

**DELAWARE HEALTH CARE COMMISSION  
DECEMBER 2, 2010  
DELDOT ADMINISTRATION BUILDING  
FARMINGTON/FELTON CONFERENCE ROOM  
DOVER**

**MINUTES**

**Commission Members Present:** Bettina Riveros, Chair; A. Richard Heffron; Rita Landgraf, Secretary, Delaware Health and Social Services; Janice E. Nevin, MD; and Fred Townsend

**Commission Members Absent:** Thomas J. Cook, Secretary of Finance; Theodore W. Becker, Jr.; Dennis Rochford; Karen Weldin Stewart, Insurance Commissioner; and Vivian Rapposelli, Secretary, Services for Children, Youth and Their Families

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

**CALL TO ORDER**

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

**MEETING MINUTES OF OCTOBER 7, 2010**

Since there was not a quorum of Commissioners in attendance, there could not be a vote to approve the October 7, 2010 minutes.

**Presentation - Health Care Reform – Perspectives from Christiana Care** - Robert J. Laskowski, MD, MBA, President and Chief Executive Officer of Christiana Care Health System

Commission Chair Bettina Riveros introduced Dr. Robert Laskowski, who also sits on the Christiana Care Board of Directors, is a board certified internist specializing in geriatric medicine, a professor at Jefferson Medical College, a graduate of and former associate professor and dean at Penn State University School of Medicine and holds an MBA from the Wharton School of Business. Dr. Laskowski has been very active in the community, having served as chair of the United Way, past chair of the Delaware Healthcare Association, the Wilmington Hospital Commission, and the Delaware State Chamber as a trustee of the Delaware Public Policy Institute.

Dr. Laskowski conveyed four basic messages to the Commission and members of the public in attendance: 1. Christiana Care is an enthusiastic supporter of health care reform, even with the imperfections of the Affordable Care Act; 2. Christiana Care sees its role and responsibility to be a leader in Affordable Care Act implementation, in Delaware and in the region; 3. true reform of health care, moves beyond changing incentives and requires a fundamental change in the culture of medicine and the culture of health in Delaware; 4. effecting this change requires broad partnerships with leaders and organizations, partnerships with the

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Robert J. Laskowski, MD, MBA, President and Chief Executive Officer of Christiana Care Health System gave a presentation 'Health Care Reform – Perspectives from Christiana Care'

people Christiana Care serves and partnerships with the formal mechanisms the State of Delaware uniquely has. Without those partnerships, there will be no health care reform.

Dr. Laskowski addressed five major areas of reform, some of which are in the Affordable Care Act and some are indirectly addressed through ACA, and relayed Christiana Care's perspectives on them: (1). health information technology; (2). prevention; (3). the concept of medical homes; (4). the concept of accountable care organizations and related to that, the concept of health care innovation zones and (5) the role and importance of partnerships, specifically the role of the State can and should play in helping to lead health reform efforts in the State.

Christiana Care Health System (CCHS) is the largest private employer in the State. It has 11,000 employees (1,400 of whom are physicians), and literally touches everybody in the community in some way at some time. This is a considerable responsibility which CCHS as a non-profit it takes very seriously.

Although at its core Christiana is a big hospital, it is much more, because of its role as a regional academic health system. That is very relevant to the role it feels is its responsibility to play in health reform – CCHS is an organizing system for managing care in the community.

CCHS has 50+ clinical sites in a four state region; a statewide VNA (Visiting Nurses Association) with hundreds of thousands of visits to people's homes, every day, throughout the State of Delaware. There are 1,400 physicians on staff - 200 of those are employed by the medical group of Christiana Care and another 150 physicians are under tight contractual relationships with CCHS. This affords CCHS the potential to be a multi-disciplinary medical group of 350 individuals. Of the 1,400 doctors on the staff, 500 are quite active and the others are peripherally active.

CCHS endorses health care reform because it believes: (1) there is a moral imperative to assure access to health care and, (2) society cannot continue to provide health care services in the future they way they are provided and be sustainable – there simply is not enough money. CCHS needs to engage the people it serves in the transformation of health care or it will fail.

Two and a half years ago, CCHS set out to transform health care - not simply 'newness' but with a renewed purpose to increase value. CCHS believes the value increased is achieved by providing services from a patient centric perspective - on people's behalf, for people's good and in a way that people recognize it.

CCHS benchmarks favorably in the vast majority of the quartile (lowest cost) of cost structure for all academic medical centers in the United States. However, CCHS will strive to do significantly better. One overall annual goal has been to increase value while controlling cost. Last year, CCHS's unit cost of *adjusted patient discharge* declined. While important, cost is not the only factor in improving value. Value should be measured in safety, quality of care given, but in an affordable way. CCHS has developed *value improvement teams* that measure quality, safety, patient satisfaction, adherence to national standards of clinical performance and cost, and a balanced metric used to review and grade itself. Value is a holistic concept, not one simply focused on cost.

\* *Adjusted discharge* blends in-patient work and out-patient work into a financial metric.

As an academic organization CCHS trains 275 residents as future physicians and at any given time there are 1,000 other students on campus every day – nursing students, physician assistant students, radiation, physical therapy students. The academic role is important in two ways: (1) contributes to workforce development and (2) sharpens the minds of faculty as it responds to the questions they ask. The educational mission is an important engine in reforming health care.

CCHS also has an important research mission. This is expected to become more important with the development of the Health Science Alliance. CCHS conducts \$50 million dollars of externally funded research per year. For example, Dr. William Weintraub, Chief of Cardiology at Christiana Care, heads up the Christiana Care Center for Outcomes Research. His expertise is looking at the effects of health care technology and health care systems on the lives of people. About a year and a half ago he was the lead author on a groundbreaking paper that compared the use of antibiotic coated stents with bare metal stents. The coated stents had complications that were unrecognized and were being overused. Through a national study, Dr. Weintraub discovered that and it made national news. The result was a dramatic change in the use of coated stents. That's the fodder, the raw material for health care reform – understanding better, more effective ways of practice.

Redesign of care is very, very important. Medicine is a "team sport" but seldom practiced that way. Under the direction of Dr. Janice Nevin, who is also a Delaware Health Care Commission member, Christiana Care practices patient and family centered care. The patient and family are the center of Christiana's attention and a team of individuals literally work side by side to facilitate care. Dramatic effects - cost goes down, safety goes up, satisfaction is higher.

Christiana Care feels strongly about health care reform and the Dr. Laskowski has made it a personal priority to be actively involved nationally. He has met with Federal government officials involved with health care reform. It is really clear that health care cannot take up much more of the nation GDP than it does today.

Dr. Laskowski view health information technology and the Delaware Health Information Network as the most ground breaking. He has seen it transform Christiana Care. For example, when computerized physician order entry was instituted a year ago, there was a marked decrease in ancillary use – laboratory tests went down, radiology tests went down. The problem is that because health services are reimbursed on a fee-for-service basis, the reduction in test resulted in a revenue reduction of \$3 million dollars. That what happens in a fee-for-service system.

Dr. Laskowski addressed the issue of medical homes. About 30 years ago, while at Kaiser Permanente, he was involved in operating a medical home. While the concept is sound, he has concern about the narrowness floating around about the way the concept is being addressed. Everybody wants to be a medical home. Without careful design, a medical home only gives physicians the incentive to shop for prices on ancillary services; it does nothing to change the way they practice. All it does is move nickels from one side of the table to the other. Christiana is very interested in medical homes but their approach needs to be comprehensive, involving a relationship between primary care physicians and specialists.

Dr. Laskowski believes strongly in. Christiana has concluded that prevention cannot truly be addressed without partnerships. Preventive thinking is a cultural issue – a societal issue – we have to think differently as people. This is an area where the State can be enormously helpful. It is very easy to “burn” much money and not achieve desired goals. A researched based approach towards prevention is essential.

Accountable care organizations (ACOs) are interesting and offer some hope, but not yet fully developed on the ground. The basic concept involves serving an identified population with the people serving it having some financial responsibility. The Center for Medicare and Medicaid Services Innovation, newly created by the Affordable Care Act, will issue ACO regulations in January 2011 for Medicare plans.

Governor Markell signed a resolution that Delaware intends to be a health care improvement zone.

State government is critically and uniquely important because of its ability to convene and encourage people to work together. The State has a large bully pulpit is large, especially in areas such as prevention. It should be a supporter; a leader; insist there be well thought-out medical homes, experiments in payment reforms, such as bundling. State government can use its position as an employer to conduct ACO experiments.

### *Discussion*

The floor was opened to commissioners and members of the public address questions to Dr. Laskowski.

Ray Sukumar, an endocrinologist, said he was a proud supporter of health reform, but was surprised and disappointed that many of his colleagues in the Medical Society of Delaware opposed it. He asked how Dr. Laskowski to address it.

Dr. Laskowski responded that at this point, since health care reform has been enacted it is better to look forward than backward. It is human nature to worry about change and its impact, especially now with worry over jobs and mortgages. The fact is there is not enough money to sustain the current health care system. If we don't change the way we practice medicine in a prudent fashion, there just isn't going to be enough money. It is important to find strategies that work, demonstrate that they work and build the energy off them. Many stakeholders in the medical field, including physicians, pharmaceuticals and medical device firms are protecting their interests. In an organization like CCHS money runs out, patients cannot be served. "Big thoughts" are nice but concrete actions will be transformative.

Dr. Laskowski was asked to expand his thoughts on health innovation zones and how Christiana is thinking about addressing primary care needs in the State.

Dr. Laskowski responded that a health care innovation zone essentially is an ACO. The concept Christiana is working on focuses on a high risk population who utilize a lot of services. Typically they are in and out of the hospital and nursing home. By looking at how to realign resources, for a modest amount of more money, practice patterns could keep many people out of the nursing home and at home where they would rather be. Unfortunately doctors, don't think like that. ACO should be paired with an education program and include professionals who are expert at caring sick people at home.

Primary care must be practiced differently. Currently there are not enough primary care doctors and, there will not be enough in the foreseeable future. Primary care teams can include physician assistants and nurse practitioners who deliver more services and

leave primary care doctors to function in an executive role, delegating work to colleagues who can do it better. Fortunately through the Delaware Health Science Alliance innovative ideas are developing for training primary care practitioners in a team approach to take care of our health care needs.

Lolita Lopez said the AAFP, AAP, ACP, and AOA came together and issued a joint definition of principles related to medical homes and asked Dr. Laskowski what is his opinion about them.

Dr. Laskowski said he thought the principles were good. There is a long checklist to get certified. In his opinion, the certification is less relevant than the relationships being built with the patients, the infrastructure to support those patients and the relationships with colleagues. He is very wary of professional egoism manifesting itself in medical homes. This was a factor in the 1990s during managed care.

Ms. Riveros asked if Dr. Laskowski had ideas about cultural changes that would encourage more people to choose primary care as a specialty.

Dr. Laskowski responded that often educators and many physicians respond more to tradition than innovation. Many turf issues and traditional rules are not borne out in fact – for example the idea that internists can't teach family doctors. There is a lot of tradition in medicine and not an easy change. He hopes to implement change, document the changes and communicate the results. His vision includes producing more nurse practitioners and physician assistants.

Paula Roy noted the income discrepancies among primary care physicians and other specialties, and asked if Dr. Laskowski thinks changes in payment for primary care may make a difference.

Dr. Laskowski said there has to be changes. Primary care physicians make too little money. Some proposals to raise rates, say by 10 percent, is not enough, and with budget neutrality constraints in the federal budget, it is unlikely that rates can be raised enough to make a difference. He believes it is preferable to expand the number of people a primary care doctor supervises.

Ms. Roy asked if he were optimistic that the new Center for Medicaid and Medicare Innovation created under the Affordable Care Act will truly encourage that kind of innovation.

Dr. Laskowski said he has had discussions with the new Director of CMMI, but did not ask him about alternative reimbursement strategies.

Dr. Laskowski was asked about communication -how is all of this going to shake out in patients' relationship with their doctors?

He responded that right now, it appears that health care reform is disconnected from the public. Those who follow it the most (other than professionals in the field) are those who did not have access to care or were uninsured. The rest of the public is confused and fear that any change will adversely affect their personal situation. Much more public dialog is needed.

Dr. Sukumar said he is a big supporter of DHIN but has observed a big resistance among physicians, particularly in the Medical Society. How can they be educated?

Dr. Laskowski thinks linking to DHIN is very important. Implementing an Electronic Health Record (EHR), is not easy and most physicians need help and resources. This is an area where the State could play a leadership role. For example, an HER could be required in order to practice medicine.

Ms. Riveros asked if Dr. Laskowski saw other areas where the leverage of the State or others could be used to exchange ideas.

The doctor answered that the State does a lot of contracting. The State has a lot of employees and a lot of beneficiaries, and could at least push experimentation in those areas.

Ms. Riveros asked if there are specific things give him pause or keep him up at night?

He said there are two - one item that should be looked at is involving the public. That should be front and center of health care reform. Otherwise it will fail.

The second is the role of competition. There is good competition and bad competition.

Ms. Riveros thanked Dr. Nevin for facilitating the presentation by Dr. Laskowski.

## **RESEARCH AND POLICY DEVELOPMENT**

The Role of the Delaware Health Care Commission in Affordable Care Act implementation.– Bettina Riveros

A draft outline of the *Role of the Delaware Health Care Commission* was distributed to Commissioners and available to attendees.

Ms. Riveros reiterated Dr. Laskowski's closing remarks were that Christiana Care was there to serve the public. The Health Care Commission's role is also to serve the public. There is strong attendance at Commission meetings by the public. The public needs to be engaged and the Commission needs to get input from its stakeholders in order to move forward in the Patient Protection and Affordable Care Act.

Ms. Riveros reminded everyone that at the last Commission meeting a discussion was started about the role of the Delaware Health Care Commission.

She asked the question how do we get national health care reform right for Delaware – for individuals, Delaware families, Delaware businesses, Delaware health care providers?

In the Patient Protection and Affordable Care Act there are some things that are Federal mandates and we need to move forward and implement those things. There are also other areas where there are key decisions to be made at the State level that will guide how those items are implemented and there will be decision making authority that governs that and drives the direction of how those mandates are implemented in Delaware for the benefit of Delawareans as noted.

She asked for discussion on the role of the Health Care Commission. What does Delaware need from the Commission? What is being asked of Commission members? Recognize there is a role of the Health Care Commission beyond the Affordable Care Act. There are responsibilities to DIDER, DIMER and CHAP and other responsibilities.

Looking at our role, is the Commission:

1. Advisory Only?
2. Convener of Public Stakeholders?
3. Policy Research, Review, and Recommendations?
4. Recommend a Broad Vision and Guiding Principles?
5. Decision Maker?
6. Other Roles?

Dr. Nevin said she appreciates the Commission was having this discussion because it is important and a big issue. She observed that it is likely that the discussion will just get started today. As Dr. Nevin was listening to Dr. Laskowski and making notes, she thought there is so much more to health care reform than simply looking at insurance, Exchanges and regulation. What is the overall structure in the State and what is the specific role of the Health Care Commission with regard to the system we create in the State to provide health for people who live here? Dr. Nevin views her

responsibility to date, rightly or wrongly, is to do more. The Commission has done CHAP, DHIN, DIMER and DIDER. CHAP is going to disappear, change or look very different. She sees DIMER and DIDER as part of health reform in terms of workforce and wants to think about some of the innovative ways that we can re-shape those programs to achieve our goal? DHIN is now taking its own route but we need to make sure we all stay connected because DHIN will also be a critical component of health reform. She wonders if the Commission should revisit vision and principles and build around that. Dr. Nevin is interested in hearing what people around the room have to say.

Dr. JoAnn Fields agrees with Dr. Nevin that there is a whole lot more to health reform than insurance and Exchanges. The State has a critical responsibility to make sure there is reform in the insurance market and implementation of the Exchanges. It has vast implications for expanding health care for individuals and small groups. Dr. Fields cautions that attempting to address all of the issues at once jeopardizes focus on the most important thing in her opinion— reform of the insurance market and development of the Exchanges. She said she believes creating exchanges requires legislation.

Ms. Riveros said it likely does require legislation; there are different options for states under the Affordable Care Act. States can develop State exchanges, partner with other states and establish regional exchanges, or default to the Federal government in which care the federal government would operate an Exchange. Ms. Riveros does not believe a state Exchange can be established through the regulatory process.

Dr. Fields added the no one entity can establish a framework for setting up an Exchange and reforming the insurance markets – the Medical Society, Christiana, or a group of citizens. Dr. Fields looks to the Commission to do what she cannot do and nobody else in the room can do and that is have the legal and policy work done so the Legislature can pass legislation and the Exchanges can go forward.

Paula Roy said it is easy to become overwhelmed when looking at the ten titles of the Affordable Care Act. There are some things that do fall to the states and with the Exchange, there are a many policy options available to the State, depending on how the state wishes to use the Exchange. It has the potential to go beyond insurance reform.

Dr. Nevin said she did not mean to imply that Exchanges weren't important but wanted to underscore that the decisions and policies that are created around the Exchange might ultimately drive how health care is practiced. Do you create the Exchange in isolation or

do you say this is what we would like to accomplish and then create the payment mechanisms to make what you want to happen.

Ms. Riveros said that was a good point. There are some views that the Exchange can be used to exert leverage to exact benefits, whether that be cost containment, participation in technology initiatives or other things. Do you need to address some of those things first and understand what you have to achieve through the Exchange - getting the bigger picture.

Rita Landgraf said it is a combination of both. The law definitely gives guidance relative to a timeline perspective. That's where there may be some anxiety relative to the development of the Exchange because there are certain things, including a legislative initiative that must be addressed before the Exchange is able to be established. The State must ensure that it is positioned and understands what that Exchange will look like for the State of Delaware. However, looking at the delivery of health care as part of that process is also important. The Affordable Care Act is clear that we have to look at regulatory practices and reforming of the insurance market, but the purpose of the act is to get better health outcomes for United States citizens.

Rich Heffron said he believes Dr. Fields brought up a good point in dealing with the Legislature. Issues like health reform are complicated, and many can't or won't understand. Legislators hear many voices on these issues - some which they might trust, some which they aren't too sure about and some which obviously are special interests and have particular views. Legislators will look to a fair and non-partisan arbitrator to advise them. The Commission should say, 'Here is the issue, here is how we look at it, here is what you need to consider and here are your options.' Mr. Heffron thinks that is the role the Commission can play. It is an important role.

Lolita Lopez remarked that what Secretary Landgraf said reflects her views. Therein lies the dilemma – the regulations are coming very fast and that makes Ms. Lopez see the Commission as more of the broad vision and guiding principle. It takes a lot of thinking to develop a broad vision and to agree on it. To do that the Commission needs to be the convener of public stakeholders, the policy research and recommendations, making decisions. She thinks the Commission is a good group to do that. In particular, this will allow an organized approach to issues such as Exchange development. It can also foster greater creativity, such as issues that Dr. Laskowski addressed.

Mr. Heffron told Ms. Lopez that he wanted to hear what everyone has to say. He said his role on the Commission was to represent the business community, but he also has a responsibility to learn what

the community at large has to say. Mr. Heffron believes he is on the Commission to represent the public.

Ms. Lopez said a unique role for state government is one of convening public stakeholders. The Commission is the best body to do that.

George Meldrum said last Spring the Commission voted to support the *concept* of menu labeling that Nemours was involved with and a bill was introduced to the Legislature. Supporting the concept is very different from supporting the bill. Mr. Meldrum was pleased with the way that was handled. That bill was used to help leverage a national menu labeling, which is part of health care reform. Nemours got very involved in the regulations. Based on some experience with Philadelphia, Nemours was able to advise HHS to be more effective. Mr. Meldrum thought the Commission's role in doing that was very effective because it represents a lot of expertise and respect in the community and Legislature. He likes the idea of advising the Legislature in a non-partisan way about an issue that affects the general population.

As the representative of a stakeholder, one public observer said they believe the Commission has the role of five of the six options indicated in the outline of the *Role of the Delaware Health Care Commission*. There is so much at stake and so much confusion in the general population that an organization designed to represent everyone is needed.

Ms. Riveros said her comments triggered another thought in her mind: does the Commission have a role in misconceptions, concerns, public outreach, education and clarifying misconceptions.

Another public observer thought that would be a hugely important role. Another way the Commission could be particularly helpful would be keeping track of who is doing what. There are two or three really talented people with the State she wanted to talk to about a specific issue but none of them knew who was doing what. It's no one's fault, it is because it is so complex and so unknown.

Dr. Sukumar wanted to look at these thoughts in a different way. Many on his staff have little knowledge about health care reform. He had a town hall meeting with his clients and he was amazed that so many were uninformed about the information technology provisions in ARRA or the concept that physicians will have to demonstrate "meaningful use" when acquiring electronic health records. He suggested that the Commission hold town hall meetings to inform people? The opponents of reform are so vocal, and he believes active advertising and "getting into the trenches" and educating the public and the Legislators.

Joann Hasse said the lack of a quorum at Commission meetings is a concern. She feels very strongly that at least the ex-officio members of this Commission, as part of their job, ought to be at the meetings. Some of them have rarely attended. One does not attend at all. If the Commission is going to be a sounding board for the public there should at least be a quorum of members present to approve the minutes so that some people who were unable to attend, could know what happened previously.

Dr. Nevin believes the Commission needs to make sure it has the right people advising it. She personally worries about making the right decision about insurance Exchanges. Does she have enough background in finance and insurance regulations to feel sure she can make a wise decision? She can understand how something would impact her world. It is more than that we need to be responsible for. Having voices from the collective folks who really represent health is important.

Ms. Landgraf added that the Exchange is going to be a marketplace where people can buy insurance and it is going to be a seamless system with the Medicaid program. Some design issues do not require expertise on the reform piece or the regulatory piece, but rather policy guidance to make it attractive to Delawareans. Ms. Landgraf has had the opportunity to sit in on town meetings sponsored up and down the State on behalf of AARP. It is very interesting to hear from the consumer's perspective. Ms. Landgraf's perspective is going to be biased, not only because of the level of information she has access to as Secretary of Health but also because Medicaid is an insurance industry and she has those lenses. The consumer perspective and what they need to make it user friendly is key so we don't leave people behind. For example, many people are not enrolling in the high risk pool because of the federal requirement that they not have coverage for six months. They are depleting their savings because if they wait six months they said they would be dead. What Ms. Landgraf has found very useful is that with an audience that already trusts you as the vehicle to convene and have State representatives come, many times it presents a more friendly, trustful environment than if the State dictates and goes out and get those people who come.

Ms. Roy asked how does the Commission want to organize itself in order for Secretary Landgraf to get the information and provide the education? She asked if commissioner thought that one monthly meeting going would be sufficient.

Ms. Landgraf said some organizations are putting together position papers on how they are interpreting the Exchanges, on how they are interpreting the Affordable Care Act. What could be beneficial for the

Health Care Commission is that, as part of that research component, we can bring all of that together and present it to the Commission and say, 'Here is the research that has been done, here is the organization's viewpoint on whether Delaware should advance this' and then we are getting that information from the ground as we are proceeding forward on our decision making. We can ask the public itself to bring forth their policies and how they view implementation of the Affordable Care Act and take that as part of our decision making process.

Ms. Riveros said the Commission could also provide some of the considerations, some of the options and that type of thing. Can we agree on at least which ones of the five roles outlined in the *Role of the Delaware Health Care Commission*?

Jeanne Chiquione of the American Cancer Society (ACS) said that ACS decided to break down elements of the ACA into a conceptual framework – affordability, availability, adequacy, administrative simplicity. After that they looked at Exchanges, and examined various pieces.

Dr. Nevin says this approach makes the most sense.. The Commission needs some dedicated, 'roll up your sleeves' time. This time and place in history is very important.

Ms. Roy recalled that in the early 1990s during the Clinton era health reform discussions, the Commission met in longer blocks of time and would have two meetings a month – one, a regular business meeting a second workshop type meeting. This was offered only as an example of how the Commission might want to organize itself.

Dr. Nevin believes the Commission needs a session to figure out what is needed and how it wants to do things. It should develop an action plan.

Ms. Riveros suggested scheduling a half or longer day retreat or meeting, shortly after the holidays, sometime in January 2011, to work through the issues and decide how to move forward.

## **INFORMATION AND TECHNOLOGY**

- Update on Delaware Health Information Network (DHIN)

This is the last Health Care Commission meeting before the DHIN moves out from under the Health Care Commission and transitions to its own agency. As Chair, and on behalf of the Commission, Ms. Riveros wanted to thank those involved for all of the work by the DHIN, by the Board, by the staff working with the Commission, and the accomplishments which have made the health information exchange a reality in Delaware and a model. That is thanks to their

great effort and commitment of everyone involved and it is important to recognize it and of course, recognize Gina Perez.

Rob White, chairman of the DHIN, was unable to attend this meeting, so Gina Perez thanked the Commission on behalf of Rob, the Board and herself for the last 13 years that the Commission has shepherded DHIN. As Dr. Laskowski said, the DHIN would not have happened without the Commission's leadership. Another point he made was about the State's ongoing commitment and that's critically important, and DHIN will continue to look to the Commission for guidance.

- Transfer of DHIN Contracts from DHCC to DHIN

Ms. Roy said the Commission will need to pass a resolution that formally transfers all of the contracts with the vendors from the Commission to the DHIN. The contracts are currently with the Commission since the DHIN falls under the auspices of the Commission. This will be an important action item in January. According to the legislation, the DHIN becomes its own entity January 1. Looking at the calendar, the first business day after January 1 is January 4 and the Commission meets meeting on January 6.

Some of the DHIN Board members could be on hand and the Commission could give it the recognition it is due.

### **UNINSURED ACTION PLAN**

- Update on Community Healthcare Access Program (CHAP)  
Betsy Wheeler updated the Commission with current CHAP statistics.
- As of 11/30/2010 the current program enrollment is 8,805
- In June 2011, CHAP will have its tenth year anniversary.
- In November, CHAP received 448 applications (Ever 37,405) and enrolled 447 applicants
- Medicaid enrollments over the lifetime of CHAP is now at 3,954 (as of 11/30/2010)
- As of 11/30 there are currently 542 participating VIP Providers
- As of the last Quarterly Report (July-September/1<sup>st</sup> quarter of FY 2011) donated hospital services totaled just under of \$2.6 Million (\$2,598,739.84)
- As of the last Quarterly Report (July-September/1<sup>st</sup> quarter of FY 2011)
- Prescription Assistance researched 494 medications which resulted in 460 being filled for a projected savings to the patient of \$134,714

Ms. Wheeler paraphrased parts of a letter that was recently received from a CHAP patient:

A patient stated that she "is not a deadbeat who won't work." She worked in the medical field, but the office where she works She stated that so many people out there treat everyone without health insurance the same – "Like I'm lazy and don't want to work" or their attitudes are rude and condescending whether she's there in person or on the phone, with the exception of the people who work with CHAP. She stated that we have been "lifesavers with her healthcare and medicine". A quote from her thank you card to the program office reads "I'm an insulin dependent diabetic and I am also on oral medication. Beatrice (CHAP Care Coordinator) helped me get hooked up to a private doctor at VIP, and to Christiana Care--- and Pam (CHAP Care Coordinator) helped me get my insulin through the manufacturer for a year at no-cost. You guys are compassionate, generous with your time, so patient and so helpful. I need to find out where you are and take you out to lunch for everything you've done for me. You might think I'm just kidding, but you have been wonderful. Thank you for all that you've done for me!"

Ms. Riveros asked if Jill Rogers would address the Commission on technology integration at its January 6<sup>th</sup> meeting and Ms. Roger agreed.

Ms. Roy called Commissioner's attention to the draft outline of the annual report distributed to Commissioners. After the Commissioner's have an opportunity to review, please call Ms. Roy with any comments.

Because of the Commission's role, the Affordable Care Act and the new work that is going to fall to the Commission, it was thought this would be the year to change the information in the annual report. Ms. Roy prepared an outline that switches the focus to the Affordable Care Act. As updated drafts are crafted in December, they will be given to Commissioners and must be adopted in time for the final Annual Report to be submitted to the Legislature by the January 15<sup>th</sup> deadline.

Ms. Roy pointed out that all changes to the funding updates, which have been provided to Commissioners monthly, differences in the updates from October have been highlighted for ease of use.

With respect to the Annual Report, Ms. Riveros and Ms. Roy have had good discussions about the content and wanted to share the outline, as meeting details are firmed and how that integrates with the Report and when it is finalized.

**NEXT MEETING**

The next meeting of the Delaware Health Care Commission will be held on Thursday, January 6, 2011 at 9:00 a.m. at the DeIDOT Administration Building in the Farmington/Felton Conference Room, 800 Bay Road, Dover.

**ADJOURN**

The meeting adjourned at 11:15 a.m.

**NEXT MEETING**

The next meeting of the Delaware Health Care Commission will be held on Thursday, January 6, 2011 at 9:00 a.m. at the DeIDOT Administration Building in the Farmington/Felton Conference Room, 800 Bay Road, Dover.

## GUESTS

Anthony Brazen, D.O.	Division of Medicaid and Medical Assistance
Judith Chaconas	DHSS/Division of Public Health/Bureau of Health Planning Management
Jeanne Chiquione	American Cancer Society
Kathy Collison	Division of Public Health
Barbara DeBastiani	Wheeler and Associates
Dr. JoAnn Fields	Family Practice Physician
Robert Frelich	Medical Society of Delaware
Donna Goodman	Westside Family Healthcare
Joann Hasse	League of Women Voters
Lolita Lopez	Westside Family Healthcare
Linda Nemes	Department of Insurance
Sheila Nutter	Hewlett Packard
Brian Olson	LaRed Health Center
Mary Parykaza	Division of Public Health
Gina Perez	DHIN/Advances in Management
Rosa Rivera	Henrietta Johnson Medical Center
Jill Rogers	Division of Public Health
Lenetta Roberts	Westside Family Healthcare
Lillian Ronneberg	Hewlett Packard
Betsy Wheeler	Wheeler and Associates