

Delaware Health Care Commission

# Annual Report and Strategic Plan, 2008

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

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# Mission Statement & Key Objectives

**Mission:** To promote accessible, affordable, quality health care for all Delawareans.

## Key Objectives:

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

**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 2008 Annual Report to the Governor and to the Delaware General Assembly. This report summarizes the extent to which the Commission's mission and goals have been met, the challenges that exist, and strategies that are needed to address them.

Health care issues are again at the forefront of discussions among state and national leaders who face an array of challenges related to rising health care costs, declining insurance coverage, and the prevalence of chronic disease. Innovative insurance coverage plans, disease management and prevention, workforce recruitment and adoption of health information technology are common strategies being explored to ensure access to quality, affordable health care for all citizens.

The health care system in Delaware has strengths and challenges. Delaware outperforms regional and national averages on the proportion of the population that is uninsured. However, challenges exist in maintaining insurance coverage levels, particularly for small businesses. Other concerns include childhood and adult obesity rates, 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.

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

# Five Things You Should Know About Health Care in Delaware

## **About 12 percent of us are uninsured:**

- Approximately 106,000 Delawareans (12.5 percent of the population) are without health insurance. About 26 percent, or 27,430 people who are uninsured are actually eligible for public coverage through either Medicaid (18 percent or 18,590 people) or the Delaware Healthy Children Program – S-CHIP (8 percent or 8,840 people). Another 20 percent (about 20,720 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:**

- For example, the probability of being uninsured is linked to individuals' income levels, which are linked to their level of education and where they work. Employees of small firms and organizations are less likely to have insurance than employees of large firms. The higher the level of education, the higher the income and the greater the chance of having a job that offers insurance or the financial stability to purchase it. The exception is for the very poor, who are eligible for public programs such as Medicaid and S-CHIP.

## **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. For example, a black newborn in Delaware is expected to live 74 years, while a white newborn is expected to live 78 years. Another example of disparities is found in the infant mortality rates in Delaware from 2001-2005. Overall, the rate in DE for blacks was 17.1 percent, compared to 6.8 percent for whites. 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.

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

- Overall, \$5.9 billion was spent on personal health care (about \$7,000 per person) in Delaware in 2006, compared to \$5 billion in 2003 and \$5.8 billion in 2005. The annual rate of growth averages about 6 percent per year. The largest share of spending is on hospital care (39 percent), physicians (25 percent), and drugs (15 percent). Notably, the health care sector is a significant source of employment for the Delaware economy, accounting for 11 percent of the total workforce and 11 percent of all reportable wages. Today about 49,000 people are employed in the health care industry, compared to just 29,000 in 1990.



# Executive Summary

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

- 1. Uninsured Action Plan** – 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 of health care professionals through the *State Loan Repayment Program* and the *Health Workforce Data 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 insurance coverage options for Delaware. Over the course of the past six years 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).

In 2008 the Commission will introduce legislation seeking to reform current small group insurance regulations (Chapter 72, Title 18) to make them easier to understand and enforce, and to reduce rate variation so premiums are more stable and predictable. Also, the Commission will cooperate with the State Insurance Department, endorsing legislation to create a subsidized insurance purchasing pool for small group employers. Rising health care costs and insurance premiums have made it difficult for some businesses and non-profit organizations to afford coverage for their employees. High costs are often passed on to low-

income employees, and as a result, coverage may be dropped. The goal of a purchasing pool is to assist small group employers with purchasing health insurance for their employees, thus preserving existing coverage.

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. Additionally, an analysis of delivery designs, including cost estimates, will be conducted for a program that would provide preventive and primary care services to a broad array of Delawareans to improve health. Lastly, a marketing study of how and why consumers use community health centers will be expanded to include additional federally qualified health centers, and strategies will be developed to promote the use of these facilities.

The Commission's long-term coverage strategy is the analysis of universal insurance coverage systems for Delaware. In 2008 two models will be analyzed using econometric modeling: traditional single-payer and a "building block" model that makes use of existing systems and other state reforms.

### ***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 "safely net" and it connects low-income uninsured Delawareans with physicians and health care resources such as prescription medication, physical therapy, radiology, and laboratory services offered at reduced cost. Patients with incomes below 200 percent of the federal poverty level (FPL) who are ineligible for other state or federal medical assistance are matched with doctors at hospitals, private practices, and community health centers throughout the state. The target population for CHAP is comprised of approximately 20 percent of the state's uninsured population, about 20,720 adults. Since the inception of the program in 2001, and as of September 30, 2007, CHAP has served over 13,487 uninsured patients and enrolled 2,893 in other state and federal medical assistance programs like Medicaid and the Veteran's Administration.

In 2006 a health risk assessment and disease management component was added to CHAP, allowing the program's focus to shift to those enrollees with chronic conditions and the highest medical need. In 2007 evaluation began, which demonstrated some success of CHAP in improving personal health outcomes. In 2008, evaluation will continue as well as recruitment of uninsured participants and, when appropriate, enrollment of eligible citizens in other medical assistance programs.

## **2. INFORMATION & TECHNOLOGY**

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

Health information technology has emerged as a national priority and Delaware has become a leader in the development of a statewide health information exchange network. DHIN oversees the development and adoption of a statewide clinical health information exchange designed to provide secure, fast and reliable electronic exchange of health information between providers (hospitals, physicians, laboratories, pharmacies, etc.) The goal is to improve patient safety and quality of care. A major contributing factor to medical errors is

the lack of information at the time and place of service. This problem also contributes to an increase in costs resulting from the unnecessary duplication of diagnostic tests and procedures that are performed in the absence of data that exists but is unavailable to health care providers.

Implementation of Phase 1 of DHIN, secure results delivery, was successfully completed in March 2007. Currently DHIN provides a streamlined results distribution system that delivers approximately 85 percent of lab tests and 81 percent of hospital admissions to over 130 health care providers at five hospitals and fifteen physician practices throughout the state. In 2008 DHIN will implement Phase 2: patient record inquiry. 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. 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).

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

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

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

DIMER and DIDER were established by the Delaware General Assembly to address the shortage of health professionals in Delaware. They provide enhanced opportunities for Delaware residents to obtain medical and dental education as a cost effective alternative to the State establishing its own schools for these professions. Through DIMER, financial support is provided to Jefferson Medical College and Philadelphia College of Osteopathic Medicine (PCOM) in exchange for reserved admission slots for Delaware students. Scholarships and tuition supplements are also available for the students. In 2008 the Commission will continue to promote health professions to young people while striving to increase the geographic, racial, and ethnic diversity of Delawareans participating in the Jefferson and PCOM partnerships.

In 2008 the Commission will continue to promote a new agreement between DIDER and the Maurice H. Kornberg School of Dentistry at Temple University in Philadelphia, Pennsylvania. 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.

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

This program is designed to recruit health care professionals to federally designated health professional shortage areas throughout the state. Participating clinicians provide health services in an underserved area for a minimum of two years in exchange for payments toward their educational loans. The program has been very successful since increasing the maximum award to \$70,000 for a two-year contract and adding twelve new specialties to the list of eligible clinicians. Since the program's inception in 2001, nine dentists, twenty-seven physicians, two certified nurse midwives and three certified nurse practitioners have been placed in underserved areas of the state. In 2008 the Commission will continue efforts to market the program, with a specific focus on the recruitment of a diverse group of health professionals.

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

The Health Workforce Data 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 helps streamline the fragmented data collection systems that exist throughout the state, creating a comprehensive and objective workforce data resource for stakeholders.

In 2007 the Workforce Data Committee completed a comprehensive study of health education programs, including the full array of programs available in Delaware; the supply of health professional faculty at colleges and universities; and the length of time required for students to complete their education and enter the workforce. The committee will reconvene to determine recommendations for next steps. Also, in 2008 a study designed to assess the supply and distribution of allied health professionals and pharmacists will be completed and published, providing valuable information about shortages among these members of the health workforce.

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

In order to provide accurate and up-to-date information to policy and decision-makers, the Commission performs ongoing research and publishes findings in reports made available to the public. In 2008 the "*Delawareans Without Health Insurance*" report will be continued. Additionally, the "*Total Cost of Health Care in Delaware*" report will be continued and ways to restructure the report to make it more useful will be identified, which may include the replication of a 1999 study on the effects of cost shift.

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

Occasionally, specific health care conditions are so prevalent in Delaware that they warrant special attention. In 2008 the Commission will continue to focus attention on the following issues: mental health, chronic illness and stroke, racial & ethnic disparities, and health insurance pooling. In addition, the Commission is often assigned to cooperate with various bodies created by the General Assembly. Staff will participate and a representative of the Commission will be designated to serve on the *Health Resources Board*, which serves as an advisory body, issuing the Certificate of Public Review for new health-related capital construction projects in the State. Additionally, three commissioners are assigned to serve on the *Health Fund Advisory Committee*, which provides guidance on the allocation of funds received from the State's Tobacco Master Settlement Agreement.

# 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>1</sup> Additionally, a person without insurance is more likely than their insured counterparts to use the emergency department, the most costly source of health services.

## **Uninsured in Delaware**

In 2007 about 12.5 percent of Delaware's total population (pop = 862,000 people) went without health insurance, representing approximately 106,000 uninsured Delawareans<sup>2</sup>. This is an increase from 12.2 percent (101,000 people) in 2006. However, Delaware performs slightly better than regional states and the nation in providing health insurance for its residents<sup>3</sup>. The uninsured rate for the region, which includes Maryland, Delaware, Pennsylvania, New Jersey, and New York, was 13.2 percent and 15.8 for the nation during the same period.

A general profile of the uninsured population in Delaware:

- 76 % are over the age of 18 years
- 56 % are male
- 70 % describe their race as White
- 20 % describe their ethnicity as Hispanic
- 60 % own or are buying their own home
- 18 % live alone
- 82 % are above the poverty line

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

<sup>2</sup> To improve accuracy, the uninsured figures are based on a three-year moving average (2005-2007), which removes year-to-year fluctuations due to random variation associated with sample surveys.

<sup>3</sup> Delawareans Without Health Insurance 2007, Edward C. Ratledge, CADSR, University of Delaware.

35 % have household incomes over \$50,000

58 % are working adults

8 % are self-employed

20 % are non-citizens

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

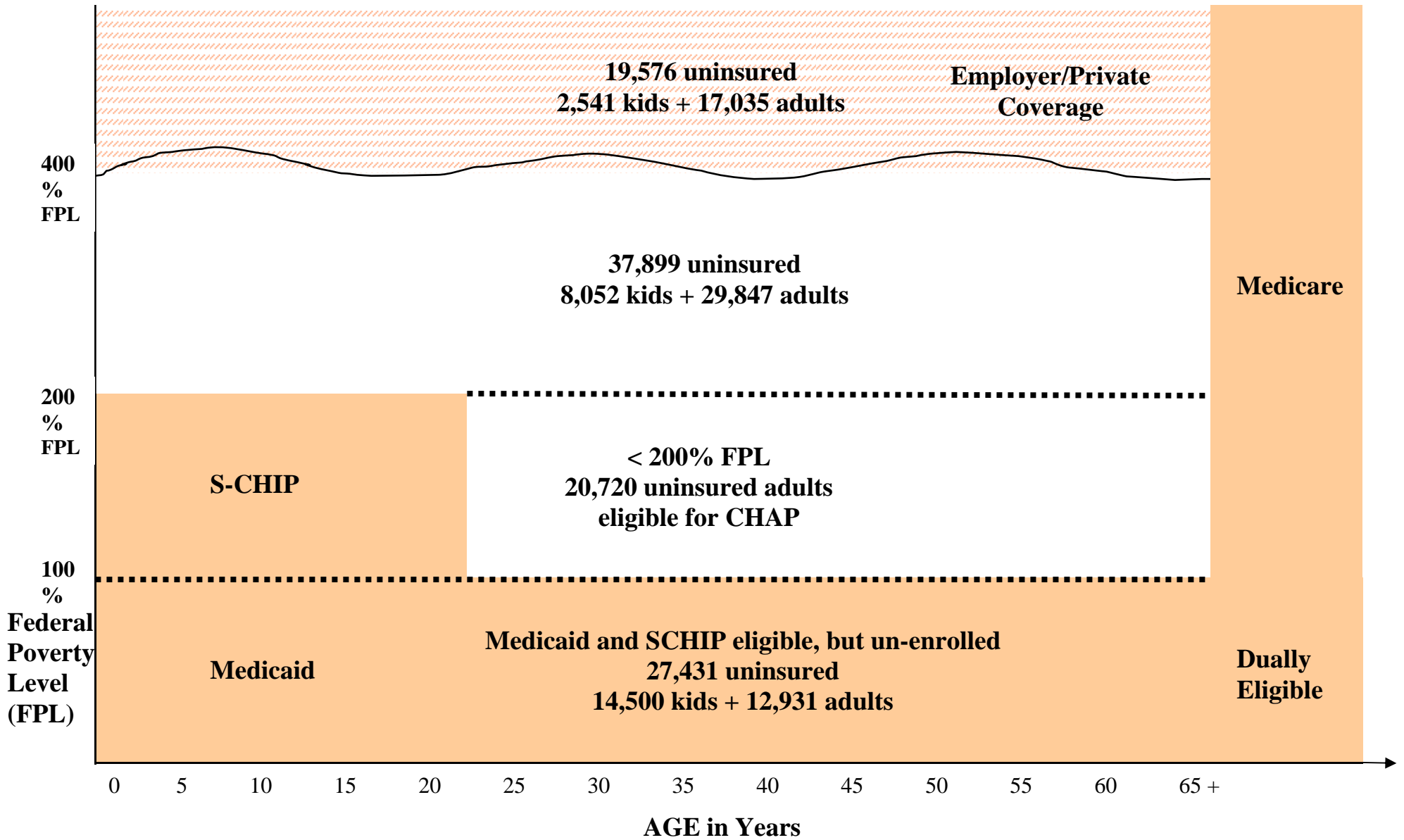
Consider the following:

- Nearly 26 percent of the uninsured population, approximately 27,430 people, are eligible for existing public coverage but are not enrolled. This includes about 12,930 adults and 5,660 children in families with incomes below 100 percent of the federal poverty level (FPL), which is \$20,650 for a family of four<sup>4</sup>. Most of this group is eligible for Medicaid. Additionally, 8,840 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 20,720 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 54 percent, or 57,480 uninsured people in Delaware have family incomes above 200 percent FPL. This includes 10,600 children and 46,880 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.

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<sup>4</sup> *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148.

**Delaware Health Insurance Coverage**  
**Total: 105,626 uninsured (2007)**





**Uninsured in Delaware by Age and Poverty Level-**  
(3-year average 2005-2007)

<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 (2007)</b>
<100 FPL	5,660*	12,931*	18,591	\$20,650 @ 100%
100-199% FPL	8,840 <sup>#</sup>	20,720 <sup>^</sup>	29,560	\$41,300 @ 200%
200-299% FPL	4927	18065	22992	\$61,950 @ 300%
300-399% FPL	3125	11782	14907	\$82,600 @ 400%
400-499% FPL	1367	5844	7211	\$103,250 @ 500%
500+ FPL	1,174	11,191	12,365	>\$103,251

TOTAL UNINSURED = 105,626 people

\* Income eligible for Medicaid.

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

<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 25 percent of Delawareans that work for firms with fewer than 25 employees and 14 percent of those that work for firms with 25-100 employees are uninsured. This is up from 19 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 uninsured (32 percent) followed by people in the trade industry (14 percent) and service industry (14 percent). Those who are self employed are more likely to be uninsured (22 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 2007, compared with 66 percent in 2003 and 69 percent in 2000.<sup>5</sup>

**County Residence**

People who live in Sussex County are more likely to be uninsured (16.5 percent) than people who reside in Kent County (12.9 percent) and New Castle County (11.1 percent). However, although the rate of un-insurance is lowest in New Castle County, the actual number of

<sup>5</sup> Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits- 2007 Summary of Findings. <http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf>

uninsured people is higher there than the other counties. Approximately 57,300 people who live in New Castle County are without health insurance compared to Kent County where 21,300 people are uninsured and to Sussex County where 27,100 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 (10.4 and 10.2 percent respectively), while single person households are the most likely to report being uninsured (13.8 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	12.1%
5-17 years	11.5%
18-29 years	21.2%
30-64 years	13.2%
65+ years	Not measured due to Medicare coverage

**Race and Ethnicity**

Delawareans who classify their race as black have a 13.7 percent chance of being uninsured, compared to 11.8 percent of those who report being white. In terms of ethnicity, 36.6 percent of Hispanics are uninsured (a significant increase from 25 percent in 2003), compared to 10.7 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. The State is currently in the process of applying for federal shortage area designations for mental health professionals as well.

Throughout Delaware there are shortages of primary care physicians<sup>6</sup> and mental health providers<sup>7</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>8</sup> Based on predictions, thousands of health professionals need to be educated and/or recruited over the next five to ten years to meet the needs of Delaware's growing and aging population.<sup>9</sup>

Additionally, critical shortages among radiological technicians, laboratory technicians, pharmacists, and other allied health professionals are reported among practitioners "in the field". In 2008 a study designed to assess the supply and distribution of allied health professionals and pharmacists in the state will be 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. Results are being collected and analyzed by CADSR and a final report is expected in early 2008.

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. Since the program's inception in 2001, a total of 41 professionals have been placed in underserved areas. This is comprised of nine dentists, twenty-seven physicians, two certified nurse midwives and three certified nurse practitioners that have been placed in underserved areas of the state. Thirteen practitioners were placed in New Castle County, ten in Kent County and eighteen in Sussex County.

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. Through financial agreements with DIMER and DIDER, annual admissions slots are held for Delawareans at three reputable medical and dental schools in the region: Jefferson Medical College (20 slots), Philadelphia

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<sup>6</sup> Primary Care Physicians in Delaware 2006, prepared for the Delaware Division of Public Health by Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

<sup>7</sup> Mental Health Professionals in Delaware 2005, prepared by Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

<sup>8</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>9</sup> Delaware Healthcare Association. "Acute Care Hospitals and Health Systems Workforce Needs." June 2004.

College of Osteopathic Medicine (5 slots) and the Temple University School of Dentistry (6 slots). Also, through the generosity of the Delaware General Assembly funds are provided to the Delawareans attending these schools in the form of tuition stipends.

The Commission's Health Workforce Data Committee is charged with identifying needs for health workforce information, collecting data and providing resources to coordinate strategies to predict and prevent shortages. This Committee helps streamline the fragmented data collection systems that exist throughout the state today, creating a comprehensive and objective workforce data resource for stakeholders. The Committee hopes to partner with the Division of Professional Regulation to determine options for the collection of valuable health professional data through the on-line licensure process. Discussions are also underway in cooperation with the Division of Substance Abuse and Mental Health to create an online mental health professional directory as a resource for referrals within the provider community as well as consumers of health care services.

In 2007 the Workforce Data Committee completed a critical and comprehensive study of health education programs available in Delaware including the supply of health professional faculty at colleges and universities, and the length of time required for students to complete their education and enter the workforce. The goal was to determine whether Delaware is producing an adequate supply of health professionals to meet the needs of the state's growing population, and to better understand the unique components of educational programs, such as how long it takes to train various professions as well as any particular challenges that might exist in the "educational pipeline" for our health workforce. In 2007 the committee will reconvene to determine recommendations for next steps.

# Health Care – Cost

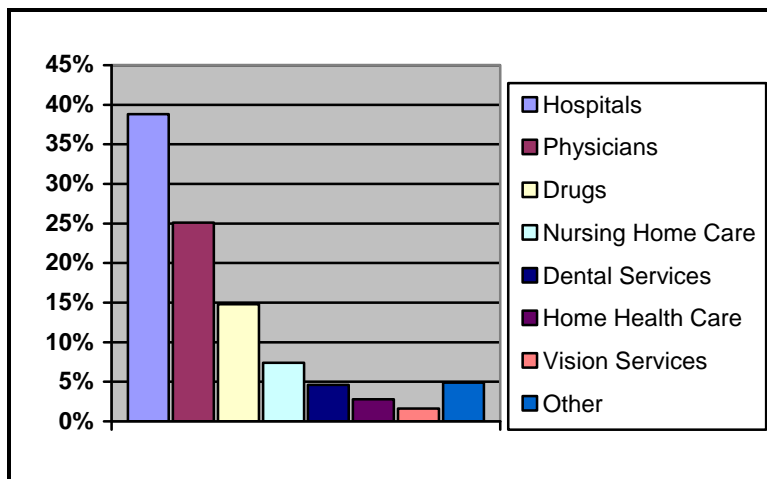
In 2006 about \$5.9 billion was spent on personal health care in Delaware (about \$7,000 per person), an increase from about \$5 billion in 2003 and \$5.8 billion in 2005. Comparatively, the United States spends about \$6,000 per person on health care. Delaware is generally in the mainstream among states 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 6 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 177,000 people have joined Delaware’s population (a growth rate of 28 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, 39 percent is spent on hospital care and 25 percent on physicians and other health professionals. Most of the remainder is comprised of drugs (15%), nursing home care (7%), dental services (5%), home health care (3%), vision services (2%), and other (5%).

**Personal Health Care Expenditures in Delaware:  
Share of Total Expenditures in 2006 by Category**



Source: Center for Applied Demography and Survey Research, University of Delaware.

The structure of the health care industry is becoming leaner and more efficient. While the population has increased just over 19 percent during the period of 1993 to 2004, the number of hospital beds, admissions and inpatient days declined. Much of this can be attributed to technological improvements, allowing for fewer hospital admissions, shorter lengths of stay and an increase in the provision of outpatient services.

**Economic Impact**

While the U.S. devotes 16 percent of gross domestic product to health care and Delaware only 13 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 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 11 percent of the workforce and 11 percent of reportable wages. Today about 49,000 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 2006, medical services employment growth rate is 2.4%. Hospital employment, by far the largest segment of medical services employment, has exceeded 2% annual growth since 2000.

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 and social services will account for 15% of total job growth between 2002 and 2012, second only to business. Of the 12 fastest growing occupations in Delaware 2002- 2012, six are health-related. Medical assistants and physician assistants are expected to see 49% and 48% growth respectively.

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

<b>Occupation</b>	<b>Average Annual Wages</b>
Licensed Practical Nurse (LPN)	\$42,300
Registered Nurse (RN)	\$57,900
Dental Hygienist	\$49,800
Radiologic Technologists & Technicians	\$42,800
Pharmacists	\$81,800
Optometrist	\$90,800
General Practitioner/Physician	\$111,700

**Source: Delaware Wages 2004, Office of Occupational and Labor Market Information, Delaware Department of Labor.**

**Cost Shift**

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 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 two and a half times 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 over \$28.0 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. In 2006, the proportion of elderly Delawareans over 65 years (the heaviest users of medical care) was about 14 percent. By 2020 this figure will rise to about 19 percent (or 180,000 people). This 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. Between 1992 and 2001, the number of prescriptions purchased increased 68 percent (from 1.9 billion to 3.2 billion.) The average number of prescriptions per person increased from 7.3 to 11.1. Several factors foster this growth. For example, the U.S. Food and Drug Administration (FDA) accelerated its approval process of new drugs and the drug industry increased its promotion of these drugs with direct-to-consumer advertising. The outlook for drug expenditures is for continued strong growth.

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

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

# Health Care – Quality

## **Health Indicators**

### *Delaware Vital Statistics Annual Report (DVSAR) 2005*

One way to monitor health care quality in Delaware is through public health indicators. According to Delaware Vital Statistics Annual Report (DVSAR) 2005 (the latest year available at time of printing), the first and second leading causes of death continue to be heart disease and cancer, at 27 percent and 24 percent respectively, accounting for more than half of all deaths. Chronic respiratory disease accounts for 6 percent, followed by stroke (5 percent), accidents (4 percent) and diabetes (3 percent). The “all other causes” category represents the remaining 31 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, 2001-2005, DVSAR 2005 statistics show a rate of 9.2 infant deaths per 1,000 births, significantly higher than the U.S. rate of 6.8. For the same time period, Delaware’s age adjusted cancer mortality and HIV death rate were significantly higher than the U.S. rate. On the other hand, Delaware’s age-adjusted stroke mortality rate was significantly lower than the U.S. rate.

### ***America’s Health: State Health Rankings – 2007 Edition***

Overall, according to *America’s Health: State Health Rankings - 2007 Edition* Delaware ranks 34<sup>th</sup>; it was 30<sup>th</sup> in 2006. The report, the 19<sup>th</sup> in a series, is produced by the United Health Foundation in partnership with the American Public Health Association and the Partnership for Prevention. The study methodology weighs the contributions of various factors, including a number of risk factors -- such as the presence of health insurance and the prevalence of smoking -- and health outcomes, such as cancer deaths and heart deaths.

According to the report, Delaware’s strengths include high immunization coverage with 84.3 percent of children ages 19 to 35 months receiving complete immunizations, and a low percentage of children in poverty. Delaware is ranked 8<sup>th</sup> in the nation in per capita public health spending at \$246 per person.

Challenges include a high incidence of infectious disease at 31.7 cases per 100,000 population (46<sup>th</sup> in the nation), a high violent crime rate (increased from 432 to 682 offenses per 100,000 population), and a high prevalence of binge drinking at 19.0 percent of the population. Another challenge is the rising rate of obesity: in the past year, the prevalence of obesity increased by twelve percent, from 21 percent in 2005 to 26 percent of the population in 2007. Also, Delaware is ranked 47<sup>th</sup> in the nation, with the 4<sup>th</sup> highest infant mortality rate.

## **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 2005 Report<sup>10</sup>, life expectancy rates for babies born in 2005 exemplify the fact that health disparities exist in Delaware:

White males, 75.7 years	Black males, 71.3 years
White females, 81.1 years	Black females 76.6 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 2001-2005 mortality rate of 33.4 deaths per 100,000 was fourteen times higher than the rates for whites. In the 2001-2005 time period blacks accounted for 78 percent of all deaths due to HIV/AIDS.

Another clear example of disparities is found in the infant mortality rates in Delaware from 2001-2005. Overall, the rate in DE for blacks was 17.1 percent, compared to 6.8 percent for whites. 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.

In 2005, Governor Minner, under Executive Order #68, convened a Task Force (TF) to examine strategies to address racial and ethnic health disparities in Delaware. The TF was to "develop broad-based recommendations for the reduction of health disparities in Delaware, which are based upon scientific evidence, defined partnerships, expected contributions, timelines, review and evaluation."<sup>11</sup> The Commission was represented on the TF by its Chair, Lt. Governor Carney. The TF was assigned with the following tasks:

Recommendations from the Task Force report issued in June 2007 related to Health Care Commission initiatives are:

1. Recommend the Delaware Health Information Network (DHIN) support the collection of chronic disease health indicators (minimum data elements) as part of standard provider reporting.
  - Identify which minimum data elements should be collected on clients including indicators for mental illness, diabetes, cardiovascular illness, stroke, asthma, cancer and other diseases as identified.
  - Recommend that relevant agencies participate in DHIN implementation.
2. Diversify the health workforce in Delaware:
  - Support an initiative of the Health Care Commission and the Division of Professional Regulation to explore the routine collection of certain HIPAA-compliant data on race/ethnicity/language from health professionals through the licensure renewal process.

<sup>10</sup> Due to data limitations, statistics in the DAVSR 2005 are only presented for black and white populations.

<sup>11</sup> Executive Order Number 68: <http://www.state.de.us/governor/orders/webexecorder68.shtml#TopOfPage>

- Support budgetary requests for additional funding for the State Loan Repayment Program (through the Health Care Commission) to recruit a racially/ethnically diverse pool of providers to practice in underserved areas of the state.
- Support increased funding to encourage DIDER and DIMER to begin to establish relationships with Historically Black Colleges.

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

## 2008 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 has 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.

### Preservation:

Small Group Insurance Reforms (Delaware Code Title 18, Chapter 72)  
Small Group Health Insurance Pooling (New Task Force – HB 38)  
Greenaght® Downstate Insurance Initiative

### Expansion

S-CHIP – more aggressive enrollment of eligible children  
Community Health Center Marketing  
Primary & Preventive Care Expansion

### Universal Coverage:

Single-Payer and Building Block Approaches - the Commission's long-term coverage strategy is the analysis of universal insurance coverage systems for Delaware. In 2007 a contract was signed with Jonathan Gruber, PhD to conduct econometric simulation and analysis of two models: traditional single-payer and a "building block" model that makes use of existing systems and other state reforms. Results from this study are due to the Commission no later than June 2008.

## **PRESERVE: SMALL GROUP HEALTH INSURANCE REFORMS**

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.

One overall problem uncovered during the most recent analysis was that the current law is complicated, difficult to understand and difficult to enforce. Specific problems identified include the following:

**1. Problem: Rate Variation** – High risk groups pay much more than low risk groups. Generally the variation is five times more, but could be as much as 9 times more. (9:1)

**Recommendation:** Compress the allowable rate variation, phasing in a reduction over a four year period. The initial allowable rate variation would be 5:1, and would decrease by .5 annually until it reaches 3:1. The result of compressing the rates is that some very low risk groups may experience increases, while high risk groups experience some rate reduction. The gradual decrease will mitigate any potential “shock” of these rate changes.

**2. Problem: Multiple rating factors** – The current law includes seven factors that can be considered when determining rates:

Age	Health-related factors	Group size	Class of business
Industry	Location/geography	Gender	

Multiple factors give more leeway in determining rates and negate the intent of making rates more predictable and stable.

**Recommendation:** Reduce the number of allowable rating factors to three:

Age  
Health Status  
Group Size

All three are legitimate predictors of risk, and the reduction will serve to keep rates compressed and reduce variation.

**3. Problem: Groups of One** – Many states with similar laws define small groups as those ranging from 2 – 50. Delaware opted to include “groups” of one to allow sole proprietors to advantages of purchasing health insurance in the group market, rather than the individual market. Interviews revealed that this allows an individual the option of purchasing insurance in either the individual or group market, depending upon which is more advantageous. Cost for a group of one is extremely difficult to predict, since only one adverse event will raise costs and there is nowhere to spread the risk. However, since the purchase of insurance in the group market by groups of one has been permitted for several years, the committee believed it imprudent to prohibit it.

**Recommendation:** Retain the current definition of 1-50, but allow a one point higher rate variation than groups of 2-50. Hence, the initial rate variation for groups of one would be 6:1 and would gradually reduce to 4:1.

**4. Problem: Rate stability** – As group characteristics changed from low risk to high risk, premiums were subject to very large increases. In addition to compressing the allowable rate variation another mechanism to make rates more stable from year to year needs to be implemented.

**Recommendation:** Limit the amount of increases due to changes in health status (one of the allowable rating factors) to 15 percent.

**5. Potential Problem: “Virtual” self-insurance with stop loss coverage**

Although not documented in Delaware, other states report fears that those purchasing insurance in the small group market could avoid the laws by paying out of pocket for all services up to a designated limit (example, the first \$10,000 of cost) and purchasing stop loss or reinsurance at a very low “attachment point” – in the current example, \$10,000. Unlike large firms that typically do self-insure, small firms are not well equipped to act as self-insureds. This is not a typical scenario in Delaware, but one which the Committee recommends should be avoided.

**Recommendation:** Prohibit the sale of stop loss insurance in the small group market.

Legislation based on these recommendations has been drafted and will be circulated to the Commission’s Small Business Committee for final review.

**2008 ACTION- Small Group Health Insurance Reforms**

- 1. Introduce legislation to implement recommendations in January 2008.**

<b>PRESERVE: SMALL GROUP INSURANCE POOLING</b>
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Another recommendation from the Commission’s Small Business Health Insurance Committee is the creation of a small group health insurance pool. In 2008 the Commission will cooperate with the State Insurance Department, endorsing legislation to create a subsidized insurance purchasing pool for small group employers. Rising health care costs and insurance premiums have made it difficult for some businesses and non-profit organizations to afford coverage for their employees. High costs are often passed on to low-income employees, and as a result, coverage may be dropped. The goal of a purchasing pool is to assist small group employers with purchasing health insurance for their employees. In 2006 and 2007 two bills were introduced but did not pass: SB 146 and SB 6, respectively.

In June 2007, a House Resolution (HR 38) passed, establishing a Health Insurance Pool Task Force, for which the Commission has co- staffing responsibilities. A final report and recommendations are due by March 15, 2008.

**2008 ACTION- Small Group Insurance Pooling**

- 1. Continue to support legislation to create a subsidized insurance pool for small group employers.**
- 2. Participate as directed in the Health Insurance Pooling Task Force.**

## **PRESERVE: CREENAGHT® – DOWNSTATE INSURANCE INITIATIVE**

While the Commission continues to address issues related to the small group health insurance market, a consortium of Sussex County businesses and local chambers of commerce have developed a health insurance plan targeting small employers and individuals. The benefit plans are based on a disease management model with an emphasis on individual health management responsibility and accountability. Clients receive financial incentives in the form of reduced cost deductibles if they participate in screenings for health risk factors and, if warranted, participate in disease management programs to improve individual health outcomes.

The Commission provided support early-on with the provision of an initial analysis of the disease burden in the target population. This product serves as a useful test of whether a disease management model can reduce costs for small business and improve health insurance coverage. More information can be found at: <http://creenaght.com/index.html>

### **2008 ACTION- Creenaght® – Downstate Insurance Initiative**

**1. Continue to follow the implementation and progress of this program and invite key stakeholders to update the Commission in the spring of 2008.**

## **EXPAND: S-CHIP (Delaware Healthy Children Program)**

The second part of the Commission's two-pronged, short-term strategy is the expansion of insurance coverage. In 2006 a strategy was considered to extend coverage to parents of children who qualify for the S-CHIP program, a coverage initiative under the Delaware Healthy Children Program. This approach would create seamless family coverage for families at less than 200 percent of the Federal Poverty Level. However, given the current environment within the federal government, including difficulty achieving program re-authorization and a propensity to deny states' requests for expansion waivers, it was agreed that this approach is not the most realistic at this point in time.

In 2008 the Commission will shift its focus to the enrollment of additional children that are eligible but not enrolled in the program (approximately 8,840 children).

### **2008 ACTION- S-CHIP Expansion**

**1. Re-focus attention on S-CHIP to registering eligible, yet non-enrolled children.**

## **EXPAND: PRIMARY & PREVENTIVE CARE EXPANSION**

Another approach to expansion that is being explored is the comprehensive provision of primary and preventive care for a broad array of Delawareans. An analysis of delivery designs, including cost estimates, will be conducted for a program that would provide preventive and primary care services to a broad array of Delawareans to improve health.

### **2008 ACTION- Primary & Preventive Care Expansion**

- 1. Examine findings from a primary care expansion analysis.**
- 2. Determine how results fit into an overall coverage expansion plan.**

## **EXPAND: COMMUNITY HEALTH CENTER MARKETING**

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. These health centers play an integral part in maintaining the success of CHAP and informing program designs.

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 an 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 (MAAHC) two other FQHC's in Delaware, La Red Health Center and Delmarva Rural Ministries, plan to replicate 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 will turn over their raw data to JSI for analysis. The costs for the data analysis will be split between the Commission and the Division of Public Health.

### **2008 ACTION- Community Health Center Marketing**

- 1. Obtain a detailed cost and deliverable proposal from JSI.**
- 2. Support the project by providing half of the costs of the JSI data analysis.**



## **EXPAND: UNIVERSAL COVERAGE**

*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 last year. It included a framework of basic system design, which will be used as a basis for modeling the financing of such a system. The next step, a detailed analysis of design and implementation strategies for a single payer system, is nearly complete.

*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 recently proposed in California were included in the project.

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.

Three proposals were received and in September 2007 the Commission awarded the contract to Jonathan Gruber, PhD from the Massachusetts Institute of Technology. A final report is due no later than June 2008.

### **2008 ACTION- Universal Coverage**

- 1. Complete micro-simulation modeling of both approaches to universal coverage to describe costs and financing more precisely.**
- 2. Invite Commissioners and members of the Small Business Insurance Committee to participate in universal coverage activities.**
- 3. Receive and respond to modeling results and offer objective analysis.**
- 4. Engage legislators in modeling activities.**

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

The Community Healthcare Access Program (CHAP) helps find low-cost health care services for uninsured people with incomes below 200 percent of the federal poverty level (= \$41,300 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.

Medical services for CHAP enrollees are provided through community hospitals, community health centers, and a network of over 500 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: Bayhealth Medical Center (Kent and Milford locations), Beebe Medical Center, Christiana Care Health Services (Newark and Wilmington locations), Claymont Family Health Services, Westside Health Clinic, Henrietta Johnson Medical Center, Delmarva Rural Ministries, 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 20,720 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 20,682 applications for initial enrollment were received and 13,487 people were enrolled at some point in CHAP. As of September 30, 2007, 3,635 people were actively enrolled and receiving services through the program. An additional 2,793 applicants were identified as eligible for Medicaid and 100 were referred to the Veteran's Administration (VA).

A total of 5,960 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. 2,793 of them were enrolled in 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. A new contract between the Health Care Commission and the Center for Applied Demography and Survey Research (CADSR), at the University of Delaware will reveal more details about target populations and the possible implications of program expansion. (More information is available on page 43 of this report.)

In 2007 AstraZeneca (AZ), a Delaware based pharmaceutical company, announced the start of a new initiative called Healthy Delawareans Today and Tomorrow. Through this partnership with Delaware's public and private sector health care community, AZ provided \$500,000 to augment CHAP by supporting "health navigators" at community health centers who will work as case managers to help the uninsured access healthcare facilities and services. Also, as a further step toward harmonization, AZ will accept CHAP reporting mechanisms used to collect data and reported by the FQHCs as the same reporting mechanism for their investment. In 2008, the CHAP Workgroup will actively strive for increased coordination with AZ for an ongoing partnership to enhance CHAP.

### Evaluation

In 2006, a new component of CHAP was implemented: the administration of a health risk assessment (HRA) to all new enrollees to identified high risk patients. This process helps to identify enrollees who need more care and are considered "high risk", including clients who smoke, are over the age of 50 years, and/or who have diabetes, hypertension, or asthma. From May 2006 through May 2007, a follow up assessment was conducted to analyze baseline data for enrollees that participated a full-year. Results indicate that CHAP enrolls a high percent of people with high risk conditions and chronic illness. The evaluation also revealed that high risk enrollees are seeing health improvements in most areas.

### 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.

- As of September 30, 2007, over 13,000 uninsured patients have been enrolled and received care at a participating health home or private practitioner.

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)

## Outreach

Currently CHAP has two types of outreach partners; hospitals and non-profit organizations who can reach the target population. Hospitals have the unique means to identify potential CHAP enrollees through their direct daily operation and community programming. Similarly, some non-profit organizations can help find and assist CHAP enrollees. A challenge in 2007 was to evaluate the effects of the program's outreach strategies. 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. In 2008 a strategy to improve outreach evaluation by consolidating contracts, establishing performance measures, standardizing activities and providing CHAP with documentation of outcomes will be considered and implemented by the CHAP Workgroup.

### **2008 ACTION- Community Healthcare Access Program (CHAP)**

#### **1. Implement the following components of a CHAP Workgroup Action Plan:**

- **Engage with AstraZeneca and recommend strategies for better coordination.**
- **Examine opportunities for collaboration with the Health Resources Board.**
- **Determine how to consolidate outreach activities under one contract and improve the ability to evaluate effectiveness of outreach efforts.**
- **Examine the enrollment system's contribution to the CHAP program.**
- **Continue evaluation; receive a report in April 2008 and determine next steps.**

## 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. 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 and Program Management Committee. The DHIN organizational purpose includes:

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

### **DHIN Project:**

DHIN is a secure, reliable communication system that is available to healthcare providers throughout Delaware. Through a combination of the latest in 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 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. Medicity is teaming with Perot Systems to deliver specific infrastructure portions of the DHIN project. Perot Systems provides data center services, technical and provider help desks and outreach training, as well as on-site customer service and system implementation.

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 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 and LabCorp. Data receivers – those who order diagnostic tests, radiology and/or admit patients for in-patient care – include 15 physician practices (over 130 physicians, some with multiple locations) with statewide representation and 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 85 percent of lab tests and 81 percent of hospital admissions in the state. Health care providers receive lab, radiology and other test results via telephone, fax, courier, 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. 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 are fourfold:

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 of system implementation, participating providers will be 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 March 2008 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.

### **Added Functionality**

Ongoing 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.

### **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).

In June 2006 and June 2007, 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"). Per a requirement for DHIN to draw down these appropriations, DHIN secured matching private sector funds.

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 will begin 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. All use cases are consistent with DHIN's long term goals.

The implementation and administration of the NHIN contract will require additional DHIN personnel, which will be supported through NHIN contract funds. In November 2008 DHIN released an RFP to seek a vendor to provide staffing services and project personnel to support the ongoing development of the DHIN and the implementation of a new contract with the NHIN. It is anticipated that new project personnel will begin in January 2008.

### **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**

The DHIN project is on track to meet the "go-live" target for Phase 2, patient record inquiry, in March 2008. DHIN will continue to recruit and enroll additional physician users throughout the state. Current users include 15 physician groups (some with multiple locations), which account for over 130 doctors in the state. Also, Delaware's four federally qualified health centers (La Red Health Center, Westside Health Services, Delmarva Rural Ministries and Henrietta Johnson Medical Center) are set to begin using DHIN by the end of 2007.

### **2008 ACTION- Delaware Health Information Network (DHIN)**

- 1. Stay informed and support DHIN development and implementation.**
- 2. Support continued State funding with a request for funds in Fiscal Year 2009.**
- 3. Continue administrative support.**
- 4. Fill Board vacancies that are Health Care Commission appointments.**



# Health Professional Workforce Development –

## **Delaware Institute of Medical Education and Research (DIMER)<sup>12</sup>**

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

A key function of DIMER is to provide financial support for Jefferson Medical College (JMC) and Philadelphia College of Osteopathic Medicine (PCOM) in exchange for reserved admission slots for Delawareans, 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 be good 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 – 9 students were accepted and 7 matriculated. At JMC matriculations increased; 29 students were accepted and 20 matriculated, higher than in 2006 when only 17 students matriculated.

Since JMC and PCOM are private colleges, the high tuition rates may be a deterrent to some students. Tuition for the 2007-08 school year is \$41,101 at JMC and \$36,954 at PCOM. 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.

Geographical, racial and ethnic diversity of participating students remains a challenge. A review of the admission statistics show a lower number of Delaware minority students and residents of Kent and Sussex Counties in lower Delaware apply than residents of more urban New Castle County. It is an ongoing challenge to recruit students of color (particularly black and Hispanic) and rural residents to medical school.

Notably, DIMER payments to Jefferson Medical College have remained at the same level (\$1.0 million per year) over the last twenty years despite rising costs incurred by the college. JMC representative Dr. David Paskin, Senior Associate Dean for Graduate Medical Education and Affiliations, attended the Health Care Commission Annual Retreat to request additional

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<sup>12</sup> See the Appendix to review the 2007 DIMER Annual Report.

funding in Fiscal Year 2008 to support the significant benefit derived from the JMC/DIMER relationship to Delaware (such as the residency training programs at Christiana Care Health Services and DuPont Hospital for Children). The DIMER Board of Directors has requested a \$2.0 million increase in the DIMER budget - \$1.6 million for JMC and \$400,000 for PCOM. The cost of medical education has risen significantly over the past decades. For example, total JMC expenditures in 1991 were \$76 million, compared to \$285 million in 2007.

### **2008 ACTION- Delaware Institute of Medical Education and Research (DIMER)**

**1. Research the history and basis for the funding formula for Jefferson Medical College to help determine whether the Commission should support the requested increase in funding based on the rising cost of medical education and the benefits derived from the relationship, both direct and indirect.**

### **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, 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 9 dentists to practice in underserved areas of Delaware. Efforts are being made to also begin recruiting dental hygienists to help make use of a portion of unspent 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. In 2006, six students were accepted and three matriculated at Temple, and in 2007 seven students were accepted and six matriculated.

Additionally, since tuition at Temple (\$46,170 for the 2007-08 school year) is slightly higher than tuition at JMC and PCOM, and through the generosity of the Delaware State General Assembly, DIDER provides \$75,000 each academic year for tuition stipends to be divided among the Delaware residents who attend Temple. For the foreseeable future, each student from Delaware will receive, at a minimum, a tuition stipend of \$5,000 per academic year. Any remaining funds are allocated based on financial need – to be determined using Temple's financial aid formulas.

### **2008 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. Appoint a Health Care Commission member to the DIDER Board.**
- 3. Continue to support and aggressively promote the State Loan Repayment Program as a means to recruit dentists and hygienists to Delaware.**

### **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. 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). The program is funded annually through the DIMER (\$150,000) and DIDER (\$100,000) budgets. Also, in August 2007 the DHCC applied for and was awarded \$100,000 in federal funds through the U.S. Health Resources and Services Administration.

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 private facility. Additionally, health care providers must be HSPA appropriate for their discipline: primary care physicians in a Primary Care HPSA and dental providers in a Dental HPSA. Also, an application has been submitted to obtain a federal mental health HPSA designation, which will increase the program's ability to place clinicians at sites that meet federal guidelines and qualify for the federal matching funds. 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.

**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, which proved effective and will be continued in 2008. 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 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	TOTAL
Physicians Approved:	2	2	3	2	3	4	5	6	27
Mid-Level Approved:	n/a	n/a	n/a	n/a	n/a	0	2	3	5
Dentists Approved:	0	2	1	1	0	1	2	2	9
Total By Year:	2	4	4	3	3	5	9	11	41

Gender	
Female	27
Male	15

County	
New Castle	13
Kent	11
Sussex	18

Race/Ethnicity:	
White	23
Black	4
Hispanic	1
Asian	3
Indian	3
Korean	2
Pakistani	1
Cuban	1
Vietnamese	1
Not reported	3

Languages Spoken:	
Spanish	10
Chinese Mandarin	2
French	1
Indian (Hindi, Telugu, Tamil)	2
Korean	1
African (Urdu, Gujarati)	2
Vietnamese	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 future requests for increased funding for DIMER. There is also need to re-visit whether priority should be given to physicians over other eligible professionals.

**2008 ACTION- State Loan Repayment Program**

1. Develop a priority policy on professions funded.
2. Discuss the issues with the General Assembly and engage feedback.
3. Continue the current application review process and schedule.

## Health Workforce Data Committee

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

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

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). The Committee will reconvene in early 2008 to consider the findings and compile a list of next steps and recommendations.

In 2008 a study designed to assess the supply and distribution of allied health professionals and pharmacists in the state will be 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. Results are being collected and analyzed by CADSR and a final report is expected in early 2008.

The Committee plans to partner with the Division of Professional Regulation to determine options for the collection of health professional data through the online licensure process. Preliminary discussions are also underway in cooperation with the Division of Substance Abuse and Mental Health to create an online mental health professional directory as a resource for referrals within the provider community as well as consumers of health care services.

### **2008 ACTION- Health Workforce Data Committee**

**1. Continue the Committee work.**

**2. Receive and distribute the upcoming report on Allied Health Professionals.**

# 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.

## ***Total Cost of Health Care and Delawareans Without Health Insurance***

The *Total Cost* 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. The 2006 report includes a brief update on research on cost shift conducted by The Lewin Group for the Commission in 1999. A full replication and update of the original report will require the collection of additional data, including outpatient discharge data.

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

### **2008 ACTION**

- 1. Continue to produce both reports annually.**
- 2. Determine the requirements to update the cost shift report.**
- 3. Determine how cost shift will be addressed in the microsimulation work being conducted by Jonathan Gruber.**
- 4. Re-visit efforts to expand data reporting to include out-patient procedures.**

## **HEALTH FUND ADVISORY COMMITTEE**

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 around December 2007 so that recommendations can be incorporated into Governor Minner's recommended budget for FY 2009.

### **2008 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. The Commission was previously represented by Herbert Nehrling and Robert Miller. Presently, new representation is needed.

HRB is required to:

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

To date, most HRB activities have been project specific rather than policy oriented. However, policy changes may require more interaction between the Commission and the HRB. The Certificate of Public Review process includes requirements for charity care, currently set at 2.75 percent of a facility's total gross revenue. Policy and enforcement procedures are being developed subsequent to legislation being passed that 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. A new contract between DHCC and the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware will reveal more details about target populations.

### **2008 ACTION- Health Resources Board**

- 1. Receive a report from CADSR and review the data with the CHAP workgroup to determine next steps.**
- 2. Continue coordination between DHCC and HRB staff.**
- 3. Appoint representation from DHCC to serve on the HRB.**

## New: Women's Healthy Heart Task Force

In June 2007, a resolution was passed in the House of Representatives (HR #29) establishing a Women's Healthy Heart Task Force to study the issues of women's heart risk in Delaware to develop a comprehensive strategy to encourage healthy heart activities for women. The Health Care Commission is represented by the Chair of the Commission or his designee. A report is due by March 2008.

### **2008 ACTION- Women's Healthy Heart Task Force**

- 1. Continue support and participation as necessary.**



## **Mental Health Issues Committee**

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. Several of the recommendations require action by the Commission. Staff will continue work on a plan for implementation.

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

The Mental Health Issues Committee has generated enthusiasm and activity; tremendous progress has been made, and more is needed.

### **2008 ACTION- Mental Health Issues Committee**

- 1. Continue to convene and support the Committee.**

## **Chronic Illness Task Force and Stroke Task Force**

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 covers the entire continuum of stroke care including: prevention, emergency response, acute/sub-acute treatment, rehabilitation, and continuous quality improvement. This 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. In 2008 the Chronic Illness TF will re-convene to develop a plan for implementation and next steps.

### **2008 ACTION- Chronic Illness and Stroke Task Forces**

- 1. Continue coordination and support as necessary.**

# 2008 Action Steps: At-A-Glance

## 1. Uninsured Action Plan

### Small Group Health Insurance Reforms

1. Introduce legislation to implement recommendations in January 2008.

### Small Group Insurance Pooling

1. Continue to support legislation to create a subsidized insurance pool for small group employers.
2. Participate as directed in the Health Insurance Pooling Task Force.

### Greenlight<sup>®</sup> – Downstate Insurance Initiative

1. Continue to follow the implementation and progress of this program and invite key stakeholders to update the Commission in the spring of 2008.

### S-CHIP Expansion

1. Re-focus attention on S-CHIP to registering eligible, yet non-enrolled children.

### Primary & Preventive Care Expansion

1. Examine findings from a primary care expansion analysis.
2. Determine how results fit into an overall coverage expansion plan.

### Community Health Center Marketing

1. Obtain a detailed cost and deliverable proposal from JSI.
2. Support the project by providing half of the costs of the JSI data analysis.

### Universal Coverage

1. Complete micro-simulation modeling of both approaches to universal coverage to describe costs and financing more precisely.
2. Invite Commissioners and members of the Small Business Insurance Committee to participate in universal coverage activities.
3. Receive and respond to modeling results and offer objective analysis.
4. Engage legislators in modeling activities.

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

1. Implement the following components of a CHAP Workgroup Action Plan:
  - Engage with AstraZeneca and recommend strategies for better coordination.
  - Examine opportunities for collaboration with the Health Resources Board.
  - Determine how to consolidate outreach activities under one contract and improve the ability to evaluate effectiveness of outreach efforts.
  - Examine the enrollment system's contribution to the CHAP program.
  - Continue evaluation; receive a report in April 2008 and determine next steps.

## **2. Information & Technology**

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

1. Stay informed and support DHIN development and implementation.
2. Support continued State funding with a request for funds in Fiscal Year 2009.
3. Continue administrative support.
4. Fill Board vacancies that are Health Care Commission appointments.

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

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

1. Research the history and basis for the funding formula for Jefferson Medical College to help determine whether the Commission should support the requested increase in funding based on the rising cost of medical education and the benefits derived from the relationship, both direct and indirect.

### **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. Appoint a Health Care Commission member to the DIDER Board.
3. Continue to support and aggressively promote the State Loan Repayment Program as a means to recruit dentists and hygienists to Delaware.

### **State Loan Repayment Program**

1. Develop a priority policy on professions funded.
2. Discuss the issues with the General Assembly and engage feedback.
3. Continue the current application review process and schedule.

### **Health Professional Workforce Committee**

1. Continue the Committee work.
2. Receive and distribute the upcoming report on Allied Health Professionals.

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

### **Research Reports**

1. Continue to produce both reports annually.
2. Determine the requirements to update the cost shift report.
3. Determine how cost shift will be addressed in the microsimulation work being conducted by Jonathan Gruber.
4. Re-visit efforts to expand data reporting to include out-patient procedures.

### **Health Fund Advisory Committee**

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

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

### **Health Resources Board**

1. Receive a report from CADSR and review the data with the CHAP workgroup to determine next steps.
2. Continue coordination between DHCC and HRB staff.
3. Appoint representation from DHCC to serve on the HRB.

### **New: Women's Healthy Heart Task Force**

1. Continue support and participation as necessary.

### **Mental Health Issues Committee**

1. Continue to convene and support the Committee.

### **Chronic Illness Task Force**

1. Continue coordination and support as necessary.

# APPENDICIES

A) Delaware Health Care Commission: History and Background

B) 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 Data Committee

State Loan Repayment Committee

C) DIMER Annual Report 2008

## Delaware Health Care Commission: History and Background

The Health Care Commission is an independent public body reporting to the Governor and the Delaware General Assembly. It was created by the General Assembly in 1990 to develop a pathway to promote accessible, affordable, quality health care for all Delawareans. It was one of several steps taken following a report issued by the Commission's predecessor, the Indigent Health Care Task Force.

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

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

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

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

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

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

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

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

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

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*Delaware Physicians Care, Inc.*

## VICE-CHAIR

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*Center for Applied Demography and Survey Research  
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**William E. Kirk, III, Esq.\***

*Blue Cross Blue Shield of Delaware*

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*Bayhealth Medical Center*

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*Neurologist, CNMRI*

**Thomas Jarrett**

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**Barbara Vugrinec**

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(\* Indicates Executive Committee Membership)



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*Delaware State Dental Society*

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

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*Ex-Officio State Dental Director*

**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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*Delaware Technical & Community College*

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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 Data Committee

## CHAIR

**Vacant**

*Delaware Health Care Commission*

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*Division of Public Health*

# State Loan Repayment Program Committee

## COMMITTEE MEMBERS

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*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*

**Vacant**

*Delaware Health Care Commission*

**Gregory McClure, DMD, MPH**

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

**Vacant**

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

**Carylin Brinkley**

*Delaware Higher Education Commission*

**STATE OF DELAWARE**

**Delaware Health Care Commission**

**Delaware Institute of Medical Education and Research**

**Annual Report**

**January 15, 2008**

**State of Delaware  
Ruth Ann Minner, Governor**

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

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

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Michael Alexander, MD  
Anthony D. Alfieri, DO  
Lisa C. Barkley, MD  
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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James Richards, PhD  
Jaime H. Rivera, MD, FAAP  
Ileana M. Smith, EdD  
Wayne A. Smith \***

**Jefferson Medical College Liaisons  
Thomas Nasca, MD  
David Paskin, MD**

**Philadelphia College of Osteopathic Medicine Liaison  
Carol A. Fox**

\* David Bercaw, MD – began term August 31, 2007

\* Joseph A. Lieberman, III, MD, MPH – December 4, 2001 through June 7, 2007

\* Janice Nevin, MD, MPH – October 8, 2003 through February 3, 2007

\* Wayne A. Smith – began term March 27, 2007



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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 29 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 2007 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 29 Delaware applicants in its 2007 entering class. Of those, 20 matriculated.

### Admissions to Philadelphia College of Osteopathic Medicine

Through DIMER, the Philadelphia College of Osteopathic Medicine accepted 9 Delaware applicants in its 2007 entering class. Of those, 7 matriculated.

### DIMER Grant/Loan Program

Two grant/loan recipients completed residency training in 2007. One received an academic dismissal and is in cash repayment. The final grant/loan recipient is expected to complete residency training in 2008.

In 2001, the DIMER Board of Directors evaluated the 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 has been phased out. A new program has been 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 2007-2008 academic year 73 tuition supplements were awarded to all four classes at Jefferson Medical College. Need-based scholarships were awarded to 13 freshmen, 13 sophomores, 7 juniors and 14 seniors for a total of 47 scholarships.

For the 2007-2008 academic year, 18 tuition supplements were awarded to all four classes at PCOM. Need-based scholarships were awarded to 3 freshmen, 3 sophomores, 6 juniors, and 2 seniors for a total of 14 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. Twenty-seven physicians, three certified nurse practitioners, and two certified nurse midwives 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 targeted at Juniors and Seniors 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 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.

## **2008 Agenda**

For 2008, 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 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 32 professionals have been placed in underserved areas. This is comprised of twenty-seven physicians, two 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 and Philadelphia College of Osteopathic Medicine

Year	Applied to any Med School	Applied to Jefferson	Matriculated at any Med School	Accepted at Jefferson*	Accepted at PCOM**
2007	92	50	39	29	9
2006	78	53	38	28	10
2005	78	62	35	23	7
2004	64	54	39	23	7
2003	71	56	34	23	6
2002	70	57	31	23	7
2001	64	50	31	21	4
2000	93	84	49	36	6
1999	82	72	50	32	n/a
1998	90	76	40	28	n/a
1997	100	91	41	34	n/a
1996	110	n/a	51	26	n/a

\* Number of students Jefferson accepted out of the total number of Delawareans who matriculated

\*\* Number of students PCOM accepted out of the total number of Delawareans who matriculated

n/a - Information is not available

## **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>
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>
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 2007 Entering Class**

<b>County:</b>	<b>New Castle</b>	<b>Kent</b>	<b>Sussex</b>
<b>Total DIMER Applicants</b>	41	3	6
<b>DIMER Applicants Interviewed</b>	28	3	4
<b>Acceptances Offered</b>	23	3	3
<b>Students Matriculated</b>	18	0	2

**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE:**

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

**Year 2007 Entering Class**

<b>County:</b>	<b>New Castle</b>	<b>Kent</b>	<b>Sussex</b>
<b>Total DIMER Applicants</b>	27	3	3
<b>DIMER Applicants Interviewed</b>	13	1	2
<b>Acceptances Offered</b>	9	0	1
<b>Students Matriculated</b>	6	0	1

**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
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>172</i>	<i>9</i>	<i>2</i>	<i>13</i>	<i>7</i>	<i>2</i>	<i>12</i>	<i>4</i>	<i>17</i>	<i>5</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	Hispanic	Indian/Pakistani	Vietnamese
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>38</i>	<i>3</i>	<i>1</i>	<i>6</i>	<i>1</i>

**JEFFERSON MEDICAL COLLEGE:**

**Gender of  
Delaware Students Attending**

Year	Male	Female
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>140</i>	<i>109</i>

**PHILADELPHIA COLLEGE OF  
OSTEOPATHIC MEDICINE:**

**Gender of  
Delaware Students Attending**

Year	Male	Female
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>30</i>	<i>21</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 1999 and began practice in New Castle County, Delaware.

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

Six students completed their residency training in 2001; three have entered primary care practice in Delaware and three have entered cash repayment of the loans.

Four students completed their residency training in 2002; three have entered primary care practice in Delaware and one has been granted a one-year deferment from repayment while her spouse conducts research on a one-year grant in North Carolina.

Six students completed their residency training in 2003; four have entered primary care practice in Delaware; one has taken a position in Elkton, Maryland and continues to seek employment in Delaware; and one chose to pursue a specialty and pay back the loan.

Five students completed their residency training in 2004; two have entered primary care practice in Delaware; two requested a one-year extension to complete a Chief Residency program; and one was accepted into a fellowship.

Four students completed their residency training in 2005; one has entered primary care practice in Delaware; one plans to begin practicing in January 2006; one has been granted an extension until June 2006 to complete a Chief Residency; one will complete an additional year of training on primary care/muscle and skeletal care; two students withdrew from medical school and are repaying the loan; 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 has been granted an extension to complete a Cardiology residency, after which he will return to Delaware to practice Cardiology and enter cash repayment; 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 is expected to complete her residency in 2008.

*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.

*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.

## **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 \$41,101 per year. Tuition and fees at PCOM are \$36,954 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 eleven year period tuition has increased by about 62 percent from \$25,235 in 1996 to \$41,101 in 2007. A 62 percent increase in scholarship and tuition supplement funds would amount to an additional \$248,000 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 seven years tuition has increased by about 49 percent from \$24,725 in 2000 to \$36,954 in 2007. A 49 percent increase in scholarship and tuition supplement funds would amount to an additional \$39,200 for students at PCOM.

Tuition and fees (not including health insurance) for first year medical students at Jefferson Medical College and PCOM for the 2007-2008 academic year:

Jefferson Medical College	\$41,101
PCOM	36,954

Tuition and fees (not including health insurance) for first year medical students in public medical schools in surrounding states for the 2007-2008 academic year:

<u>State</u>	<u>Resident</u>	<u>Non-Resident</u>
Connecticut	\$24,142	\$46,778
Maryland	21,998	40,233
North Carolina	11,964	35,630
Pennsylvania State	33,058	44,920
South Carolina	22,594	59,910
SUNY- Downstate	19,370	34,070
SUNY – Upstate	19,956	34,656
Virginia	31,305	41,305
West Virginia	19,204	41,866

Tuition and fees (not including health insurance) for first year medical students in private medical schools in surrounding states for the 2007-2008 academic year:

George Washington	\$44,201
Georgetown	44,915
Harvard	40,499
Howard	29,846
Johns Hopkins	37,579
New York Medical	41,036
New York University	40,729
University of Pennsylvania	42,873
University of Pittsburgh	39,856
Temple	47,004
Tufts	47,116
Eastern Virginia	43,400
Yale	41,220

## **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	\$ 63,608
2 <sup>nd</sup> year students	63,070
3 <sup>rd</sup> year students	67,231
4 <sup>th</sup> year students	<u>63,635</u>
Total	\$257,544

### **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	\$ 59,439
2 <sup>nd</sup> year students	59,279
3 <sup>rd</sup> year students	65,664
4 <sup>th</sup> year students	<u>66,654</u>
Total	\$251,036

## **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

**Betty J. Paulanka, EdD, RN**

University of Delaware

**Lisa C. Barkley, MD**

Delaware State University

**James Richards, PhD**

University of Delaware

**David Bercaw, MD**

Christiana Care Health Services

**Jaime H. Rivera, MD, FAAP**

Division of Public Health

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

Public Member, Kent County

**Ileana M. Smith, EdD**

Higher Education Commission

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

St. Francis Hospital

**Wayne A. Smith**

Delaware Healthcare Association

### *Jefferson Medical College Liaisons*

**Thomas Nasca, MD**

**David Paskin, MD**

### *Philadelphia College of Osteopathic Medicine Liaison*

**Carol A. Fox**

### *Staff*

**Paula K. Roy**

**Sarah M. Matthews**

**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 2008. 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 2007 – 2008 Academic Year**

### First Year Freshman

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

### Second Year Sophomores

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

### Third Year Juniors

Epstein, Rachael  
Guarino, Jeffrey  
Hurd, Jennifer  
Ikeda, Daniel  
Martin, Christopher  
Mascitti, Alexis  
Moroz, Leslie  
Pembroke, Thomas  
Quigley, Glen  
Seaton, Elaine  
Sheridan, Kelly  
Soltys, Anna  
Vaidyanathan, Nishant

### Fourth Year Seniors

Axe, Jeremie  
Cherian, Dinu  
Chiang, David  
Cook, Brianna  
Dattani, Seema  
Eanes, Kevin  
Foy, Andrew  
Franck, Bryan  
Gardecki, Michelle  
Harrison, Ashley  
Hocutt, Beth  
Lazzopina, Peter  
Linek, Julie  
Massey, Patrick  
Milligan, Erin  
Patel, Rujuta  
Saad, Miriam  
Salva, Nicole  
Swierzbinski, Matthew  
Talareck, Chad  
Trotter, Michael  
Vijayaraghavan, Swathi  
Walls, Jason  
Wrigley, Clinton



## Addendum IV: DIMER Grant/Loan Recipient Status

<u>Name</u>	<u>Actual or Anticipated JMC Graduation Year</u>	<u>Residency Completion</u>
Peluso, Susan	1995	1998 (service repayment)
Anzilotti, Kert	1996	1999 (cash repayment)
Clute, Stephen	1997	2000 (cash repayment)
Longo, Michael	1997	2000 (service repayment)
O'Brien, Matthew	1997	2000 (service repayment)
Williams, Jane	1997	2000 (service repayment)
Bowman, Adam	1998	Psychiatry Fellowship (service repayment)
Burke, Stephen	1998	2001 (service repayment)
Simpkins, John	1998	2001 (cash repayment )
Phillips, Christine	1998	2001 (cash repayment)
Schmeig, Andrea	1998	2001 (cash repayment)
Sordi, Mark	1998	2001 (service repayment)
Brown, Barrington	1999	2002 (service repayment)
Grady, Matthew	1999	2002 (service repayment)
Poppiti (Manfredi), Alissa	1999	2002 (cash repayment)
Villasenor, Paul	1999	2002 (service repayment)
Mancuso, Maria	1999	2002 (service repayment)
Pak, Susan	1999	2002 (cash repayment)
Davis, Angelique	2000	2003 (cash repayment)
Nelson, Anne	2000	2003 (service repayment)
Neuberger, Deborah	2000	2003 (service repayment)
Robinson, Amy	2000	2003 (service repayment)
Zeberkiewicz (Reinhardt), Claire	2000	2003 (cash repayment)
Peters, Michael	1998	2003 (cash repayment)
Hammer, Scott	2001	2004 (service repayment)
Young, Robert	2001	2004 (service repayment)
Elliott, Daniel	2001	2005 (Chief Residency)
Jordon, Trisha	2001	2005 (service prepayment)
Pondok, Theresa	2001	2005 (cash repayment)
Rappaport, David	2001	2005 (service repayment)
Corradi, Emily	2002	2005 (cash repayment)
Dassel, Jeffrey	2002	2005 (service repayment)
Dukes, Donald	2002	2005 (loans cancelled)
Jackson, Edward	2002	2005 (cash repayment)
Lehane, Christina	2003	2007 (deferred until 2010)
Davis, Angelique	2004	2007 (cash repayment)
McGillen, Brian	2004	2007 (Christiana residency)
Myers, Gene Robert	2004	2007 (extended training)
Black, Kara Lynn	2005	2008 (U of CA residency)

**Addendum V: Philadelphia College of Osteopathic Medicine Students  
2007 – 2008 Academic Year**

First Year Freshman

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

Second Year Sophomores

Cohen, Valerie  
Khasat, Vikram  
Nashed, Nadia  
Nguyen, Lam  
Rutter, Heather  
Solanki, Anjali  
Walsh, Brian

Third Year Juniors

Alexander, Christopher  
Jerusik, Brian  
Little, Eric  
Pirestani, Alireza  
Pryor, Brian  
Replenski, Stephen  
Richardson, Nicholas

Fourth Year Seniors

Barbosa, Malissa  
Parikh, Amol M.  
Stevens, Jillian G.  
Voltz, Matthew K.