaware Higher Education Commission.

Upon completion of their education, physicians who choose to practice in a designated shortage area may apply for this program, which is designed to recruit health care professionals to underserved areas of Delaware. Participants receive awards for repayment of outstanding government and commercial loans incurred during undergraduate or graduate education.

Physicians participating in the program must provide services in an underserved practice setting for a minimum of two years with the option to extend the contract for up to two additional years. Practice sites may include public or private non-profit settings and private practices.

In 2006, new award thresholds were established for participants:

- *Advanced-degree Practitioners* may be granted up to \$70,000 total for a two (2) year commitment, or \$105,000 for a three (3) year contract.\*
- *Mid-level Practitioners* may be granted up to \$35,000 total for a two (2) year commitment, or \$52,500 maximum for a three (3) year contract.\*

\*Note that these figures represent the *maximum* award possible over 3 years; they are *not* guaranteed amounts, nor are they representative of recent awards. All awards are paid on a graduated scale.

Since the program's inception in 2001, a total of 51 health professionals have been placed in underserved areas. This is comprised of thirty-one physicians, four certified nurse midwives and three certified nurse practitioners that have been placed in underserved areas of the state.

## DIMER STATISTICS

Statistics show that Delaware's relationships with Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA and Philadelphia College of Osteopathic Medicine function as important resources for Delaware students interested in attending medical school. Statistics also show that of the Delawareans who apply to medical schools nationally, most apply to Jefferson Medical College.

### Number of Delawareans that Applied and Were Accepted Nationally and by Jefferson Medical College

<b>Year</b>	<b>Applied to any Med School *</b>	<b>Matriculated at any Med School</b>	<b>Applied to Jefferson</b>	<b>Accepted at Jefferson</b>	<b>Matriculated at Jefferson</b>
2009	99	47	83	34	29
2008	77	35	61	30	22
2007	92	39	50	29	20
2006	78	38	53	28	17
2005	78	35	62	23	13
2004	64	39	54	23	23
2003	71	34	56	23	23
2002	70	31	57	23	12
2001	64	31	50	21	16
2000	93	49	84	36	24
1999	82	50	72	32	30
1998	90	40	76	28	20
1997	100	41	91	34	26
1996	110	51	51	26	22

\* Source: Association of American Medical Colleges (AAMC), 2009  
[www.aamc.org/data/facts](http://www.aamc.org/data/facts)

**Number of Delawareans that Applied and Were Accepted  
by Philadelphia College of Osteopathic Medicine**

<b>Year</b>	<b>Applied to PCOM</b>	<b>Accepted at PCOM</b>	<b>Matriculated at PCOM</b>
2009	32	15	11
2008	23	7	4
2007	33	9	7
2006	30	10	7
2005	21	7	7
2004	11	7	6
2003	25	6	7
2002	26	7	7
2001	23	4	4
2000	20	6	6

## **DIMER STUDENT APPLICATION AND SELECTION PROCESS**

Students interested in attending any medical school, including Jefferson Medical College, must apply through the American Medical College Application Service (AMCAS) in Washington, DC. After receipt of the AMCAS application, Jefferson identifies Delaware residents and sends them a special form to complete which assures them consideration under the DIMER program. Through DIMER, Jefferson reserves at least 20 admissions for Delaware residents. Applicants must meet the premedical academic requirements of Jefferson Medical College and Jefferson makes the acceptance decisions.

DIMER expanded its program to include a relationship with Philadelphia College of Osteopathic Medicine in 2000. Similarly, students interested in attending Philadelphia College of Osteopathic Medicine apply through the American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS) in Chevy Chase, Maryland. After receipt of the AACOMAS application, PCOM identifies the Delaware residents for consideration under the DIMER program. Through the program, PCOM reserves at least 5 admission slots for Delaware residents. Applicants must meet the academic requirements of PCOM and PCOM makes the acceptance decisions.

### **DIMER Student Enrollment Status at Jefferson**

<b>Year</b>	<b>1st Year</b>	<b>2nd Year</b>	<b>3rd Year</b>	<b>4th Year</b>	<b>Total Enrolled</b>
2009	29	22	20	17	88
2008	22	20	17	13	72
2007	20	17	13	24	74
2006	17	13	24	21	75
2005	13	23	23	12	71
2004	23	23	12	16	74
2003	23	12	16	24	75
2002	12	16	24	26	78
2001	16	24	26	22	88
2000	24	28	21	23	96
1999	30	16	22	22	90
1998	21	25	21	19	86

**DIMER Student Enrollment Status at PCOM**

<b>Year</b>	<b>1st Year</b>	<b>2nd Year</b>	<b>3rd Year</b>	<b>4th Year</b>	<b>Total Enrolled</b>
2009	11	4	6	8	29
2008	4	7	8	7	26
2007	7	7	7	4	25
2006	7	7	4	8	26
2005	7	4	9	10	30
2004	6	7	7	4	24
2003	7	7	4	6	24
2002	7	4	6	n/a	17

\* Program began in 2000, so no fourth year students were enrolled until 2003.

**JEFFERSON MEDICAL COLLEGE:**

**Geographic Distribution of Delaware Students Interviewed, Accepted and Matriculated**

**Year 2009 Entering Class**

<b>County:</b>	<b>New Castle</b>	<b>Kent</b>	<b>Sussex</b>
<b>Total DIMER Applicants</b>	73	4	6
<b>DIMER Applicants Interviewed</b>	40	0	3
<b>Acceptances Offered</b>	31	0	3
<b>Students Matriculated</b>	26	0	3

**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE:**

**Geographic Distribution of Delaware Students Interviewed, Accepted and Matriculated**

**Year 2009 Entering Class**

<b>County:</b>	<b>New Castle</b>	<b>Kent</b>	<b>Sussex</b>
<b>Total DIMER Applicants</b>	26	2	4
<b>DIMER Applicants Interviewed</b>	14	2	2
<b>Acceptances Offered</b>	11	2	2
<b>Students Matriculated</b>	7	2	2

**JEFFERSON MEDICAL COLLEGE:**

**Demographic Characteristics of Delaware Students Attending**

**Race and Ethnicity  
(As self-reported by students)**

Year	Race/ethnicity										
	White	Black	Hispanic	Asian	Korean	Japanese	Chinese	Filipino	Indian/Pakistani	Vietnamese	Hawaiian
2009	18			6	1		2		1	1	
2008	17			3	1						
2007	12	1		6						1	
2006	14		1	1	1						
2005	11			1		1					
2004	17					1	1	1	3		
2003	12			2			2	2	5		
2002	9	1						1	1		
2001	12				1		1		1	1	
2000	14	1		1	2		1		4		1
1999*	17	2			3		3		3		
1998	15	2	1	2			1				
1997	21	1					3			1	
1996*	18	1								2	
<i>Totals</i>	<i>190</i>	<i>9</i>	<i>2</i>	<i>19</i>	<i>8</i>	<i>2</i>	<i>14</i>	<i>4</i>	<i>18</i>	<i>6</i>	<i>1</i>

\* Indicates "no-response" answer(s) received in the race/ethnicity category





**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE:**

**Demographic Characteristics of Delaware Students Attending**

**Race and Ethnicity  
(As self-reported by students)**

Year	Race/ethnicity					
	White	Black	Filipino	Hispanic	Indian/ Pakistani	Vietnamese
2009	6	1	1		3	
2008	4					
2007	5	1			1	
2006	4				2	1
2005	7					
2004	3	2			1	
2003	5				2	
2002	6			1		
2001	4					
2000	4					
<i>Totals</i>	<i>44</i>	<i>4</i>	<i>1</i>	<i>1</i>	<i>9</i>	<i>1</i>

**JEFFERSON MEDICAL COLLEGE:**

**Gender of  
Delaware Students Attending**

Year	Male	Female
2009	12	17
2008	13	8
2007	10	10
2006	6	11
2005	6	7
2004	12	11
2003	12	11
2002	11	1
2001	8	8
2000	15	9
1999	18	11
1998	12	9
1997	17	9
1996	13	12
<i>Totals</i>	<i>165</i>	<i>134</i>

**PHILADELPHIA COLLEGE OF  
OSTEOPATHIC MEDICINE:**

**Gender of  
Delaware Students Attending**

Year	Male	Female
2009	6	5
2008	2	2
2007	3	4
2006	3	4
2005	7	0
2004	3	3
2003	3	4
2002	4	3
2001	3	1
2000	4	2
<i>Totals</i>	<i>38</i>	<i>28</i>

## DIMER LOAN STATUS

New student loans were not awarded after 2000. The DIMER loan program was phased out and replaced with a tuition supplement and need based scholarship program.

In 2000, the last year of the program, four medical students attending Jefferson Medical College were awarded first time loans. Demographic characteristics of the loan recipients are as follows:

<u>Gender</u>	<u>Race</u>	<u>Geography</u>	<u>Years in School</u>
2 male	3 White	2 New Castle	2 1 <sup>st</sup> year
2 female	1 African American	2 Kent	2 2nd year

New student loans were not awarded in 1999, while the program was being evaluated and restructured.

In 1998, six medical students were awarded first time loans. Demographic characteristics of the loan recipients are as follows:

<u>Gender</u>	<u>Race</u>	<u>Geography</u>	<u>Years in School</u>
4 male	4 Caucasian	5 New Castle County	3 1st year
2 female	1 African American	1 Sussex County	2 2nd year
	1 Asian		1 3rd year

A total of 37 students had service obligations through the loan program by September 2001. No awards were granted in 2001, as the program was being phased out.

The first student to complete residency training did so in 1998 and began practice in New Castle County, Delaware.

One student completed residency training in 1999. He chose to pursue a specialty and repaid his loan in full.

Four students completed their residency training in 2000; three of the four entered primary care practice in Delaware and one chose to pay back his loans.

Six students completed their residency training in 2001; three entered primary care practice in Delaware and three chose to repay their loans.

Five students completed their residency training in 2002; four entered primary care practice in Delaware; one chose to stop practicing medicine and repaid his loan; one chose to repay her loan when her spouse was unable to find an electrophysiology position in Delaware and accepted a position in Greenville, South Carolina; and a sixth student withdrew from medical school and repaid her loan.

Five students completed their residency training in 2003; three entered primary care practice in Delaware; one chose to pursue a specialty and repaid his loan; one chose to repay her loan when her husband was not able to find suitable employment in or close to Delaware and they decided to relocate their family to North Carolina; and a sixth student was academically dismissed and repaid her loan.

Two students completed their residency training in 2004 and entered primary care practice in Delaware.

Five students completed their residency training in 2005; four entered primary care practice in Delaware; one was accepted into a fellowship, chose not to return to Delaware and repaid her debt in full. Two other students withdrew from medical school and repaid their loans; and one withdrew from medical school and had the loan cancelled.

No students with loans completed residency training in 2006 because there was one year when loans were not awarded while the program was being restructured.

Three students completed their residency training in 2007; one has been granted an extension until July 2010 while her significant other completes an Orthopedics Residency in Philadelphia, after which she plans to return to Delaware to practice; one was granted an extension to complete a Cardiology residency, after which he repaid his loan in full; one has entered primary care practice in Delaware; and a fourth student was academically dismissed and has entered cash repayment of the loan.

The final grant/loan recipient completed her residency in 2008, and was granted a deferment until July 2009 to complete a health policy fellowship in California. She chose not to return to Delaware and repaid her loan in full.

*Note: Because the length of time it takes students to complete medical school and the length of residencies can vary, it is possible these dates may change.*

## EVALUATION OF THE DIMER GRANT/LOAN PROGRAM

Close monitoring of the DIMER loan program led the Board to determine that a formal evaluation of the program was needed. The evaluation began in 2000 with a review of the data. Initial findings indicated the need for changes to the basic structure. These findings included the following:

- The program did not effectively and efficiently help Delaware meet its immediate health care needs; it was generally seven years after the first loan installment until the service repayment obligation began.
- The program did not improve the ability of Delaware students to attend Jefferson Medical College. Students were approved for the loans after being accepted into Jefferson and securing other means of funding.
- Under federal tax law, it appeared that the funds might be considered taxable income to the students at the time they began to fulfill their service repayment obligation. This significantly reduced the financial advantage the loans were intended to provide.
- The attrition rate was almost 25 percent.

In 2001 the DIMER Board phased out the grant/loan program and replaced it with a tuition supplement and need based scholarship program.

The grant/loan program was phased out as follows:

- Grant/loan recipients up to 2000 retained their obligations to return to Delaware to practice.
- From that point forward the repayment obligation was removed from the scholarships and they were phased out in the following manner:
  - Year one – 2001-2002 academic year - recipients received 80 percent of the award
  - Year two – 2002-2003 academic year - recipients received 60 percent of the award
  - Year three – 2003-2004 academic year - recipients received 40 percent of the award
  - Grant/loan recipients were able to apply for a need-based scholarship to supplement their tuition.
  - Grant/loan recipients were able to apply for the loan repayment program in exchange for returning to Delaware to practice in a designated specialty and geographic shortage area.

The former grant/loan program has been replaced with a new tuition supplement and need-based scholarship program:

*Jefferson Medical College*

- The students selected during the June 20, 2001 interview process were each awarded a one-time scholarship of \$10,000 with no repayment obligation.
- All remaining 2001 freshmen were eligible to compete for a need-based scholarship; 11 scholarships were awarded, ranging from \$2,671 to \$19,476.
- All 2001 Delaware freshmen received a tuition supplement of \$1,000.
- All 2001 Sophomores, Juniors, and Seniors received a one-time tuition supplement of \$1,500.
- In 2002, it was determined that there were enough funds to provide tuition supplements and need based scholarships to all four classes immediately, rather than phasing a class into the program each year. This was largely due to the fact that fewer students were enrolled than estimated when the plan was developed. As a result, all Freshmen, Sophomores, Juniors and Seniors received a \$1,000 tuition supplement, and were eligible to compete for a need-based scholarship; 33 scholarships were awarded, ranging from \$1,448 to \$14,174
- In 2003, 68 students received a \$1,000 tuition supplement and were eligible to compete for a need-based scholarship; 43 scholarships were awarded, ranging from \$323 to \$10,840.
- In 2004, 68 students received a \$1,000 tuition supplement, and 2 students received a \$500 tuition supplement. All 70 students were eligible to compete for a need-based scholarship; 47 scholarships were awarded, ranging from \$1,112 to \$12,141.
- In 2005, 70 students received a \$1,000 tuition supplement and 72 scholarships were awarded, ranging from \$291 to \$12,114.

- In 2006, 75 students received a \$1,000 tuition supplement and 50 scholarships were awarded, ranging from \$383 to \$10,811.
- In 2007, 73 students received a \$1,000 tuition supplement and 47 scholarships were awarded, ranging from \$958 to \$10,396.
- In 2008, 72 students received a \$1,000 tuition supplement and 48 scholarships were awarded, ranging from \$246 to \$11,334.
- In 2009, 85 students received a \$1,000 tuition supplement and 47 scholarships were awarded, ranging from \$3,994 to \$11,370.

*Philadelphia College of Osteopathic Medicine*

- All 2001 and 2002 Delaware Freshmen and Sophomores received a tuition supplement of \$1,000 and were eligible to compete for a need-based scholarship; 6 scholarships were awarded in 2001, ranging from \$2,207 to \$6,302; 9 scholarships were awarded in 2002, ranging from \$1,317 to \$5,430.
- All 2001 Delaware Freshmen received an additional one-time tuition supplement of \$500.
- In 2003, Delaware Freshmen, Sophomores and Juniors received a tuition supplement of \$1,000 and were eligible to compete for a need-based scholarship; 19 tuition supplements were awarded and 17 scholarships were awarded, ranging from \$882 to \$3,611.
- In 2004, Delaware Freshmen, Sophomores, Juniors and Seniors received a tuition supplement of \$1,000 and were eligible to compete for a need-based scholarship; 21 tuition supplements were awarded and 17 scholarships were awarded, ranging from \$1,523 to \$5,500.
- In 2005, 25 students received a \$1,000 tuition supplement and 20 scholarships were awarded, ranging from \$896 to \$4,379.
- In 2006, 23 students received a \$1,000 tuition supplement and 20 scholarships were awarded, ranging from \$935 to \$4,082.
- In 2007, 18 students received a \$1,000 tuition supplement and 14 scholarships were awarded, ranging from \$2,170 to \$5,828.
- In 2008, 26 students received a \$1,000 tuition supplement and 18 scholarships were awarded, ranging from \$1,566 to \$4,214.
- In 2009, 29 students received a \$1,000 tuition supplement and 21 scholarships were awarded, ranging from \$500 to \$3,972.

## **TUITION AND FEES AT JEFFERSON MEDICAL COLLEGE, PCOM AND SURROUNDING STATES**

DIMER was formed as an alternative for establishing a medical school in Delaware. Through agreements with Jefferson Medical College and the Philadelphia College of Osteopathic Medicine slots are reserved for Delawareans who meet each school's entrance requirements. Since both schools are private, and therefore, carry high tuition rates, funds are provided to students in either the form of tuition supplements or scholarships based on financial need.

The DIMER Board is growing concerned that the high tuition of both schools may present barriers to some Delawareans taking advantage of the program. Tuition and fees at Jefferson are currently \$44,547 per year. Tuition and fees at PCOM are \$38,625 per year. The Board has recommended consideration of increasing the amount of funds allocated for scholarships and tuition supplements. When the original scholarship line amount of \$400,000 was allocated, 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 Fiscal Year 1996.

The high tuition, and corresponding prospect of accumulating significant debt upon graduation from medical school is regarded as a barrier to recruiting key target populations to the DIMER program.

The \$400,000 allocation for scholarships and tuition supplements at Jefferson Medical College has remained constant since 1996. During this thirteen year period tuition has increased by about 74 percent from \$25,235 in 1996 to \$44,022 in 2009. A 74 percent increase in scholarship and tuition supplement funds would amount to an additional \$296,000 for students at Jefferson.

Funds were allocated for scholarships and tuition supplements at PCOM in 2000 and phased in over a four-year period at the rate of \$20,000 per class. During the past nine years tuition has increased by about 56 percent from \$24,725 in 2000 to \$38,625 in 2009. A 56 percent increase in scholarship and tuition supplement funds would amount to an additional \$44,800 for students at PCOM.



Tuition and fees (not including health insurance) for first year medical students at Jefferson Medical College and PCOM for the 2009-2010 academic year:

Jefferson Medical College	\$44,547
PCOM	38,625

Tuition and fees (not including health insurance) for first year medical students in public medical schools in surrounding states for the 2009-2010 academic year:

<u>School</u>	<u>Resident</u>	<u>Non-Resident</u>
Connecticut	\$26,956	\$50,001
Maryland	25,719	45,763
North Carolina	13,408	37,474
Pennsylvania State	36,086	47,664
South Carolina	28,278	62,112
SUNY- Downstate	23,363	41,203
SUNY – Upstate	24,112	41,952
Virginia	35,150	45,150
West Virginia	21,270	46,018

Tuition and fees (not including health insurance) for first year medical students in private medical schools in surrounding states for the 2009-2010 academic year:

<u>School</u>	<u>Resident</u>	<u>Non-Resident</u>
George Washington	\$47,644	\$47,644
Georgetown	46,177	46,177
Harvard	44,119	44,119
Howard	36,781	36,781
Johns Hopkins	40,608	40,608
New York Medical	44,472	44,156
New York University	45,353	45,353
University of Pennsylvania	45,644	45,644
University of Pittsburgh	37,486	41,506
Temple	41,936	51,202
Tufts	50,968	50,968
Yale	44,350	44,350

## **STUDENT EXPENSE BUDGETS AT JEFFERSON MEDICAL COLLEGE AND PCOM**

In addition to tuition and fees, students at Jefferson Medical College and PCOM encounter additional expenses. The sum total of tuition, fees and other expenses is known as the standard budget for medical students.

### **Standard Budget for Medical Students at Jefferson Medical College**

The following is the standard budget for medical students at Jefferson Medical College, including tuition, room, board, books, supplies and transportation:

1 <sup>st</sup> year students	\$ 68,669
2 <sup>nd</sup> year students	68,156
3 <sup>rd</sup> year students	72,736
4 <sup>th</sup> year students	<u>68,956</u>
Total	\$278,517

### **Standard Budget for Medical Students at PCOM**

The following is the standard budget for medical students at PCOM, including tuition, room, board, books, supplies and transportation:

1 <sup>st</sup> year students	\$ 63,080
2 <sup>nd</sup> year students	62,245
3 <sup>rd</sup> year students	69,870
4 <sup>th</sup> year students	<u>68,885</u>
Total	\$264,080

**Addendum I: DIMER Board of Directors**

*Chair*

**Sherman L. Townsend**

*Board Members*

**Brian M. Aboff, MD, FACP**

Christiana Care Health Services

**Brian W. Little, MD, PhD**

Christiana Care Health Services

**Michael Alexander, MD**

A. I. DuPont Hospital for Children

**Vincent Lobo, Jr., DO**

Public Member, Sussex County

**Anthony D. Alfieri, DO**

Public Member, Wilmington

**Kathleen S. Matt, PhD**

University of Delaware

**Lisa C. Barkley, MD**

Delaware State University

**Karyl T. Rattay, MD, MS, FAAP, FACPM**

Division of Public Health

**David A. Barlow, PhD**

Delaware Higher Education Commission

**James Richards, PhD**

University of Delaware

**David Bercaw, MD**

Christiana Care Health Services

**Wayne A. Smith**

Delaware Healthcare Association

**John A. J. Forest, Jr., MD**

Public Member, Kent County

**Carl Turner, MD**

Public Member, New Castle County

**Galicano F. Inguito, Jr., MD, MBA, CPE**

St. Francis Hospital

*Jefferson Medical College Liaisons*

**David Paskin, MD**

*Philadelphia College of Osteopathic Medicine Liaison*

**Carol A. Fox**

*Staff*

**Paula K. Roy**

**Leah A. Jones**

**Marlyn Marvel**

Delaware Health Care Commission

**Stuart Drowos**

Department of Justice

**Maureen Laffey**

**Carylin Brinkley**

Delaware Higher Education Commission

## **Addendum II: DIMER Budget**

The Delaware General Assembly appropriated \$2,130,000 to the Delaware Institute of Medical Education and Research for Fiscal Year 2010. The amount was allocated as follows:

Jefferson Medical College	\$1,000,000
Philadelphia College of Osteopathic Medicine	250,000
University of Delaware	50,000
Christiana Care Health System	200,000
Scholarships/Loans	480,000
Loan Repayment	150,000
Total	\$2,130,000

## **Addendum III: Delaware Jefferson Medical College Students 2009 – 2010 Academic Year**

### First Year Freshman

Berg, Amanda  
Biederman, Laura  
Casscells, Nicholas  
Cherian, Deepthi  
Coan, Amy  
Craft, Coliin  
Gambogi, Alexander  
Jackson, Brittany  
Jain, Neeta  
Jones, Upasana  
Jordan, Nathan  
Kim, Gina  
Lee, Anne  
Lewin, Eleanor  
Mahmood, Ali  
Morrison, Todd  
Myrick, Stephanie  
Nguyen, Aivi  
Noyes, Jillian  
Ober, Aaron  
Peeke, Stephen  
Peri, Neeraja  
Richards, Christopher  
Richards, Matthew  
Varma, Archana  
Yadhavi, Akshay  
Young, Sharon  
Zaroli, Katherine  
Zussman, Benjamin

### Second Year Sophomores

Ali, Mohsin  
Andrews, Jonathan  
Bonk, Michael  
Boyd, Laura  
Chiquoine, Elise  
Choxi, Hetal  
Feld, Samantha  
Harshman, Scott  
Henderson, Stacy  
Hinman, Benjamin  
Kamireddy, Samata  
Lee, Brian  
Margules, Andrew  
McSpadden, Ryan  
Mendelson, Aaron  
Mullan, Adam  
Ortlip, Timothy  
Rivers, Lane  
Rybicki, Steven  
Sammons, Sarah  
Swank, Amanda  
Vincent, Richard

### Third Year Juniors

Anttila, Ashley  
Brighthaupt, Sarah  
Devulapalli, Chaitu  
Dobson, Phillip  
Douglas, Lauren  
Fattah, Mohammad  
Field, John  
Gopalratnam, Anusha  
Gupta, Ratika  
Hummel, Chad  
Johnson, Caitlyn  
Kulkarni, Sanjay  
Molligan, Jeremy  
Reardon, Emily  
Sabesan, Arvind  
Saligrama, Madhuri  
Sarik, Jonathan  
Schuck, Alexandra  
Strang, Abigail  
Wilkins, Cy

### Fourth Year Seniors

Cleary, Ryan  
Crowe, Elizabeth  
Davis, Erin  
Farach, Andrew  
Fierro, Michael  
Golebiewski, Stefanie  
Grenda, Tyler  
Hanley, Patrick  
Hansen, Patricia  
Healy, Kenna  
Juliano, Trisha  
Kim, Su  
Koterwas, Jennifer  
Liechty, Benjamin  
Schoch, Laura  
Witkin, Alison  
Yezdani, Mona

## Addendum IV: DIMER Grant/Loan Recipient Status

Name	JMC Graduation	Residency Completion	2009 Status
Peluso, Susan	1995	1998	Completed Service Repayment
Anzilotti, Kent	1996	1999	Completed Cash Repayment
Clute, Stephen	1997	2000	Completed Cash Repayment
Longo, Michael	1997	2000	Completed Service Repayment
O'Brien, Matthew	1997	2000	Completed Service Repayment
Williams, Jane	1997	2000	Completed Service Repayment
Bowman, Adam	1998	Psychiatric Fellowship	Completed Service Repayment
Burke, Stephen	1998	2001	Completed Service Repayment
Simpkins, John	1998	2001	Cash Repayment
Phillips, Christine	1998	2001	Completed Cash Repayment
Schmeig, Andrea	1998	2001	Cash Repayment
Sordi, Mark	1998	2001	Completed Service Repayment
Brown, Barrington	1999	2002	Completed Service Repayment
Grady, Matthew	1999	2002	Completed Service Repayment
Poppiti (Manfredi), Alissa	1999	2002	Completed Cash Repayment
Villasenor, Paul	1999	2002	Completed Cash Repayment
Mancuso, Maria	1999	2002	Completed Service Repayment
Pak, Susan	1999	Withdrew	Completed Cash Repayment
Davis, Angelique	2000	Academic Dismissal	Completed Cash Repayment
Nelson, Anne	2000	2003	Completed Service Repayment
Kirk (Neuberger), Deborah	2000	2003	Completed Service Repayment
Robinson, Amy	2000	2003	Completed Service Repayment
Zeberkewic (Reinhardt), Claire	2000	2003	Completed Cash Repayment
Peters, Michael	1998	2003	Completed Cash Repayment
Hammer, Scott	2001	2004	Completed Service Repayment
Young, Robert	2001	2004	Completed Service Repayment
Elliott, Daniel	2001	2005	Service Repayment
Jordan, Trisha	2001	2005	Service Repayment
Pondok, Theresa	2001	2005	Completed Cash Repayment
Rappaport, David	2001	2005	Completed Service Repayment
Corradi, Emily	2002	Withdrew	Completed Cash Repayment
Dassel, Jeffrey	2002	2005	Completed Service Repayment
Dukes, Donald	2002	Withdrew	Loan Obligation Cancelled
Jackson, Edward	2002	Withdrew	Completed Cash Repayment
Lehane, Christina	2003	2007	Deferment until 2010
Davis, Angelique	2004	Academic Dismissal	1 <sup>st</sup> year of a 2 year hardship deferment effective 9/25/09
McGillen, Brian	2004	2007	Pending confirmation of service repayment completion
Myers, Gene Robert	2004	2007	Completed Cash Repayment
Black, Kara Lynn	2005	2008 U of CA Residency	Completed Cash Repayment

**Addendum V: Philadelphia College of Osteopathic Medicine Students  
2009 – 2010 Academic Year**

First Year Freshman

Dougherty, Lauren  
Frasso, Charles  
Haack, Hilary  
Manolakos, Athena  
Mmagu, Obinna  
Moore, Edward  
Patel, Monil  
Patel, Kajal  
Tung, Navjot  
Wolf, Kevin  
Zarraga, Christopher

Second Year Sophomores

Loiacono (Cullen), Julia  
Molchen, Wallis  
Paoli, Matthew  
Santora, Joseph

Third Year Juniors

Batool, Amber  
Danko, John  
Doran, William  
Heckert, Anneliese  
McKiel, Holly  
Ratner, Aaron

Fourth Year Seniors

Cohen, Valerie  
Khasat, Vikram  
Little, Eric  
Mosca, Heather  
Nashed, Nadia  
Solanki, Anjali  
Tung, Puneet  
Walsh, Brian