

**DELAWARE HEALTH CARE COMMISSION
MAY 3, 2007
DELAWARE TECHNICAL & COMMUNITY COLLEGE
CONFERENCE CENTER, ROOM 400 B
DOVER**

Action Item

MINUTES

Commission Members Present: Lt. Governor John C. Carney, Jr., Chair; Theodore W. Becker, Jr.; Carol Ann DeSantis, Secretary, Department of Services for Children, Youth and their Families; Joseph A. Lieberman, III, MD, MPH; Vincent Meconi, Secretary, Delaware Health and Social Services and Lois Studte, RN.

Members Absent: Richard Cordrey, Secretary of Finance; Matthew Denn, Insurance Commissioner; Jacquelyn W. Gorum, DSW, and Dennis Rochford, President, Maritime Exchange for the Delaware River and Bay Authority.

Staff Attending: Paula Roy, Executive Director; Sarah McCloskey, Director of Planning and Policy; Marlyn Marvel, Community Relations Officer; and Linda G. Johnson, Administrative Specialist.

CALL TO ORDER

Vincent Meconi, Acting Chairman, called the meeting to order at 9:21 a.m.

MEETING MINUTES OF APRIL 5, 2007

Dr. Joseph Lieberman made a motion that the April 5, 2007 meeting minutes be approved. Ted Becker seconded the motion. There was a voice vote. The motion carried.

INFORMATION & TECHNOLOGY

**Delaware Health Information Network (DHIN)
Clinical Information Exchange Utility**

Project manager, Gina Perez, gave a presentation on the background and status of the DHIN.

The DHIN vision is to develop a network to exchange real-time clinical information among all health care providers across the state to improve patient outcomes and patient-provider relationships, while reducing service duplication and the rate of increase in health care spending.

The DHIN was statutorily created in 1997, and is governed by a public-private Board of Directors under the Delaware Health Care Commission. To the credit of the General Assembly and Governor at that time, the legislation was insightful and visionary and the project has gained national attention. DHIN has active multi-stakeholder committees which include representation from hospitals, physicians, laboratories, consumers, health plans and employers.

Action

The minutes of the April 5, 2007, meeting were approved.

Gina Perez gave a presentation on the background and status of the DHIN.

The presentation encompassed the following:

- *What is DHIN?*

DHIN is a secure network for distributing clinical results and reports from the hospital, lab or radiology center to the treating physician. Data is managed by those who order the test and those who perform the test.

- *Why do we need it?*

Most doctors receive laboratory results from five different labs all sending results in a different format and method. Clinical information is missing in 13.6 percent of primary care visits:

Lab results – 6.1 percent	Medications – 3.2 percent
Radiology results – 3.8 percent	Dictation – 5.4 percent
History and physicals – 3.7 percent	

Missing information is judged to adversely affect care in 44 percent of visits and delay care in 59 percent of visits.

One significant DHIN accomplishment has been the standardization of lab and other test result in one DHIN format. All of the participating facilities agreed to issue results in the same format, thus saving physicians and staff valuable time when reading results.

- *Who participates in DHIN?*

The participants are data *senders* and data *receivers*. Senders include Bayhealth Medical Center (Kent and Milford); Beebe Medical Center, Christiana Care Health System (Christiana and Wilmington) and LabCorp. These account for 81 percent of hospital admissions and 85 percent of laboratory testing in the state.

Data receivers are Cardiology Consultants (16 offices statewide-30 physicians with an electronic medical record (EMR)), CN-MRI (two locations in Kent County-nine physicians with an EMR); Nephrology Associates (eight offices statewide-21 physicians, electronic inbox); Dover Family Physicians (one location in Kent County-four physicians, electronic inbox); Georgetown Family Medical (1 location in Sussex County-2 physicians, fax and electronic inbox). This is a total of 28 practice sites and 66 physicians.

- *What does it do?*

The first phase allows participating hospitals and labs (and eventually other facilities that perform tests) to send results through the DHIN to the treating physician. Physicians currently receive this data in numerous ways; fax, electronically or mail courier. The DHIN will streamline the process by allowing physicians to receive all results in one format of their choosing; electronic inbox, auto-fax, auto-print or through an electronic medical record (EMR), if available.

The second phase - patient record inquiry - will enable authorized users to query the DHIN to search for data available on a particular patient. Phase

DHIN is a secure network for distributing clinical results and reports to physicians.

Most physicians receive results from five different labs. Missing information adversely affects care.

DHIN has achieved a standardized lab result format.

Initial data senders: Bayhealth, Beebe, Christiana Care and LabCorp.

Twenty eight physician practice sites and 66 physicians are initial data receivers.

Physicians can choose how to receive results: electronic in-box, fax, print or electronic medical record.

two will also likely include value-added services such as medication history, consumer participation through a patient portal, and electronic order entry.

- *How is it funded?*

In 2001, the concept was launched through Health Care Commission pilot funds. In 2004 a project director (Gina Perez) was contracted with through Longwood Foundation and federal funding (beginning in September 2005). In 2006, an IT vendor (Medicity, Inc) was selected and system implementation began using state, private and federal funding. With federal funding in 2007, a chief information officer (Robert Conrad) was hired. The system went live in April 2007 with a combination of federal, state and private funds.

- *What are the benefits?*

The benefits of DHIN include: improved patient care through more complete clinical information and better communication; reduced “hassle factor” with information available to the physician at the time of a patient’s appointment and fewer forms to fill out; reduced healthcare costs with fewer duplicated tests and better medication management; and increased efficiencies with greater productivity and reduced deliver/mailling costs.

DHIN will improve patient care through more complete information, fewer duplicate tests and greater efficiencies.

- *Thank you*

Rob White, Chair of the DHIN Board of Directors, thanked three constituencies responsible for the DHIN’s progress.

The first is the volunteer Board of Directors and dedicated Executive Committee, many of whom became involved ten years ago and have regularly attended monthly meetings, which have progressed to a bi-weekly schedule.

Second is Gina Perez, for her personal contributions to the project, which has been incredibly managed.

The third is the Delaware Health Care Commission. Had the Commission not kept DHIN front and center, it could have easily “died” years ago. Mr. White thanked Paula Roy, Robin Lawrence, Sarah McCloskey, and Lieutenant Governor Carney.

Lt. Governor Carney added these acknowledgements:

Dr. Joseph Lieberman, a member of the DHIN Board of Directors since the beginning of the project; the late Herbert Nehrling, who was appointed by the Governor to initially chair the DHIN; Edward Ratledge, also a member of the DHIN Board since the beginning and expert on technical issues; Joseph Letnaunchyn, former chair of the DHIN Board; and Senator Thomas Carper and Congressman Michael Castle for their unrelenting support.

Discussion

Lois Studte asked how authority will be granted to allow a physician to access patient results in Phase 2 (patient record inquiry).

Gina Perez responded that a physician querying the system must have an established relationship with a patient. A relationship is established by the physician ordering a test for a patient, or by a primary care physician referring the patient to another doctor or specialist. Also, in the case of an emergency, an emergency department physician can enact a feature called “break the glass”, which allows them emergency access a person’s information. There has been much discussion and consideration on the part of the Consumer Advisory Committee to ensure that the concept of “breaking the glass” has all the highest levels of protection and patient security.

Ed Ratledge also clarified that the DHIN is de-centralized, and once the inquiry function is added, DHIN will act like a patient record locator system. Each participating health care facility will continue to maintain and manage its own data. Mr. White compared DHIN’s structure to Google, which does not maintain a centralized database that contains information but rather it knows where to find and locate information.

Dr. Lieberman said a benefit of DHIN will be the acceleration of the adoption of electronic health records in physician offices. As clinicians see the benefit of being able to exchange data through the system, they will be more likely to make the financial investment to upgrade their office equipment and technology.

UNINSURED ACTION PLAN

Community Health Care Access Program (CHAP) Workgroup

Ted Becker reported that two components of the CHAP program, enrollment and outreach contracts, are up for renewal. He stated that the CHAP Workgroup proposes that in the interest of avoiding any disruption in service, the Requests for Proposals (RFPs) for CHAP enrollment and outreach activities should be released without delay. The Workgroup also suggests that the scope of services for the RFPs not be modified at this time.

There was discussion about the need for rigorous monitoring and robust data collection to evaluate the effectiveness of current outreach/enrollment activities. The Workgroup has suggested that the RFP require that five percent of the total contract awarded be set aside for data collection, and that a contact person be designated to work with Dr. James Gill to provide information to be used for evaluative purposes.

Existing outreach vendors will be required to thoroughly report on their Fiscal Year 2007 activities and offer concrete reasons why such activities should be continued. The Workgroup will incorporate efforts to better coordinate outreach efforts across multiple state programs in the Fiscal Year 2009 contracting process and will spend the remainder of Fiscal Year 2007 and 2008 identifying programs for coordination.

If approved, the RFPs will be released today (May 3) immediately following the Commission meeting.

The CHAP Workgroup recommended that Requests for Proposals (RFPs) for CHAP enrollment and outreach activities be released without delay.

Ted Becker made a motion that the CHAP enrollment and outreach RFPs be released. Lois Studte seconded the motion. There was a voice vote. The motion carried.

HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT

Dentists in Delaware Report

Ed Ratledge, Director of the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware, presented the report, *Dentists in Delaware*, which was produced by CADSR with funding from the Delaware Division of Public Health.

The number of dentists was measured in two categories: general dentistry and specialists. There are 332 dentists in Delaware, with the largest number in New Castle County. This includes dentists practicing general dentistry and pediatric dentistry along with specialists in nine areas. It is also estimated that there are 261 dentists working in general or family practice and 71 dentists practicing in one of the nine specialties. In 1998, 243 dentists were in general or family practice while 59 dentists were practicing in one of the nine specialties.

The survey also allows researchers to calculate dentists' hours to determine the number of full-time equivalent (FTE) dentists in the state. A dentist delivering care to patients 40 hours or more per week was defined as a full-time dentist, or 1 FTE. For each four hours less than 40 hours, 0.1 FTE was deducted. Anything more than 40 hours was considered only as full-time. In other words, a dentist delivering 60 hours per week of dental services was still counted as one FTE dentist. (As a note, the measurement of FTE decreases as the dentist reaches the age of 55.)

The federal government also applies a productivity factor in determining full-time equivalency. They increase the FTE according to the number of auxiliary staff (dental hygienists and dental assistants) employed at a practice or facility. These non-dentist professionals increase productivity by providing services that might otherwise have to be performed by the dentist.

Given Delaware's 2005 population of 844,000, there are about 3,100 persons served by each FTE dentist, which is an increase of 500 persons per FTE dentist since 1998. *These ratios reflect only those dentists in general/family or pediatric practice.*

For the three counties, the estimates of people per FTE dentist are:

- 2,500:1 in New Castle County, up from 1,900 in 1998;
- 4,800:1 in Kent County, up from 3,400 in 1998; and
- 5,300: 1 in Sussex County, down from 5,400 in 1998.

The federal government defines an underserved area as one with more than 5,000 persons per FTE dentist. Clearly, the situation in Sussex County is far from optimal and exceeds the federal standard, and ratios in Kent County are very close as well.

Action

The CHAP enrollment and outreach RFPs will be released immediately following this meeting.

Ed Ratledge, Director of the Center for Applied Demography and Survey Research at the University of Delaware, presented the report, *Dentists in Delaware*.

Given Delaware's 2005 population of 844,000, there are about 3,100 persons served by each FTE dentist, which is an increase of 500 persons per FTE dentist since 1998.

In 1998, a disproportionate share of the youngest dentists was found in New Castle County. This situation does not appear in the 2005 survey, where newly graduated dentists increased significantly in lower Delaware. Kent County now has a somewhat larger proportion of dentists in the 65 years plus age group who are less likely to remain active in the next five years. The shortage of dentists in Kent and Sussex Counties will probably remain a problem as the population both expands and ages. It is also reasonable to expect that older populations will need more specialized care, thus contributing to the problem.

According to the survey, most dentists in Delaware report that they are accepting new patients and 35 percent report they accept Medicaid patients. Eighty percent of the dentists report providing some charity care.

The topic of demographic diversity within the dental community is seen as a way to improve the quality of care and reduce racial/ethnic disparities.

The dental community in Delaware is almost 80 percent male. Kent County has about 9 percent fewer female dentists than the state overall. The proportion of female dentists in New Castle County is significantly higher than that found in either of the two lower counties. Women are also slightly less likely (21 percent versus 17 percent) to practice as a dental specialist. At the same time those female dentists practicing a specialty are more likely to locate in New Castle County. The proportion of female dentists increased by five percentage points since the last survey in 1998.

African Americans account for more than 17 percent of Delaware's population, yet only 4.9 percent of Delaware's dentists are African American. However, since the last survey in 1998, the percentage of African American dentists has doubled from 2.4 percent.

Likewise, Delaware's population is approximately six percent Hispanic while the dentist population is just two percent. The highest proportion of Hispanic dentists is found in Sussex County (3.3 percent) where nearly seven percent of the population is Hispanic. Overall, just over 44 percent (an increase from 35 percent in 1998) of the practice sites in the state had someone available who could speak a language other than English and Spanish was the language reported most often. That proportion was highest in Sussex County where 41 percent of the sites reported speaking a language other than English and all of those employed someone who spoke Spanish.

Another measure of capacity is "wait time" or how long a person has to wait for an appointment once they have called a dentist's office. This time will vary significantly depending on whether the problem can be categorized as an emergency. Most dentists leave some openings to handle emergency cases. Wait times are, in general, less for dental specialists than they are for general dentists. In Kent County wait times are 30 percent higher than those provided by New Castle County dentists. In Sussex County general dentists have wait times similar to Kent County. Wait times for specialists in Sussex County are substantively higher than in the other two counties.

The report indicates that critical shortages of dentists exist in Kent and Sussex Counties.

Most dentists report accepting new patients. Thirty five percent report accepting Medicaid. Eighty percent report providing some charity care.

African Americans are 17 percent of Delaware's population. About 4.9 percent of Delaware's dentists are African American.

Six percent of Delaware's population is Hispanic. Two percent of the dentist population is Hispanic.

In both Kent and Sussex counties, new patients experience a 50 percent increase in wait times compared to established patients.

More than 90 percent of those practicing general dentistry in New Castle and Sussex counties use both dental assistants and hygienists to provide the necessary services expected of a general practitioner. There is little, if any difference in the distributions between those counties. The result for Kent County in both categories suggests a lower utilization rate by general dentists for both categories of employees. The lower utilization of hygienists by dental specialists reflects differences between the specialties and not a lack of interest in using non-dentist resources. For example, a periodontist would rely heavily on hygienists, while an endodontist would not. Their use of dental assistants is comparable to that for those in general dentistry.

Discussion

Paula Roy pointed out that since the State Loan Repayment Program was created in 2001, participating dentists have been required to accept a certain percentage of Medicaid patients. The results of that requirement are beginning to be reflected in the data gathered.

Lt. Governor Carney requested that the Commission be provided with data on the number of dentists and physicians recruited through the Loan Repayment Program at the next meeting and a review of recruitment efforts be provided.

SPECIFIC HEALTH ISSUES

Oral Health Coalition

Ms. Roy reported that an Oral Health Coalition was formed by the Division of Public Health and began strategic planning in December 2006.

The Coalition established three goals:

- 1.) Develop an oral health system that renders timely access to oral health care, prevention and treatment;
- 2.) Provide an educational opportunity to instill the importance of good oral health as a component of overall physical health and promote primary prevention of tooth decay throughout the life cycle; and
- 3.) Expand the oral health workforce in underserved areas and populations.

The Health Care Commission is involved with Coalition strategies dealing with access to care and the health professional workforce and is represented on those committees.

The Office of the State Dental Director (within DPH) received a grant from the federal Health Resources and Services Administration to develop case management and promote access to dental care targeting second graders.

Efforts are underway to recruit dentists to provide care to those targeted second graders. Discussions are taking place on how those activities can

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compliment and coordinate with other programs under the Division of Public Health and the Health Care Commission, such as the Community Healthcare Access Program (CHAP).

Lt. Governor Carney asked if the Delaware State Dental Society is involved and recognized their "Give A Kid A Smile" program, which serves hundreds of children. Ms. Roy responded that the program has been discussed at DIDER meetings. It provides wonderful services. The only drawback is that it is a one day event that does not necessarily include follow-up care. However, those are exactly the kinds of activities that can be built upon and hopefully expanded.

Ms. McCloskey reported that the Oral Health Coalition's Workforce Committee and the Access Committee met on April 27th and received an update on a new Stockley Center Medical Facility, which will include two dental suites. The facility has broken ground and construction is underway. The Committee also received an overview of the *Sussex Smiles* program, which is based out of the Stockley Center and provides about ten hours per month of free services for low income adults.

Ms. McCloskey provided the Workforce Committee with an overview of the DIDER agreement with Temple University School of Dentistry and an overview of the State Loan Repayment Program, which offers an incentive for dentists to practice in an underserved area. Ms. McCloskey will attend a full Oral Health Coalition Board of Directors meeting on May 4.

Ms. McCloskey also reported that she met with about 40 students from the University of Delaware's pre-dental club on April 30 and shared information about the dental program with Temple University and DIDER.

Lt. Governor Carney said that the Commission previously made an investment in Delmarva Rural Ministries (DRM) to expand services to include dentistry. Debra Singletary, Executive Director of DRM, noted that the Dental Society enhanced the Commission's investment by immediately providing a volunteer dentist. The facility currently has three dentists in the office, is recruiting for a hygienist, and has daily emergency hours from 8:00 a.m. until 10:00 a.m.

Chronic Illness Task Force Stroke Report Recommendation Implementation

Ms. Roy said the Chronic Illness Task Force met on Friday, April 27th. Two key items were discussed: 1.) progress toward implementing recommendations from the Stroke Task Force which developed a comprehensive stroke plan for Delaware and; 2.) a chronic illness summit being planned for Spring 2008.

The most critical recommendation is the formation of an Office of Cardio-Vascular Health, ideally in the Bureau of Chronic Disease within the Division of Public Health. This will serve to coordinate with other chronic illness programs because so many of the issues regarding risk factors, prevention and healthy lifestyles are integrated.

The most critical recommendation is the formation of a Cardio-Vascular Health Office, in the Bureau of Chronic

Applications have been submitted to the U.S. Centers for Disease Control and Prevention (US CDCP) for funding to establish this new office. One application is for a capacity building grant and the other is for a grant for optional funding. Optional funding would be used for programs to reduce risk factors, eliminate disparities, analyze and make recommendations on policies and systems change.

If the CDC funding is received it has been recommended that two positions be created: one for program management and one for health education. The target start date is June 30th.

OTHER BUSINESS

Cari DeSantis will represent the Commission at the Delaware Rural Health Initiative Workshop on May 4. Betsy Wheeler added that the Rural Mental Health Accessibility Workshop coordinated with national speakers who will provide a national perspective on what rural communities experience in terms of their mental health system. This will help profile Delaware's rural mental health system and engage community organizations to address system changes.

PUBLIC COMMENT

Dr. Robert Frelick stressed the importance of fluoridation in the water supply as a means to support prevention and improve oral health statewide. In spite of the state law to fluoridate all public water supplies, some cities are slow to implement this because of funding constraints.

Lt. Governor Carney asked if there was an active Public Health initiative to fluoridate the water in areas where it is not. Vince Meconi responded that there are only three public systems that are not fluoridated. Funding is being made available, and there is a plan to fluoridate them in the future.

NEXT MEETING

The next meeting of the Delaware Health Care Commission will be held on Thursday, June 7, 2007, at 9:00 a.m. at the Del Tech Terry Campus Conference Center, Room 400 B.

ADJOURN

The meeting adjourned at 10:40 a.m.

Disease within the Division of Public Health. An application has been submitted to the US CDCP to establish this office.

Cari DeSantis will represent the Commission at the Delaware Rural Health Initiative Workshop on May 4.

Next Meeting

The next meeting of the Delaware Health Care Commission will be held on June 7, 2007, at 9:00 a.m. at the Del Tech Terry Campus Conference Center, Room 400 B.

Guests Attending

Prue Albright	Advances in Management
Judy Chaconas	Division of Public Health
Isaac Daniels	Delaware Division of Public Health
Barbara DeBastiani	Wheeler and Associates/MACHC
Jeanne Chi	ACS
Robert Frelick	Medical Society of Delaware
JoAnn Fields	Physician
Joann Hasse	League of Women Voters
Lolita Lopez	Westside Health
Rita Morocco	NAMI-DE
Linda Nemes	Department of Insurance
Sheila Nutter	EDS
Brian Olson	La Red Health Center
Faith Rentz	Office of Management and Budget
Rosa Rivera	Henrietta Johnson Medical Center
Albert Shields	Office of the Lt. Governor
Debra Singletary	Delmarva Rural Ministries
Wayne Smith	Delaware Healthcare Association
Jose Tiese	EDS/DMMA
Betsy Wheeler	Wheeler and Associates
Rob White	Delaware Physicians Care, Inc.
Kathleen Widdoes	EDS
Glynn Williams	DMMA