

**DELAWARE HEALTH CARE COMMISSION
DECEMBER 1, 2011
DELDOT ADMINISTRATION BUILDING
FARMINGTON/FELTON CONFERENCE ROOM
DOVER**

MINUTES

Commission Members Present: Bettina Riveros, Chair; Theodore W. Becker, Jr.; Janice E. Nevin, MD; Karen Weldin Stewart, Insurance Commissioner, Rita Landgraf, Secretary, Delaware Health and Social Services; Kathleen S. Matt, PhD, and Fred Townsend

Commission Members Absent:

Thomas J. Cook, Secretary of Finance; A. Richard Heffron; Dennis Rochford and Vivian Rapposelli, Secretary, Services for Children, Youth and Their Families

Staff Attending: Paula Roy, Executive Director; Marlyn Marvel, Community Relations Officer; Robin Lawrence; Executive Secretary and Linda G. Johnson, Administrative Specialist III

CALL TO ORDER

The meeting was called to order at 9:05 a.m. by Bettina Riveros, Commission Chair.

MEETING MINUTES OF NOVEMBER 3, 2011

After a motion by Ted Becker which was seconded by Kathleen Matt, the minutes of the November 3, 2011 meeting were approved by a vote of the Commissioners.

RESEARCH & POLICY DEVELOPMENT

Advance Care Planning & the Delaware M.O.L.S.T. Presentation

In response to an issue raised at the November Commission meeting regarding Advance Directives Sheila Grant, Nurse Liaison at Heartland Hospice and President of the Hospice and Palliative Care Network of Delaware was invited to present on Advance Care Planning and the Delaware MOLST. (This PowerPoint presentation will be made available on the DHCC website: <http://dhss.delaware.gov/dhss/dhcc/presentations.html>).

MOLST/POLST is the acronym for *Medical (or Physician's) Orders for Life-Sustaining Treatment*, a document intended for seriously ill patients that stipulates wishes regarding life-sustaining treatment based on the patient's current condition. MOLST and POLST are interchangeably used. In Delaware **MOLST (Medical Orders)** is used to enable nurse practitioners and physician assistants to also sign those orders.

Action Items

Action

Commissioners approved the November 3, 2011 DHCC meeting minutes.

Sheila Grant, Nurse Liaison, Heartland Hospice; President, Hospice and Palliative Care Network of Delaware, gave a presentation on Advance Directives

M.O.L.S.T./P.O.L.S.T. is the acronym for Medical (or Physician's) Orders for Life Sustaining Treatment, a document intended for seriously ill patients that

Ms. Grant briefed the Commission on the purposes and objectives of the MOLST:

1. Why did we need a MOLST program in Delaware?
2. Who started the Delaware MOLST Program, and how?
3. How does the MOLST work?
4. What have we done, and what still needs to be done?
5. How can the Commission support quality end-of-life care?

Why did we need a MOLST program in Delaware

The majority of people would prefer to die at home but very few people accomplish that because the right system supports are not in place. People fall, they panic, have a mental status change - once people enter the hospital, it is difficult to get out.

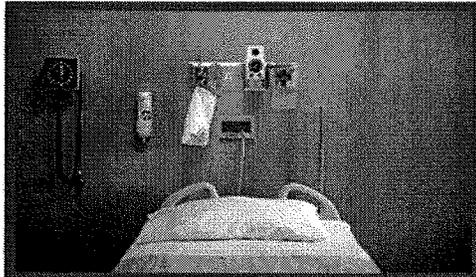
stipulates wishes for life-sustaining treatment based on the patient's current condition.

WHEN THE TIME COMES . . .

88% say they want to die at home



20% actually die at home



Source: Teno, JM et al. Family perspectives on end of life care at the last place of care. JAMA. 2004;291:88-93

In a state-by-state report card on access to palliative care in the nation's hospitals by the Center for Advancement of Palliative Care and the National Palliative Care Research Center, Delaware scored an 'F.'

Ms. Grant believes Delaware deserves a 'C' or 'C-'; not an 'F'. Through conversations with the researcher, Ms. Grant learned St. Francis Hospital, which recently started a palliative care program, was not included in the research, nor did the survey weigh the hospitals for the patients they see.

Only twenty percent of hospitals in Delaware provide palliative care, while the region's hospitals scored around fifty percent and nationally, the average was over sixty percent.

According to a report on the 50 states by the Dartmouth Institute for Health Policy and Clinical Practice, Delaware ranked as follows:

Medicare reimbursement per decedent before death (2003-2007):

Delaware	-	\$3,723
National average	-	\$3,212
Ninetieth Percentile-		\$4,947
Fiftieth	"	\$2,897
Tenth	"	\$1,785 (best performers)

Percentage of decedents enrolled in hospice during last six months of life:

Delaware	-	42.4%
National average	-	36.7%
Ninetieth Percentile-		44.4% (best performers)
Fiftieth	"	34.3%
Tenth	"	23.5%

Hospice days per decedent during last six months of life (2003-2007):

Delaware	-	18.8
National average	-	15.3
Ninetieth Percentile-		21.8 (best performers)
Fiftieth	"	13.8
Tenth	"	8.6

By gender, the level of care intensity (2007):

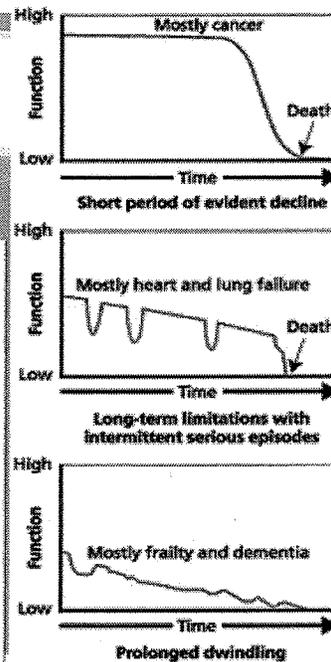
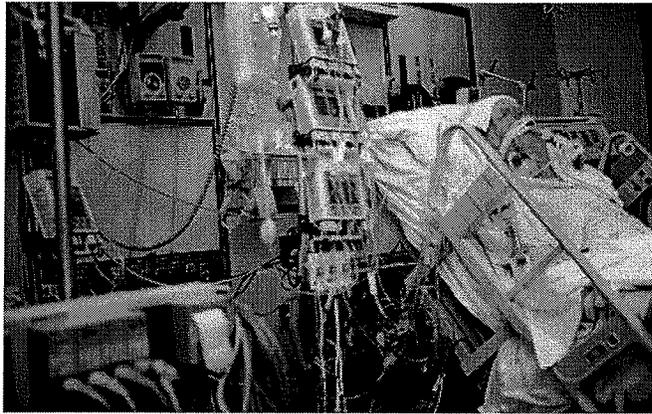
Delaware	-	10.9
National average	-	10.3
Ninetieth Percentile-		11.4 (best performers)
Fiftieth	"	9.7
Tenth	"	6.9

Percentage of decedents admitted to ICU/CCU during hospitalization in which death occurred, by gender:

Delaware	-	17.2%
National average	-	17.1%
Ninetieth Percentile-		19.2%
Fiftieth	"	15.9%
Tenth	"	11.4% (best performers)

For the old and frail, spending the last days of life in the ICU is not preferred.

What's so bad about dying in the ICU?



Why don't health care providers always honor patients' wishes

- Not all family members are 'ready to let go.'
- Physician feels 'we have to do something,' and family goes along.
- Cannot find 'living will' so no one knows 'what patient would have wanted.'
- Living will is unclear in present situation
- Family disagrees with living will or with one another

Why are families so important

The Journal of Hospice and Palliative Care Nursing did a recent survey of people who had lost a loved one in the past; some as long ago as two decades.

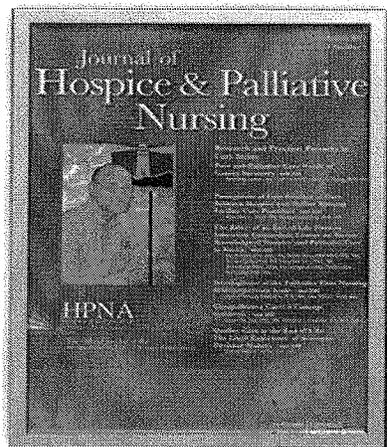
They were asked about current thoughts and symptoms they have related to that experience. These were surrogate decision makers - people were either next of kin who had to make a decision about stopping the treatment or named as power of attorney for health care. These people had symptoms that were quite severe:

- *avoidance* (such as the inability to visit a hospital, or bear the smell of alcohol, or other association with the bad experience);
- *intrusion* (while trying to focus on something, having thoughts or flashbacks of the bad experience);
- *hyper-arousal* (physical stress response of fight or flight, heart racing, perspiring).

These are the symptoms of post traumatic stress disorder (PTSD). A

sample study shows that there is an intense response in surrogate decision makers, persisting for up to two decades.

**FRESH RESEARCH—11/11
LIFE-SUSTAINING TREATMENT DECISIONS SHOULDN'T BE
ADVERSARIAL**



• Surrogate decision makers have long-term psychological morbidity* for many years after a death

- Avoidance
- Intrusion
- Hyperarousal

*These are the 3 symptoms associated with PTSD

A November 2011 study of ninety nursing facilities in Oregon, Wisconsin and West Virginia by the Journal of the American Society of Geriatrics showed a 94 percent overall consistency rate between POLST orders and treatment given.

Each facility in Delaware had its own form and there was no consistency. People were not receiving the care they had intended.

Who started the Delaware MOLST Program, and how

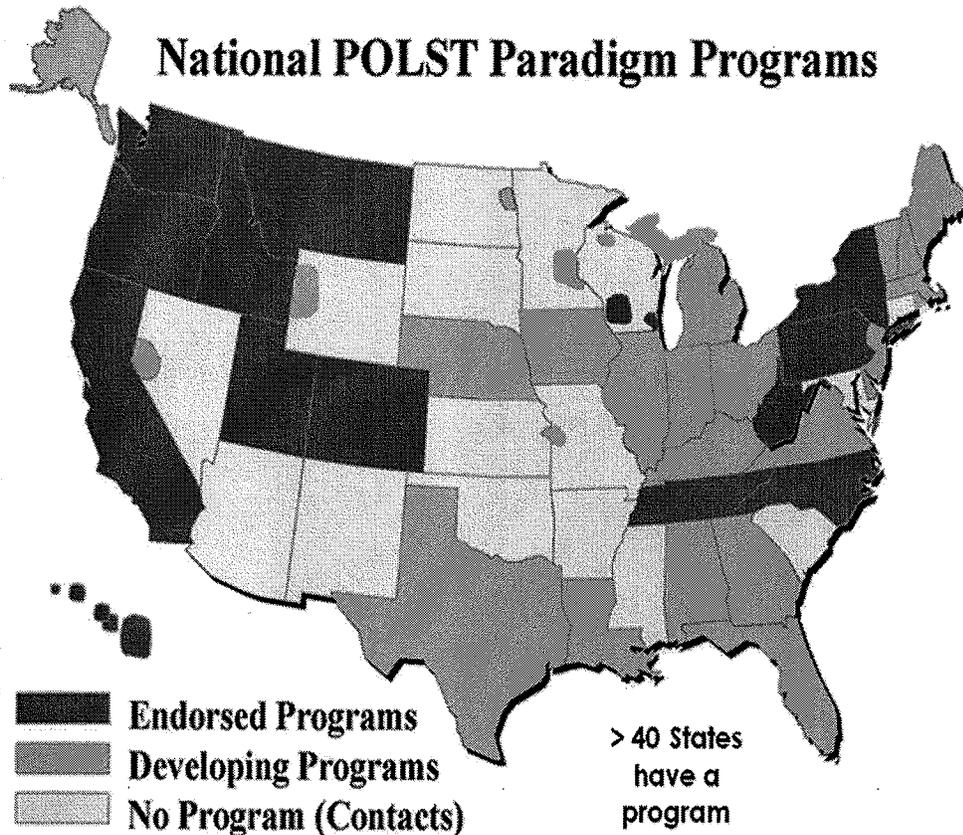
In 2009, the MOLST Core Working Group was formed by Dr. John Goodill, Director of Pain Management and Palliative Care at Christiana Care. Monthly meetings were held to educate themselves and plan a MOLST program for Delaware. The group was comprised of health professionals and an attorney.

The MOLST Core Working Group works in conjunction with State of Delaware professional staff (Debbie Gottschalk, Health Policy Advisor to Secretary Landgraf, Diane Hainsworth (EMS trainer) and Erica Tross, Division of Public Health Deputy Attorney General) to write the MOLST Emergency Medical Services (EMS) regulation.

The group created a MOLST form and EMS regulation to authorize its use; mounted a volunteer education effort, and registered the program with the National POLST Paradigm Task Force.

Palliative care is a comprehensive approach to treating serious illnesses that focuses on the physical, psychosocial and spiritual needs of the patient. The goal of palliative care is to prevent and relieve suffering and to support the best quality of life for patients and their families through such interventions as managing pain and other uncomfortable symptoms, assisting with difficult decision-making, and providing support, regardless of whether or not a patient chooses to continue curative, aggressive medical treatment.

National POLST Paradigm Programs



The Hospice and Palliative Care Network of Delaware received a \$1,800 grant from the Retirement Research Foundation and coordinated by the National POLST Paradigm Task Force-POLST.org.

How does the MOLST work:

The Delaware MOLST form is available on the Delaware Office of EMS website as a PDF. (http://dhss.delaware.gov/dph/ems/files/molst_de.pdf). It is to be printed on orchid cardstock and signed by a physician, nurse practitioner or physician assistant.

The advantages of MOLST are:

- clear, standardized instructions
- translates a patient's living will into an actionable medical order (ideally, patients will have both a living will and a MOLST)
- portable - follows patients through transitions of care
- available on-line - no cost to the State for printing and distribution

MOLST is only for those with a terminal illness who do not wish to be resuscitated in the event of an emergency. It is for people who want to be clear about which medical treatments they receive at end of life. Full resuscitation or no resuscitation are options. Any section on the MOLST form left blank is considered full treatment. Although the MOLST is for the terminally ill, Ms. Grant suggested that all adults should complete a living will and health care power of

Living will (LW) is a document in which a person specifies future medical treatments in the event of incapacity, usually at end of life or if one becomes permanently unconscious, in a persistent vegetative state or 'beyond reasonable hope of recovery.'

All adults should complete a living will and health care power of attorney.

attorney.

Hospices have been the first to use a MOLST in Delaware. A MOLST form is included in every admissions packet. Patients are asked about their advance directives on admission. Most hospice patients complete a MOLST on admission.

Hospice cost and quality

Hospice care is not cheap; Medicare Hospice Benefit ('83) is a per diem payment, costing about \$150.00 a day or \$4,000 a month in the Delaware region and includes global services. Hospice was an early model of managed care. Hospice has had 28 years of practice delivering quality care and containing costs.

Independent research out of Duke University (NC) has shown that for every Medicare beneficiary who utilizes hospice, Medicare saves about \$2,300.

What still needs to be done to improve care.

Advance care planning and POLST/MOLST are an important part of coordinated care delivery, smooth care transitions, and accountable care organizations.

How can the Commission support quality end-of-life care

Ms. Grant suggested the Delaware Health Care Commission could help:

- help develop an electronic MOLST registry
- create a Palliative Care Advisory Council
- consider working with the MOLST Core Working Group to revise Delaware's Health Care Decisions Act
- support the efforts of the Hospice and Palliative Care Network of Delaware so it could borrow ideas from the State of New York

Oregon, West Virginia, New York and La Crosse, Wisconsin already have, or are in the process of creating, an electronic POLST/MOLST form.

Eight years ago, the Maryland State Legislature created the Maryland State Advisory Council on Quality Care at End of Life (MSAC) as a permanent part of state government. It is an effective catalyst for positive change in end-of-life policy-making. The recommendation is that 'reformers elsewhere should consider this model.'

Debbie Gottschalk, Esq. and Judge DeIpesco have recommended the MOLST Core Working Group begin the process of revising Delaware's Health Care Decisions Act (Title 16, Chapter 25) as a way to improve end of life care.

(<http://delcode.delaware.gov/title16/c025/index.shtml>)

Delaware's Health Care Decisions Act needs revising.

Discussion

Ms. Riveros asked about EMS use. Ms. Grant said protocols to use the MOLST had to be written and the EMS Board of Physicians has to approve them. Some of the protocols will have to be re-written, for example, each time an EMS technician is presented with a MOLST form, the EMS office must be contacted for approval to honor it.

Ted Becker asked what is being done in terms of educating the general public. Ms. Grant was advised that the most important people to educate are hospital discharge planners, nursing homes and hospices; those who deal with the terminally ill.

Dean Matt asked Ms. Grant to clarify what she said regarding someone not honoring a Living Will. Ms. Grant explained a Living Will is not a medical order. A Living Will is something to read and take into account and try to follow as a physician or a provider, but a medical order, in this case a MOLST, is an authorization.

Ms. Riveros said Judge DelPesco has received a grant to connect 45 long-term care facilities to the DHIN. That may provide a vehicle to disseminate more information with respect to the physical form. Ms. Riveros suggested Hospice connect with DHIN leadership and coordinate with Judge DelPesco and Debbie Gottschalk with respect to the Delaware Health Care Decisions Act. She asked what others would suggest or recommend.

Secretary Landgraf thought the AARP connection would be vital, not just for Delaware but on a national standpoint. She offered to help. Relative to the Division of Long Term Care and Residents Protection, Secretary Landgraf will speak to Judge DelPesco to ensure that residents get this information; patients have a right to be informed and make end-of-life decisions.

Secretary Landgraf asked if there is a State role in all of this. She suggested Ms. Grant connect with Bill Love, Director of the Division of Services for Aging and Adults with Physical Disabilities and its Resource Center. Now that the long term care population is going to a managed care program in April, they should talk about how to connect Ms. Grant within that network, too.

Fred Townsend asked if there was one best place to look for the best MOLST form and Ms. Grant recommended he use a search engine and look for *Delaware Advance Directive*. Some people like to provide more information by using a workbook. The Midwest Center for Practical Bioethics has a very nice free workbook on its website at <http://www.practicalbioethics.org/FileUploads/FINAL.Caring%20Conversations%20Workbook%202010.pdf>

A Living Will is not a medical order. A Living Will is something to read and take into account and try to follow as a physician or a provider, but a medical order which is what a nurse or EMS would need to follow.

The Midwest Center for Practical Bioethics has a very nice free workbook on its website at <http://www.practicalbioethics.org/FileUploads/FINAL.Caring%20Conversations%20Workbook%202010.pdf>

Every hospital and nursing home has its own code status form they use. It is hoped that the MOLST form is adopted and becomes standardized. Dr. Nevin believes the DHIN could be helpful in that aspect.

Ms. Riveros said Dr. Jan Lee, executive director of DHIN, will be providing an update to the Commission in early 2012, as a result of the request by Ted Becker.

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HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT

State Loan Repayment Program - Requiring Proof of United States Citizenship

One of the requirements in the federal guidelines for the State Loan Repayment Program is that participants be a United States citizen or a legal permanent resident.

The current application form contains a check box asking if the applicant is a citizen or legal resident of the United States but does not require verification to substantiate a 'Yes' answer.

A recent State Loan Repayment Program award recipient was a foreign born naturalized citizen and their application sparked the need for confirming citizenship or legal resident status. After consulting with the DHCC Deputy Attorney General, both the DIDER and DIMER Boards recommended that the application form be revised to include a requirement that applicants submit proof of citizenship or legal resident status.

Proof could be a birth certificate, passport, green card, naturalization papers and, if an applicant is a legal permanent resident as the result of marrying a U.S. citizen, a copy of the marriage license.

Action

Secretary Landgraf made a motion to require proof of citizenship or legal status for applicants of the State Loan Repayment Program. Mr. Becker seconded the motion which carried after a voice vote.

Action

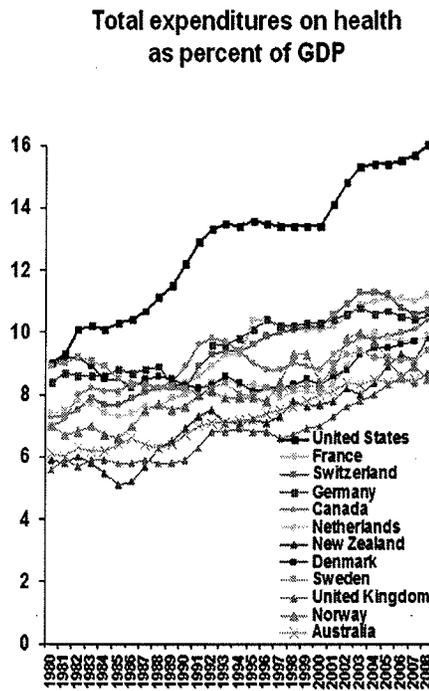
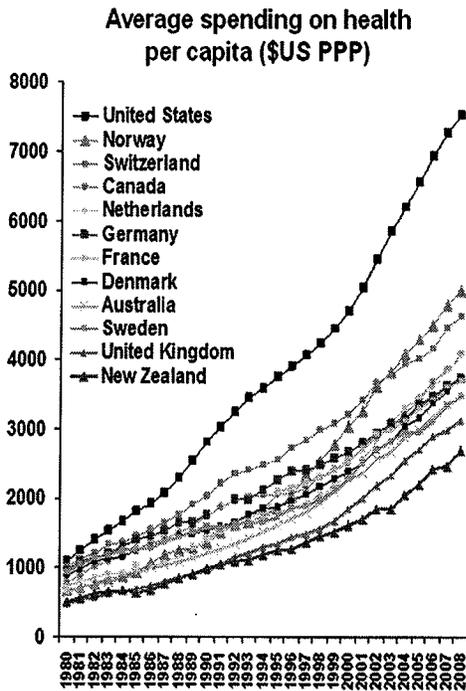
The Commission approved to require proof of citizenship or legal status for applicants of the State Loan Repayment Program.

Health Professional Workforce Presentation

Paula Roy gave a presentation on workforce development to serve as a launching point to move the Commission forward on the issue.

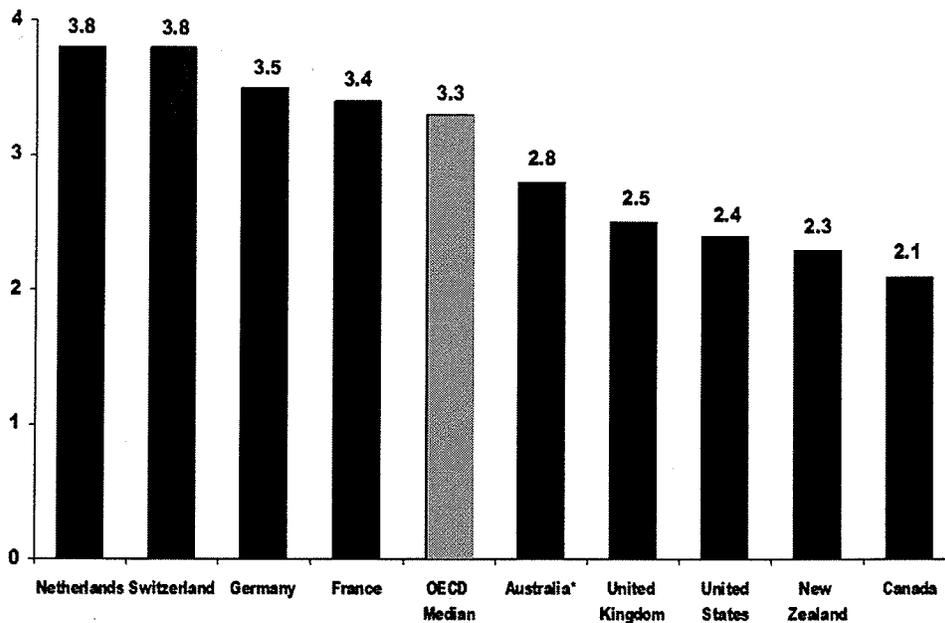
In 1980, most major developed countries were spending the same amount of money on health per capita. Over the years since, the United States has greatly outspent other major countries. For all of that spending, the United States has not produced enough physicians to meet the demands of the population.

International Comparison of Spending on Health, 1980-2008



Source: OECD Health Data 2010 (June 2010).

Number of Practicing Physicians per 1,000 Population, 2006



*2005

Source: OECD Health Data 2008, *June 2008.*

The American Association of American Colleges, the Council on Graduate Medical Education and the United States Department of Health and Human Services Health Resources and Services Administration (HRSA) all project physician shortages.

Nearly forty-five percent of physicians are over 55 years of age. Economists project a third of physicians could retire in the next 10 years.

Women are making up a larger proportion of the physician supply, but they tend, on average, to work fewer hours. The generation currently entering the medical profession is very interested in maintaining a work/life balance and choosing to work less hours. Work/life balance issues are increasingly a concern for men and women. It is a contributing factor to the projected physician shortage.

According to HRSA, older RNs over age 50 comprised 44.7 percent of the total RN population in 2008 compared with 33 percent in 2000. HRSA also projects a shortage of 157,000 pharmacists in 2020. Both pharmacy and nursing report shortages of faculty to train new professionals. The Delaware Healthcare Association projects a need

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The generation currently entering the medical profession is very interested in maintaining a work/life balance and choosing to work less hours. It is a contributing factor to the projected physician shortage. Delaware Healthcare Association projects a need for 7900 in nursing and allied health professions from 2009 – 2014. It projects a need to recruit 1300 nurses and allied health professionals a year; 830 to cover

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Demographic characteristics of physicians, pharmacists and nurses do not reflect that of the US population.

There is an estimate of 2,255 physicians in active practice in Delaware; 863 estimated to be primary care. This produces a ratio of 1 primary care physician per 1187 people in Delaware.

Half of primary care physicians are over 50 (35%) and 16.3% of them are over 65.

In 2008 64.6 percent of physicians were between the ages of 40 and 64 (29.2% were between 40–49 years old, and 35.4% were between the ages of 50–64). By 2020 only 31% of physicians will be between 40–64 years of age. It shrinks to 29% by 2030. However 40% of the total Delaware population will be over 50 in 2030.



Delaware Snapshot

- 2,255 Est. physicians active practice
- 863 Est. primary care physicians (PCP): 1 PCP to 1187 people
- Federally designated shortage areas: all Kent & Sussex & portions NCC
 - Meet or exceed 3500 to 1 ratio
 - COGME low end of acceptable – 1250 to 1
- DE Healthcare Assn
 - 7900 nurses and allied professional between 2009 - 2014
- 1 to 9582 - Psychiatrist to population ratio
- 80% bachelor's program report faculty shortage
- Average faculty age (2006)
 - 46 – diploma, certificate, associates
 - 53 – bachelor and graduate

PCP – DE Age Distribution

	PCP '08	DE '08	DE 2020	DE 2030
Under 40	19%	19%	19%	17%
40 – 49	29.2%	14.9%	11%	12%
50 – 64	35.4%	19%	20%	17%
Over 65	16.3%	14%	19%	24%

PCP – DE Race Distribution

Caucasian			
-PCP 2008	73%	Delaware 2030	72%
Asian			
-PCP 2008	20%	Delaware 2030	.04%
African-American			
-PCP 2008	4.5%	Delaware 2030	23.5%
Other			
-PCP 2008	1.2%	Delaware 2030	.04%

Hispanic & Non-Hispanic

	Hispanic	Non-Hispanic
• PCP 2008	4.2%	95.8%
• Delaware 2008	6%	94%
• Delaware 2020	10%	90%
• Delaware 2030	12.5%	87.5%

Primary Care: WHY IT MATTERS

- Aging "Boomers" will create more demand for services
- Increased insured from ACA
- Increased rates of chronic illness
- Proven efficiency; cost effective; better outcomes
- Adequate supply critical to insuring access and maintain healthy populations

Student medical debt averages \$145,000 for public medical schools and \$180,000 from private schools. Many students opt for higher paying specialties over primary care for many reasons, one being the prospect of paying off debt sooner.



Primary Care Challenges

- Medical School Debt \$145,000 - \$180,000

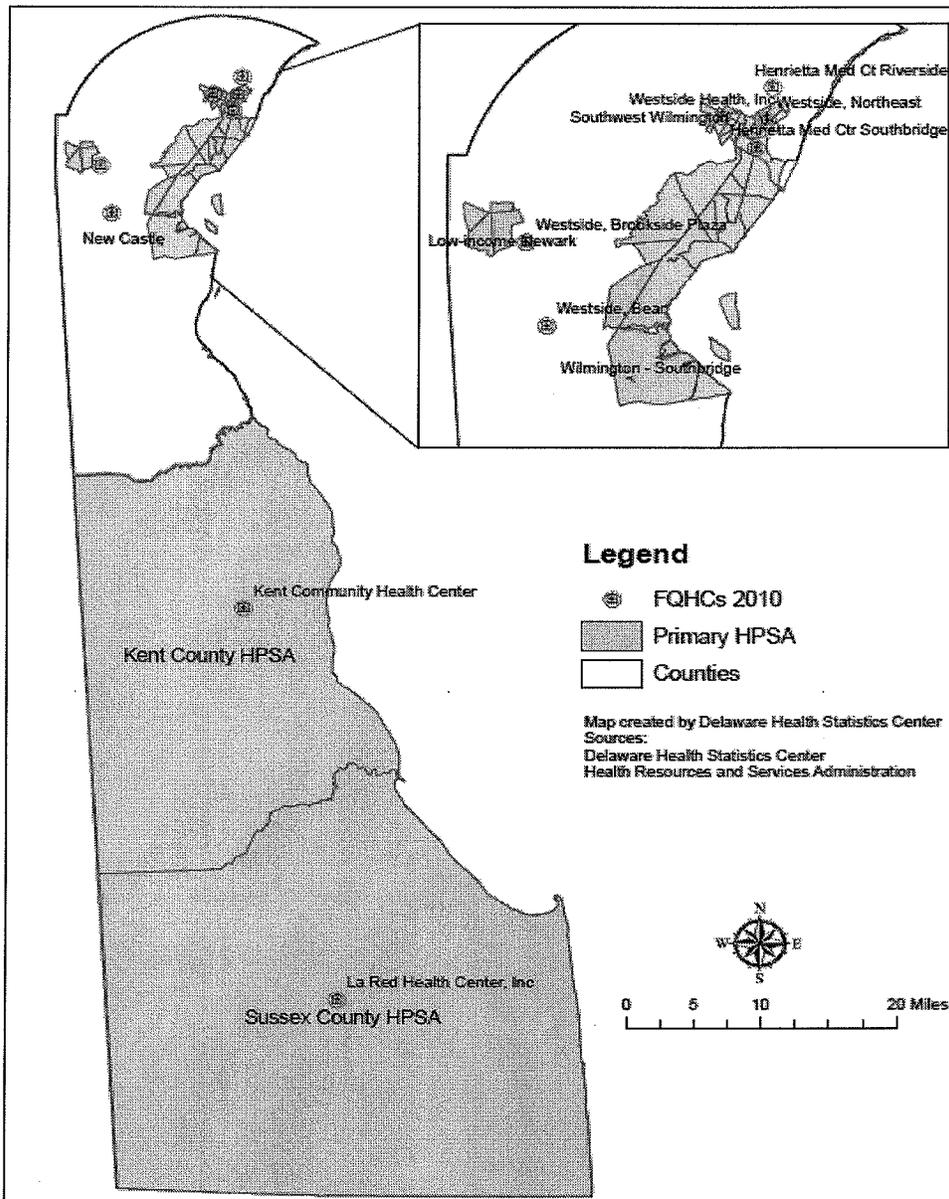
- Annual Compensation:

- Orthopedics	\$473,770
- Radiology	\$468,594
- Dermatology	\$385,088
- Pediatrics	\$192,000
- Family Medicine	\$183,999
- Geriatrics	\$179,950

- “ROAD” to success

All of Kent and Sussex Counties and portions of New Castle County are federally designated shortage areas for primary care, meaning they meet or exceed the federal definition of 3500 to 1 ratio of persons per physician. It should be noted, however, that this definition represents a severe need, far outstripping the 1250 to 1 measure of *The Council on Graduate Medical Education (COGME)* as the low end of acceptable ratio.

Primary HPSA Designation Delaware, 2010



BS 5.21.10

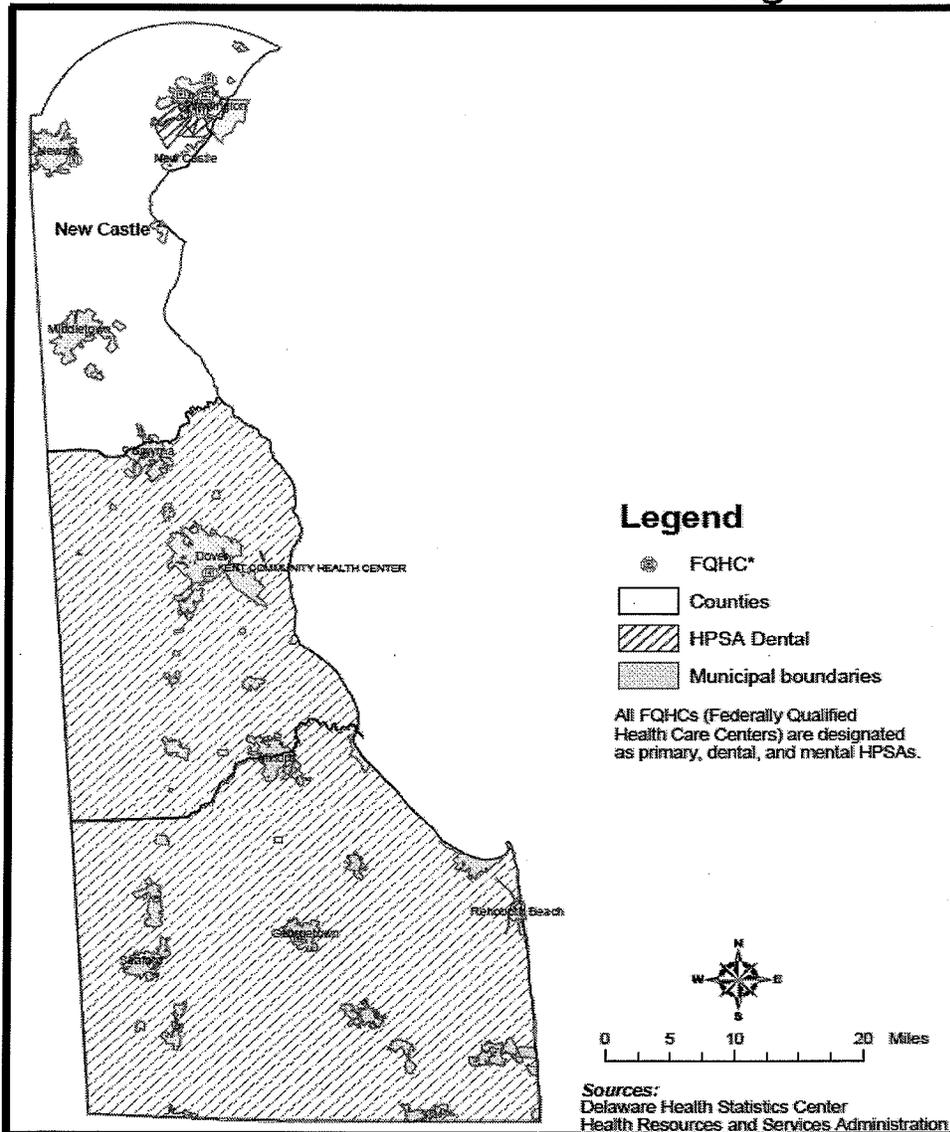
The population to dentist ratio improved from 3,100 persons per full-time equivalent dentist in 2005 to 2,300 persons per full time equivalent in 2008.

Overall the number of active dentists has increased since 2005. The number of general dentists increased from 261 to 331, while the number of specialists has decreased from 71 to 65 in 2008.

In 2008, 51 percent of dentists reported accepting Medicaid, an increase from 2005 when approximately one third reported accepting

Medicaid. However, in 2008 no specialists in Sussex County reported accepting Medicaid.

Delaware Health Professional Shortage Areas



Most pharmacists (70 percent) indicated in 2007 that they will be working five years. Seventy percent work for chain pharmacies.

Minorities and Hispanics are underrepresented in the pharmacy and allied health professions. Ninety-two percent of allied health professionals are Caucasian, 3 percent are African American, 2 percent of Asian and 3 percent were 'other.' Three percent of allied health professionals report being of Hispanic origin.

As indicated in *Delaware's Allied Health Professionals 2007*, both pharmacists and other allied health professionals report lack of

understanding of their roles by other health professionals and lack of public knowledge about professionals in their field as barriers to work in their profession.

Delaware's psychiatrist to population ratio is 1 to 9,582 persons but in Sussex County it is 1 to 27,431.

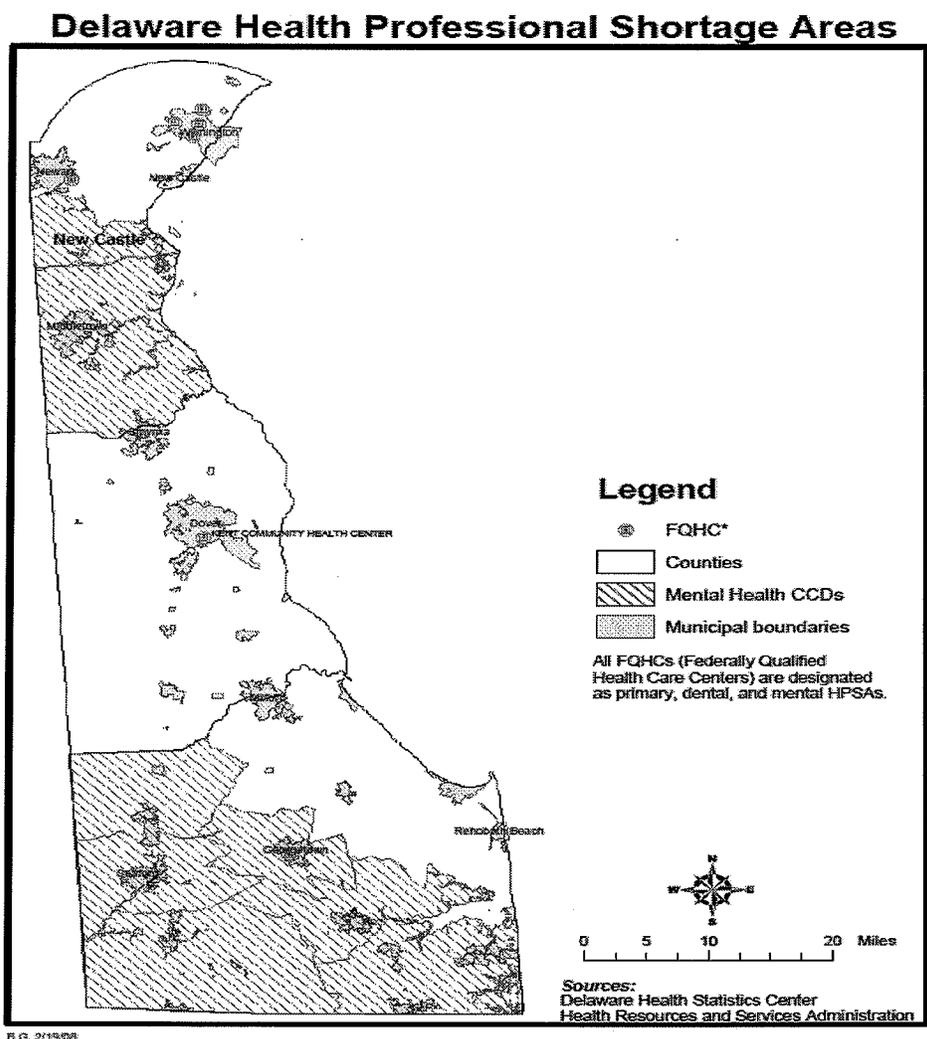
For other mental health specialists_(psychologists, social workers, professional counselors of mental health, chemical dependency professionals and psychiatric advanced practice nurses) the statewide ratio of each FTE mental health specialist is 1:2,309

Kent: 1:2,315

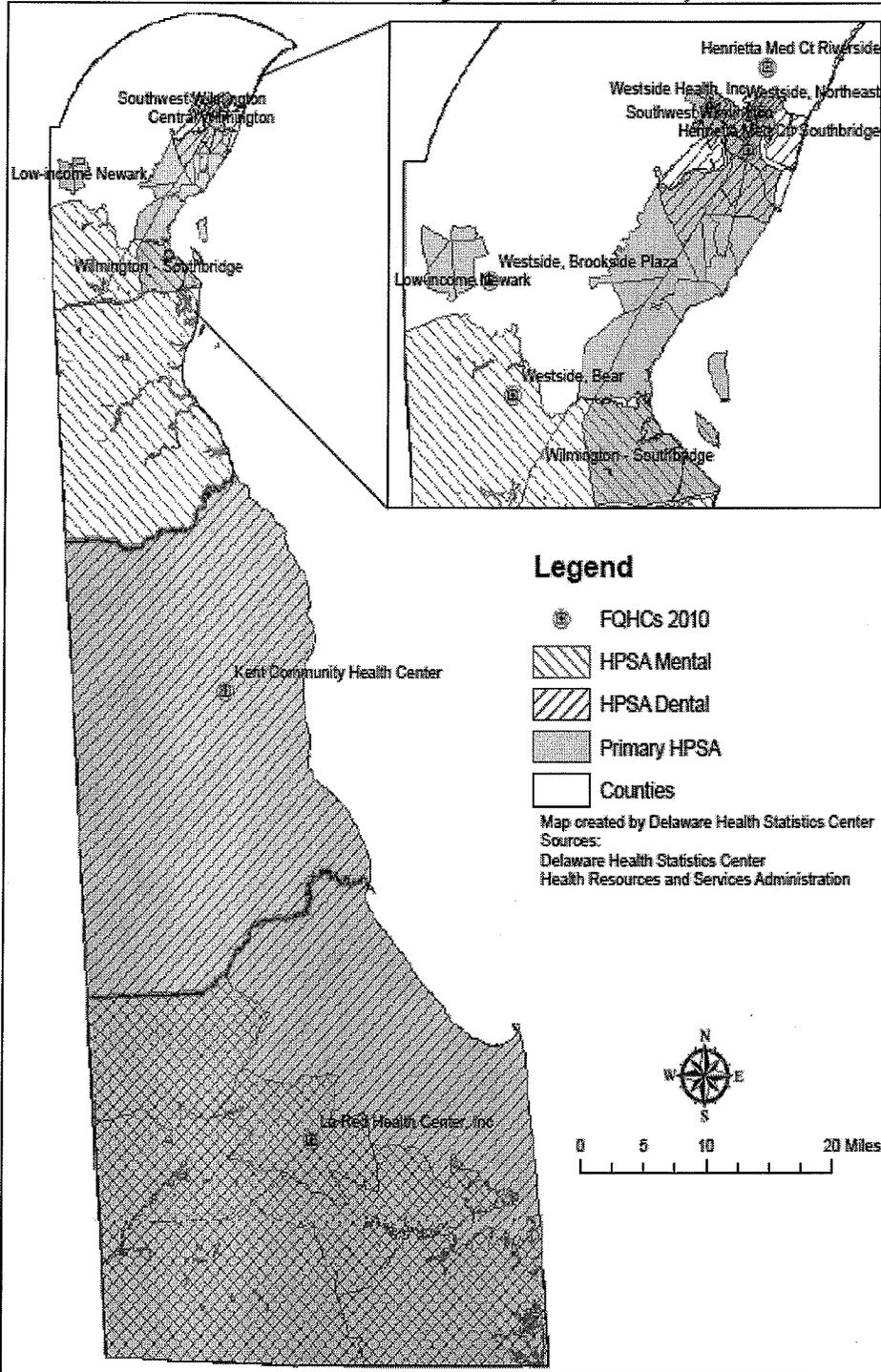
Sussex: 1:2,802

NCC has the most favorable ratio with 1:2,046

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Delaware HPSAs: Primary Care, Mental, and Dental



BG-5.26.10



DHCC Strategies

- **DIMER** (Delaware Institute of Medical Education and Research)
 - 20 slots Jefferson Medical College
 - 6 slots Philadelphia College of Osteopathic Medicine
- **DIDER** (Delaware Institute of Dental Education and Research)
 - Dental residency support – Christiana Care Health System
 - 5 slots Temple University Kornberg School of Dentistry
- **Loan Repayment**
 - Repay undergraduate and graduate education debt
 - Must locate in federally designated under-served areas
- **Workforce Development**

Over 20 institutions offer a total of 104 health education programs in Delaware. Associate degrees are the most numerous, followed by certificate programs, diploma programs, bachelor's degree programs and graduate programs.

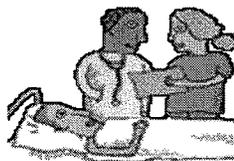
A higher proportion of minority students are enrolled in certificate programs (37%) and graduate programs (32%). Approximately 25% of the state's population is minority.

Almost 80% of bachelor's degree programs face a shortage of faculty.

The average age of faculty in diploma, certificate and associate's degree programs is 46; it is 53 for bachelor's and graduate programs.

SLRP Gets Results!

- 78 total
- 46 physicians
- 12 nurses
- 20 dentists
- 5 left after service



Looking Ahead -

- **Patient Centered Medical Home**
 - Payment Reform
 - Scope of Practice
- **Accountable Care Organizations**
 - Team approach – best care, less spending
 - Evidence based medicine
- **Technology**
 - health information exchanges and electronic medical records
- **Incentives – Loan Repayment**

Discussion

Dr. Nevin said realistically that looking at simply growing more professional workforce is not the answer. The amount of time it takes to go from A to B is too long and the needs are going to be sooner.

The challenge is to think about how we can deliver care differently so that the current workforce evolves into a workforce team. For example, the patient centered medical home model where a physician leads a team of several nurse practitioners or physician assistants, a diabetes educator, and a health coach.

If we keep doing things the same way, we are never going to catch up. It is essential to ensure that we allow people to work at the top of their trade and be effective.

Medical schools in the U.S. were charged to increase their class size about 10 years ago, which most did by adding 20 to 25 percent more students. The challenge is that the increases on the residency side have occurred but it has all been in sub-specialty training. There is a big threat now to funding for graduate medical education. You can make more students but there is nowhere for them to get the experience that they need.

Dr. Nevin said another challenge is how to develop more training programs for students. Delaware now has a health coach program, but there are not many of these programs around the country.

Ms. Riveros asked Dr. Nevin if there are specific barriers to people working at the top of their training or are there licensing issues or other issues around scope of practice. Dr. Nevin responded that there are barriers and issues.

Sheila Grant added that the Delaware Nurse Association was concerned about Hospice making the suggestion of creating a category of medication aides - nurse's aides trained and tested to give medications in the home.

Commissioner Stewart asked if there is a program to attract doctors who want to come to the United States, practice medicine and become American Citizens.

Dr. Nevin said in Family Medicine about 25 percent of the residency slots are filled by international medical graduates but there are only a certain number of residency slots. In order to do their training, international medical graduates need to have the correct type of Visa. Additionally, internationally trained physicians have to pass the exams, complete residency training and demonstrate they have the necessary competency to practice in the United States. There are a

The challenge is to think about how we deliver care differently so that the current workforce team evolves into a different looking workforce team.

In Family Medicine about 25 percent of the residency slots are filled by international medical graduates but there are only a certain number of residency slots.

large percentage of international graduates who participate each year. Some of the specialties are less competitive.

Judy Chaconas added that the J-1 Visa Program places international medical graduates who have completed their medical education in the United States in underserved areas of the state. Normally, upon completion of their education, these international medical graduates are required to return to their country of nationality for at least two years before returning to the United States. However, under the Conrad State 30/J-1 Visa Waiver Program this home residency requirement can be waived for up to thirty (30) J-1 physicians annually. In exchange, the J-1 physicians must agree to practice medicine full time at a Delaware pre-approved sponsoring site for a minimum of three years. These practice sites must be located in a federally designated Health Professional Shortage Area (HPSA).

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Ms. Roy said that, as Brian Olson pointed out, once physicians get through the licensure process, they need to be credentialed by the insurance companies, which adds more time to the process.

Commissioner Stewart said many health insurance companies are becoming international in nature at a very rapid pace. She notices a lot of growth in India and Korea with U.S. health and life insurance companies. She believes there will be some reciprocity. A doctor approved overseas by an American domiciled insurance company would have his credentialing process time shortened when coming to practice in the United States.

Emily Knearl said one of the things to be considered is how we define a patient centered medical home. The only medical care many women aged 18 to 45 years old receive is from an OB/GYN. Think about an OB/GYN as a basic medical provider.

Wayne Smith commented that the Delaware Hospital Association worked with the Board of Medical Licensure and some of the insurance companies about two years ago to streamline the process but it still has a way to go. Some states had success creating a centralized body with a common form that reduces the process time and he believes that should be something for Delaware to consider. Secretary Landgraf said that is part of what is being done with Judge DelPesco's criminal background check dashboard - people are being eased in as it goes.

Ms. Riveros said the dashboard accesses the DHIN to get the background check. She asked Wayne Smith to share the name of the contact in Maryland with her and the Commission staff to follow up on their procedures to see if there are ways to reduce the licensure time in Delaware.

Dean Matt asked how the Commission will move forward on the workforce development issue. There is an urgent need to take action. Delaware has an opportunity to think about and explore what the workforce will look like. Where does that discussion happen and how do we come back to look at this again as a state? Some solutions and ideas need to be put forward to decide how to be pro-active instead of reactive.

Ms. Riveros asked what the Commission members believe would be the best action in the workforce development front to move the ball forward so ideas can be executed.

Wayne Smith commented that the hospital CEOs had a brainstorming session about two years ago and believed that if a separate State program was created that for \$1 – 1.5 million a year the primary care shortage in Kent and Sussex Counties could probably be solved. The State Loan Repayment Program is a great leveraging program that works. It is a matching program so there are federal constraints but, if a State pool were created, some specialty areas could be targeted.

The Governor's Council on Health Promotion and Disease Prevention is charged with advising the Governor and executive branch state agencies on the development and coordination of strategies, policies, programs and other state-wide actions to promote healthy lifestyles and prevent chronic and lifestyle-related disease.

A member of the public asked if the recommendations of the Council may have some impact on the delivery of care, if recommendations are forthcoming and if there should be appropriate budget recommendations.

Secretary Landgraf answered that all would be appropriate steps. The Council wants to complete its work by the end of the calendar year to see what may fit into the Governor's recommended budget. However, the Council's role was not necessarily to create some type of a policy, but rather a '*call to action*' around health promotion and disease prevention. The Health Care Commission is mentioned in that document several times as a body that should be looking at this and taking action, a part of which is workforce development.

Ms. Riveros asked if there is a substantial starting point with respect to workforce development in that document.

The document contains a five year timeframe. Council members were asked to prioritize, not only based on the highest needs, but what is do-able.

The Council meets again within the next couple of weeks to finalize

the work that has been completed and to ensure that they are all in agreement relative to how that roll-out should look.

Ms. Riveros asked if it would be a logical plan to create a body to identify specific recommendations for the State to move forward on workforce development, and bring back a recommendation to the Commission in May 2012 before taking it to the Governor and General Assembly.

Insurance Commissioner Stewart asked Secretary Landgraf if the report talks about bringing in new doctors from other countries.

Secretary Landgraf does not believe the report is that specific but it may say that there be a designated group that further addresses these issues relative to workforce development and the shortage; the use of patient centered medical homes; more of an interdisciplinary approach to the delivery of health care and the Health Sciences Alliance. The report questioned who should own this and the group believed it should be the Delaware Health Care Commission. The Commission's statute was reviewed and it fit nicely that the Commission own it, tweak the general recommendations and bring action to the ground.

Action

Dean Matt made a motion to create a work group to look at health care workforce development and report back with interim reports to the Commission and recommended actions by May 2012. The motion was seconded by Secretary Landgraf and carried by a voice vote.

Action

A work group will be created to look at health care workforce development and report back to the Commission with recommended actions by May 2012.

SPECIFIC HEALTH CARE ISSUES

Tier IV Drug Pricing Project

Senate Bill 137 specifically asked the Delaware Health Care Commission to conduct a study for specialty tier prescription drugs to determine impact on patient care and submit a report on its findings by March 15, 2012. (Senate Bill 137 is available on the DHCC website: <http://dhss.delaware.gov/dhss/dhcc/presentations.html>).

Many people are interested in this project and Ms. Roy announced that the kick off meeting is scheduled for December 9, 2011, at 1 o'clock p.m., in conference room 301 of the Main Administration Building of the Delaware Health and Social Services Holloway Campus.

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OTHER BUSINESS

Delaware Health Care Commission
Meeting Minutes
December 1, 2011

Update: Sunset Review

Paula Roy said that the Joint Sunset Committee Performance Review Questionnaire was submitted to the Joint Sunset Committee on November 14, 2011.

The public hearing will be held on Tuesday, January 31, 2012, from 5:30 to 8:00 p.m. in the Joint Finance Committee Hearing Room on the ground floor of Legislative Hall in Dover. Commissioners and other interested people should consider making themselves available on that date.

Prior to the hearing, the Sunset Staff will prepare a report based on the questionnaire. The Commission will have the opportunity to review the Sunset staff report and make comments back to the Sunset staff prior to it being released to the Sunset Committee. The report could contain questions for the Sunset Committee's consideration or preliminary recommendations for the Sunset Committee. It will be the beginning of an evolving process and will play out over the next several months.

The Delaware Health Care Commission is the first of the agencies under review to be heard. There are about six agencies under review.

Delaware Institute of Medical Education and Research (DIMER)

Ms. Riveros introduced Sherman Townsend, chairman of the DIMER Board of Directors.

Mr. Townsend said that DIMER is probably the best bargain that the State of Delaware has. There are currently 91 Delaware students enrolled at Jefferson Medical College and 37 Delaware students enrolled at Philadelphia College of Osteopathic Medicine (PCOM). Mr. Townsend believes that providing Delawareans with an increased opportunity to pursue a medical education results in an increased likelihood that they will return to Delaware to practice after completing their medical training.

DIMER is working very closely with Dr. Janice Nevin and others to make sure Delaware students are given ample opportunity to enter the residency programs at Christiana Care, A. I. DuPont Hospital for Children and St. Francis Hospital.

The Delaware Health Sciences Alliance has also evolved from DIMER. Students are returning to Delaware to do their rotations and a southern campus of Jefferson Medical College has been established at the University of Delaware.

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The Delaware Health Sciences Alliance has also evolved from DIMER. Students are returning to Delaware to do their rotations and a southern campus of Jefferson Medical College has been established at the University of Delaware.

Dr. Nevin said that 11 third-year Jefferson Medical College students are spending their entire third year at the University of Delaware doing all of their core clerkships. Students have been doing rotations in Delaware for years. At Christiana Care alone, there are over 400 student rotations and those still continue. What changed is that those 11 students actually made a commitment to Delaware to get their core clerkship training here and that allows Christiana Care to do special programming for them. It really ties them to the State and they get to understand how health care is delivered in Delaware, they learn about the community, and they develop relationships. Dr. Nevin has spoken with some hospital residency program directors who are already actively recruiting some of these students to remain in Delaware. This will have a big impact when outcomes are measured.

Mr. Townsend said the programs are really trying to give these students more exposure to Delaware. That is the best opportunity to recruit physicians to stay in Delaware. Statistics show that physicians tend to establish practice within 50 miles of where they completed their residency training. That is why he is constantly pushing for Delaware students to have their residency training in Delaware if there are slots available for them.

Mr. Townsend suggested, as we look at our workforce, perhaps we should focus on special financial incentives for students to go into primary care, effectively reducing their educational debt.

He noted that Delaware previously tried to place restrictions on students by requiring them to come back and work in Delaware in exchange for having their grant/loan forgiven. But, there were many complications, including the Internal Revenue Service taxing the debt when it was forgiven.

Mr. Townsend thanked the Commission for restoring the student tuition assistance to the Commission's Fiscal Year 2013 budget request.

He wrote a letter to the Governor and General Assembly because he felt it was important for them to understand that Jefferson's budget is over \$400 million a year and Delaware actually gets 10 percent of their productivity. If Delaware has 20 to 25 students per year and Jefferson has 250 students per class, 10 percent of their entire school is educating Delaware students. Delaware contributes \$1 million when its share is actually \$40 million, thus Mr. Townsend is asking for more funds to support the education side. He said the State Loan Repayment Program does a great job in the short term of recruiting physicians to Delaware, and he encourages the State to continue that program and, if funds are available, also increase the funds allocated to that program.

Thomas Jefferson University is preparing to go through some changes. Its current president, Dr. Robert Barchi is retiring at the end of the year and a search committee is being formed to find a new president. Mr. Townsend is trying to encourage Jefferson to consider including a Delawarean on that search committee. Every time there is a new president, Mr. Townsend spends a full day educating the new president about the Delaware connection with Jefferson Medical College. It is important to show Jefferson that Delaware is serious about this relationship and wants to maintain it.

Insurance Commissioner Stewart asked Mr. Townsend if he is required to put the same energy into the relationship with Philadelphia School of Osteopathic Medicine (PCOM) as Jefferson.

Mr. Townsend said no, but he treats both schools equally and the relationship with both institutions is excellent at this point. PCOM is extremely appreciative of its relationship with Delaware. The agreement with PCOM is that they make a bona fide effort to admit at least 5 Delaware students per year and this year they admitted 12 students. The agreement with Jefferson is that they make a bona fide effort to admit 20 students per year. This year they accepted 28 students and 21 matriculated.

Delaware Health Benefit Exchange

Ms. Roy announced that Delaware was notified that it has been awarded Level I Establishment grant funding for Exchange implementation in the amount of \$3.4 million.

Paula Roy Retirement

Ms. Riveros, Rita Landgraf and Ted Becker joined each other at the podium and asked Ms. Roy to join them.

Secretary Landgraf noted that today is Ms. Roy's last Commission meeting, as she is retiring at the end of December. The Secretary read and presented Ms. Roy with a tribute from the Governor and Lt. Governor of the State of Delaware.

Ms. Riveros presented Ms. Roy with a plaque from the Commission honoring her 20 years of leadership to the Delaware Health Care Commission and 26 years with the State.

Mr. Becker gave an acclamation to Ms. Roy for all she has done for the Commission, its Chairpersons and Commissioners, and the people of the State.

Ms. Roy thanked everyone and said she had given the decision much consideration but is happily looking forward to retirement.

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PUBLIC COMMENT

Dr. Joann Fields asked for an update on Delaware’s progress with establishing a governing board for the Health Benefit Exchange.

Ms. Riveros said the Health Care Reform Steering Committee has been evaluating reports received from the Public Consulting Group. The Committee has received the new grant and is looking at sustainability plans, financial sustainability, operational plans, and opportunities to expand Medicaid. Once they have a better picture of the path forward they will move forward with a governing board.

Joann Hasse has been observing Commission meetings since before Paula became the Executive Director. Ms. Hasse has served on many committees under the Commission, most specifically and time consuming was the development of the Delaware Health Information Network (DHIN). She said it has been a pleasure working with Ms. Roy over the years and she wished her the best in her future endeavors.

NEXT MEETING

The next meeting of the Delaware Health Care Commission is 9:00 a.m. on January 5, 2012, at the Department of Transportation Administration Building, First Floor, Farmington /Felton Conference Room, 800 Bay Road, Dover.

ADJOURN

The meeting adjourned at 11:15 a.m.

Ms. Riveros presented Ms. Roy with a plaque.

Mr. Becker gave an acclamation to Ms. Roy for all she has done .

NEXT MEETING

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GUESTS

Judy Chaconas	DHSS/DPH
Jeanne Chiquone	American Cancer Society
Barbara DeBastiani	Wheeler and Associates
Dr. JoAnn Fields	Family Practice Physician
Sheila Grant	Hospice and Palliative Care Network
Joann Hasse	League of Women Voters
Cheryl Heiks	Cozen O'Connor
Rebecca Kidner	
Jonathan Kirch	American Heart Association/American Stroke Association
Emily Knearl	PPDE
Linda Nemes	Department of Insurance
Mary Nordenson	Delaware Physicians Care
Sheila Nutter	Hewlett Packard
Brian Olson	La Red Health Center
Hiran Ratnayake	Christiana Care
Rosa Rivera	Henrietta Johnson Medical Center
Christine Schultz	Parkowski, Guerke and Swayze
Paul Silverman	DHSS/Division of Public Health
Wayne Smith	Delaware Hospital Association
Jose Tieso	Hewlett Packard
Sherman Townsend	DIMER