August 2007

Contents

Delaware Statewide Environmental Assessment: Final Report to the Bureau of Primary Health Care

Prepared by Mid-Atlantic Association of Community Health Centers

Executive Summary

Federally Qualified Health Centers (FQHCs) have, as their principal mission, the provision of comprehensive primary health care to medically underserved communities and populations. They are a vital component in the health care safety net, protecting underserved communities. As of August 2007, Delaware has four FQHCs serving over 26,000 people in underserved communities.

As states face rising heath insurance costs and decreasing access to health care services, FQHCs are poised to play an increasingly important role in the health care delivery system. Health Centers need to continually adapt to current and future market realities. The Statewide Environmental Assessment (EA) provided Delaware FQHCs, Mid-Atlantic Association of Community Health Centers and the primary health care organization to analyze broad market and state issues that present the greatest opportunities and threats to the underserved and the Health Center safety Net. Furthermore, the process allowed the health centers to define the issues that were important to them and leveraged MACHC to provide in-depth analysis of statewide perceptions of FQHCs and their services. Ultimately this allowed the key players in Delaware's FQHCs to plan strategically for maximizing on opportunities and minimizing threats.

Beginning in February, 2007 and culminating in August of this year, MACHC has undertaken numerous activities to facilitate the success of the EA process in developing strategic plans for Delaware FQHCs. This report highlights the process which was followed by MACHC in engaging the FQHCs, the data collection, analyses and reporting of detailed statewide market information, and the final steps in formulating for statewide strategic actions.

Summation of the Strengths, Weaknesses, Opportunities and Threats to Delaware FQHCs

The Final Retreat held on August 2, 2007 at the Belmont Conference Center in Smyrna, Delaware a number of opportunities and threats were identified by the participants. The SWOT is summarized below with the priority opportunities and threats identified detailed.

Table 1: SWOT Summary from the Delaware Environmental Assessment Final Retreat

Strengths

(1) Existing partnerships with FQHC's – represent the entire state
(2) Quality of Care FQHC provide
(3) Capacity – FQHCs have the ability to serve and increase
(4) Culturally linguistic capability and wrap around services
(5) Collaboration as a network regarding clinical services
(6) FQHCs serve the largest percentage of uninsured

Weaknesses

(1) Perceive lack of capacity
(2) Lack of visibility in State and impact
(3) FQHCs only serve poor, diverse populations and the underserved
(4) Key stakeholders don't perceive network of FQHC or industry
(5) Non FQHCs are speaking on behalf of FQHCs
(6) The four FQHCs are not united
(7) Provider recruitment in several areas, infrastructure facilities
(8) Staffing capacity
(9) Recruiting qualified staff
(10) Inconsistent level of awareness and involvement of FQHCs

Opportunities

(1) Work with local business and the SBA to develop an insurance product
(2) New relationships with AstraZeneca and large employers like the Bank of America
(3) Hospitals need FQHC services and ability to serve diverse underserved population- must educate to get money
(4) Ability to qualify for grants
(5) Opportunity for more Medicaid patients
(6) Health care reform debate, opportunity to create risk pools and get involved in the debate; Federal funding
(7) Opportunity to see more Medicare population 65 years and older
(8) Expanding hospital/business and non traditional relationships
(9) Build relationships with public policy stakeholders
(10) Industry-wide public awareness
(11) Recruit and train new employees from empowerment zones – Workforce Investment Act/DOL, partnerships
(12) Opportunity to craft the image of FQHC segments and differentiate

Threats

(1) Perception that FQHCs give free care
(2) The four DE FQHCs are not united – need to bring the 4th FQHC into the partnership.
(3) Increasing number of uninsured
(4) FQHCs serve immigrants and undocumented. It costs money. May need to show documentation of citizenship and requirements
(5) Lack of visibility /knowledge of FQHC services
(6) Lack of relationships with public policy stakeholders
(7) Pay for performance – chronic disease management and the need to document outcomes
(8) All FQHCs are perceived as the same

The issues that were identified as the key priority threats and opportunities for FQHCs for strategic actions were (in ranked order):

Priority 1: Visibility and external awareness of FQHCs.

Lack of visibility of FQHCs within the communities they serve and in larger networks such as the business community was identified as a threat/weakness to FQHCs. From this there exists the opportunity to brand and market FQHCs locally, statewide and to key networks.

Priority 2: Capacity building and staffing of FQHCs.

The opportunity to expand current capacity of FQHCs services which includes meeting infrastructure needs and recruiting and retaining staff at all levels (front desk, medical assistants, nurses, practitioners). Recruitment and retention of staff was viewed as both an opportunity and threat as there are significant barriers in hiring and keeping providers but FHQCs also have advantages to offer providers not found in private practices (ie.Workforce Investment Act).

Priority 3: Business Opportunities to increase the payer mix.

Opportunities with small businesses, hospitals and other entities were highlighted in the final retreat with health centers focuses on revenue maximization via new business opportunities, improving reimbursements for case management and maximizing upon FQHC chronic disease management model. The impact of the Deficit Reduction Act and the rising numbers of uninsured using FQHCs were noted as potential threats related to payer-mix.

Priority 4: Policy and advocacy work.

Policy and advocacy work at the national, state and local levels.

Strategic Options and Action Plans for Selected Priorities

Working with the health centers and other key participants at the final retreat, the following strategies, actions steps, time frame and organizations responsible for achieving outcomes are summarized below. In order to set realistic goals and achieve positive outcomes without overextending the PCA, PCO and health centers capacities, MACHC and the health centers were able to commit to the strategies and action steps provided in the tables below for Priorities 1 & 2 identified in the preceding section.

TABLE 2: Strategy, Action Steps, Time Frames, and Responsible Organizations for Delaware Priority 1

Priority 1: Visibility and external awareness of FQHCs.		
Strategy: Develop a FQHC industry brand to increase visibility and awareness of FQHCs in Delaware, developing key messages to manage perceptions that are effectively communicated to stakeholders. The brand should include community oriented primary care that ties into health disparities and health care access issues.		
Action Steps	**Time Frame for Completion**	**Responsible Organizations**
(1) Develop a branding and communications strategy with key messages for targeted audiences and key stakeholders. Sell the values of the FQHCs.	Present - May 2008	MACHC, PCO
(2) Develop a branding implementation strategy regarding individual FQHC services and communication strategy for local medical providers and other stakeholders within the communities they serve. This should build upon branding and communications strategy developed in Action step 1 by MACHC and the PCO. (2.1) Define local Stakeholders and key messages and understand their current perceptions about the local FQHC.	May 2008 – August 2008. May 2008 – August 2008.	FQHCs FQHCs
(3) Incorporate FQHC and branding strategy into recruitment and hiring strategy.	May 2008 – August 2008	FQHC, MACHC, PCO
(4) Use the branding strategy and key messages to manage provider (medical and dental) competition as the public image of the FQHCs is elevated (defensive marketing).	Implementation in 2009, ongoing.	FQHCs, MACHC, PCO

TABLE 3: Strategy, Action Steps, Time Frames, and Responsible Organizations for Delaware Priority 2

Priority 2: Capacity building and staffing of FQHCs.		
Strategy: Attract and recruit a high quality staff to FQHCs to increase their capacity and effectively manage existing services, business opportunities and relationship development.		
Action Steps	**Time Frame for Completion**	**Responsible Organizations**
(1) Educate patients about FQHC services, encouraging use of all programs/services and existing staff capacity and focus on patient retention.	Implementation by December 2007, ongoing.	FQHCs, PCO
(2) 2. Identify key influencers in the community to leverage brand and public awareness to expand staff capacity and assist with recruitment.	Present – May 2008.	FQHCs, MACHC, PCO
(3) Develop strategies to enhance recruitment opportunities and use generic recruitment materials developed in conjunction with DPH, coupled with a branded communications strategy. (3.1) Broaden recruitment selection process to include the broader health care community. (3.2) Conduct cultural competency training for front office staff. (3.3) Tie into Delaware Economic Development Office (DEDO) for recruitment strategy that capitalizes on Delaware's strengths and focuses on recruitment of higher paid employees.	May 2008 – September 2008	FQHCs, MACHC, PCO

Environmental Assessment Methodology

Summary

MACHC undertook a number of sequential actions to complete the EA process. Over a period of 7 months, MACHC accomplished the following:

(1) Preliminary statewide quantitative data analysis culminating in the Delaware Environmental Analysis Report. This report reviewed statewide trends for FQHCs, the healthcare industry, health care coverage, population demographics, and market changes in Delaware. The purpose of this analysis was to provide background information for strategic discussions.

(2) Organized the Statewide Environmental Assessment Kick-Off Event which was held on March 7th of this year. At the event, the purpose of the EA and quantitative data analysis were reviewed. Following this, guided discussions by MACHC moderators were held to identify priority issue areas for the health centers. The priority issue identified in the EA kick-off event as an area to be further researched by MACHC was:

(3) "How are the Federally Qualified Health Centers in Delaware perceived by key state and local policy makers officials, and the communities that access their services?"

(4) Formation of a workgroup committee to assist in decision making and provide MACHC staff with guidance throughout the EA. Two workgroup conference calls were arranged by MACHC at key intervals in the process.

(5) Development of the research methodology which included a stakeholder analysis of key informants across five areas: policy, state public health and social service agencies, local public health offices, hospitals, the business community and related organizations.

(6) Surveys were fielded among the FQHC to determine statewide priority areas for interviews.

(7) Introductory letters were sent to all stakeholder offices prioritized by the FQHCs prior to beginning the interview process to help facilitate access to high-level personnel.

(8) Interviews were conducted with over twenty key informants, while attempts were made to contact thirty-two offices and personnel. Informants were considered non-responsive if after at least three attempts were made to contact individuals without completing an interview. In most cases, more than three attempts were made utilizing a variety of communication method (i.e. telephone, email, fax, etc). All interviews were conducted by a MACHC team member.

(9) The stakeholder analysis was completed by four members of the MACHC team preparing the analysis and reaching an internal consensus on issues and themes.

(10) Preparation and organization of a final stakeholder report and the final Environmental Assessment retreat.

(11) The Final Retreat was held on August 2, 2007 at the Belmont Conference Center in Smyrna, Delaware. The purpose of this retreat was to review the findings of the stakeholder analysis report and through a moderated discussion, identify the opportunities and threats to FQHCs and the corresponding action strategies to achieve statewide results.

Participants

In addition to the MACHC team, several key players in Delaware's FQHC industry were invited to participate in this process. The key participants who were involved throughout the process were;

(1) Katherine Collison, Public Health Administrator, Division of Public Health, Delaware Department of Health and Social Services

(2) Barbara DeBastiani, Community Health Associate, Wheeler & Associates Management Services, Inc. (MACHC Delaware Consultant)

(3) Brian Olson, Chief Executive Officer, La Red Health Center

(4) Rosa Rivera-Prado, Chief Executive Officer, Henrietta Johnson Medical Center

(5) Paula Roy, Executive Director, Delaware Healthcare Commission

(6) Debra Singletary, Chief Executive Officer, Delmarva Rural Ministries, Inc.

Potential participants were identified in February of 2007 and included representatives from each of Delaware's four FQHCs, the primary care organization and the Delaware Health Care Commission. Save-the-dates and formal invitations to the EA Kick-off event were sent to each of the potential participants with explanations of the EA, the process and the potential benefits to FQHCs in participating in the EA. In addition, a commitment letter was distributed to each of the potential EA participants which asked each organization to identify a central point of contact for the duration of the project and to commit itself to the EA process (APPENDIX ITEM 1). Participants were also encouraged to invite other key staff or board members of their organization to attend.

Those with commitment letters were invited to participate in the EA workgroup. The workgroup's purpose was to engage the health centers and other key personal throughout the EA process, providing feedback and direction to MACHC when needed. Furthermore, the workgroup sessions allowed MACHC to keep participants focused and connected to the process,

which greatly contributed to the success of the Final Retreat. MACHC received three signed commitment letters from the CEO's of La Red Health Center, Henrietta Johnson Medical Center, and Delmarva Rural Ministries, Inc.. Westside Health Center declined to participate in the workgroup.

Participation with the health centers was maintained throughout the environmental assessment by engaging them in the process, specifically requesting input and feedback from the centers. This was accomplished through the following techniques:

(1) Workgroup conference calls held twice between the Kick-Off and Final Retreat Events;

(2) Surveying the health centers to rank their stakeholders priorities;

(3) Requests to review and comment on research methodologies and meeting summaries;

(4) Relaying information on status of the project.

Finalized Environmental Assessment Process

The Delaware EA was a data-driven project with the health centers playing a key role in driving what information was important to 330 health centers in order to understand the key threats and opportunities. Given that the state has just four FQHCs and is geographically small, MACHC choose to approach the Environmental Assessment for Delaware as unified market, focusing on statewide issues that could be addressed as an industry. In such, information about the EA was presented and shared with the health centers and other key players as a group throughout the assessment.

Kick-Off Event

The data prepared for the Kick-Off meeting was pulled from the EA templates (T2) Patient User Market Share, (T5) Demographic and Socio-Economic Analysis, (T6) Economic Trends and (T11) Top Industries. A number of different government and private sources were used to fill the template charts where information was missing including data from the U.S. Bureau of Labor and Statistics, the U.S. Census Bureau, and the Henry J. Kaiser Family Foundation. Additional information was used to supplement the EA template data on health care consumer expenditures, Latina health care access and information on the growing senior population in Delaware.

Using this information, a Delaware data-report was created and distributed to all the Kick-Off meeting participants and health centers (a sampling of the report is found in APPENDIX ITEM 2). Furthermore, highlights of this information were presented in a trending analysis PowerPoint at the meeting prior to the moderated discussion on hot issues/trends for further analysis. The kick-off meeting was successful in directing MACHC to investigate the following priority areas as defined by the participating FQHCs;

(1) Priority 1: How are the Federally Qualified Health Centers in Delaware perceived by key state and local policy makers/officials and the communities that access their services?

(2) Priority 2: How can the FQHCs in Delaware better market themselves and their services to the communities they serve?

Stakeholder Analysis

MACHC developed research methodologies for both priority areas which were then vetted through the first workgroup meeting. Priority 2 methodology included surveying current FQHC patients and people who have never been a patient at a FQHC. Due to the cost of the data collection and analysis, MACHC did not complete the data collection of Priority 2 for the EA. However, MACHC has been working closely with the state PCA and the Delaware Health Care Commission to secure a contract that will allow for this data collection and analysis to be competed within the next year.

Priority 1 research methodology was a stakeholder analysis completed by members of the MACHC staff. Stakeholders were identified first by working with MACHC Delaware Consultant Barbara DeBastiani. Mrs. DeBastiani has a long

career in the Delaware's health care system including work as the Administrator of the Southern Health Services Center in the Division of Public Health, DHSS. Stakeholders identified by Mrs. DeBastiani were vetted by the FQHCs using an online survey and the workgroup.

A total of 29 individuals and organizations were targeted for interviews (APPENDIX ITEM 3). The interview script for the stakeholder analysis was semi-structured, focusing on informant's knowledge and perceptions of FQHCs, past and present working relationships with section 330's and the potential for future collaborations and projects. Qualitative interviews were competed with 23 key informants from five sectors; policy, state and local public health and social service agencies, hospitals, chambers of commerce representing the business community, and related organizations. All interviews were completed with top-level administrators.

TABLE 4: Qualitative Interview Results for Delaware Stakeholder Analysis

Sector	Interview Requests	Completed Interviews	Response Rate
Policy	9	2	22%
State Public Health and Social Services	5	4	80%
Local Public Health and Social Services	3	3	100%
Hospitals	5	5 (7)	100%
Chambers of Commerce	3	3	100%
Related Organizations	4	4	100%
Total	**29**	**21 (23)**	**72%**

The interviews were compiled and analyzed into a Final Stakeholder report that was distributed to the workgroup prior to the final retreat. Analysis was completed by MACHC staff and Barbara DeBastiani. Each sector was provided its own analysis, key findings and recommendations (APPENDIX ITEM 4).

Key findings and recommendations from the stakeholder analysis are:

(1) Knowledge of Federally Qualified Health Centers is regional. People know of the health center closest to them, but may have limited or no knowledge of other centers. This was true for the business community and related organizations, hospitals, and local public health officials.

(2) Health centers were viewed as vital to the provision of prenatal health care services and there was overall interest in sustaining these programs and building upon these services. Noted issues related to these services include provider recruitment and hospital rights for FQHCs.

(3) Business opportunities exist with stakeholders, including non-traditional groups. Health centers interested in diversifying their patient base and payer mix should actively seek out and investigate these opportunities.

(4) Stakeholders throughout the state need to be educated and better connected to the FQHCs.

(5) Greater visibility and participation of FQHCs within communities is needed. Participation should be consistent.

(6) Perceptions of Delaware health centers are not universally equal in terms of services provided, visibility in the community, and capacity. There is not a singular view of health centers as an industry, but stand alone ideas of individual health centers.

(7) Health centers are not consistently included in private-sector policy discussions regarding the uninsured or the underserved.

Final Retreat

The final retreat was held in early August and the format followed an agenda very similar to the Kick-Off Event. The Final-Retreat was designed to use the stakeholder analysis

information to determine priority areas to be addressed by the health center industry in Delaware. The overall goal of the retreat was to come to a consensus as a group (FQHCs, PCO, & PCA) on critical issues and resources that can be devoted to making an impact on our industry, develop strategic actions, delegate responsibilities and determine timelines for actions. The data from the stakeholder analysis was presented, followed by a moderated discussion by an experienced facilitator for identification of opportunities and threats, priority setting, and strategic planning.

Three processes were employed at the Final-Retreat to help participants work through the stakeholder information in identification of opportunities and threats for priority setting. A stakeholder mapping process was used to identify the different levels of stakeholders for management. The Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis was an open discussion where participants were asked to consider the following questions when determining the FQHCs SWOT:

(1) In thinking about the stakeholder analysis findings and recommendations for Delaware health centers, what are the important strengths, weaknesses, opportunities and threats to health centers?

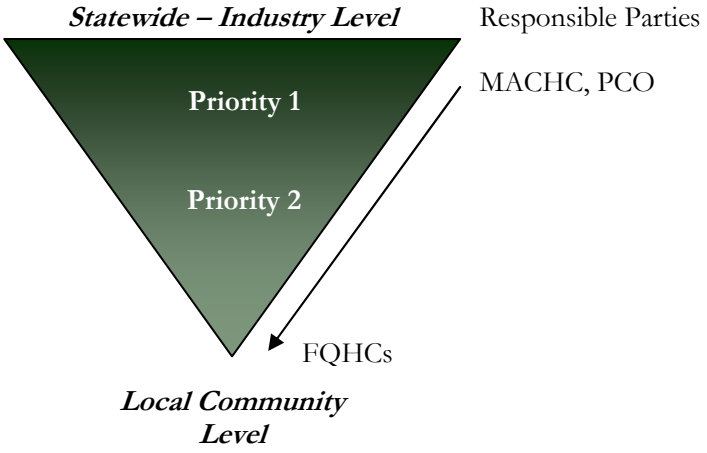
(2) How do the strengths, weaknesses, opportunities or threats impact the un/underserved? Health center services? Health center reimbursement or payer mix?

(3) What strength, weakness, opportunity or threat do you have influence or control over? What do you not have influence or control over?

Priority Setting was accomplished using a 'note-card' exercise, where each participant was asked to list their top one or two priorities areas on note-cards which were then collected and ranked. MACHC used this technique to ensure full-participation by the health centers and other key players in priority setting. The priority areas presented earlier in this report were the top issues found using this technique.

From the priority setting, a strategy was developed with key action steps for the top two-priorities by the participants at the Final-Retreat. Strategic actions were chosen during the moderated discussion with input from all the participants. The representatives of the FQHCs, MACHC and the PCO volunteered for the responsibilities of the action steps in areas that they were most capable of leading and completing. The time-frame for implementation of all the action-steps is roughly one-year for both priority areas with the assumption that programs will be ongoing (i.e. changes in staff recruitment). This time-frame will allow MACHC, the health centers and the PCA to evaluate the strategies progress in one-year and evaluate current FQHC needs relative to these priority areas.

The strategies and action steps identified for the number one and two priorities effectively build upon current organizational capacity and strengths. The priorities areas that have strategic options and action steps are two tiered, statewide and community-based.



Recommendation and Lessons Learned from the Environmental Assessment

Overall, MACHC was very pleased with the involvement of the health centers and the outcomes of the environmental process. Initial survey responses from the participants at the Final-Retreat are also very favorable to the environmental assessment process and outcomes.

MACHCs Strategic Planning Committee will be reviewing the priorities and strategies at their next meeting in September, 2007 in order to incorporate these tasks into MACHCs overall business plan.

MACHCs recommendations and lessons learned from this process:

(1) Involvement of the State Primary Care Organization and other key personnel beyond the FQHCs adds value and dimension to the environmental assessment process and should be encouraged to be involved in the EA.

(2) Engaging the FQHCs throughout the EA helps to ensure buy-in to the process, information and the strategic actions. Keep your health centers informed and request their input at every interval.

(3) Strong facilitation by an outside source was key to keeping the participants focused at the Final-retreat.

(4) The timing of the EA impeded the key-informant interviews for policy makers as it coincided with the end of the legislative session.

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APPENDIX ITEM 1

Date_____

Chief Executive Officer
Mid-Atlantic Association of Community Health Centers
4483B Forbes Blvd
Lanham, MD 20706

Dear Miguel McInnis;

The _____ is fully committed to active participation in Round 3 of the Health Resources and Services Administration/Bureau of Primary Health Care (BPHC) and National Association of Community Health Centers (NACHC) continuing Environmental Assessment (EA) initiative.

The purpose of the EA is to provide Health Centers and the State Primary Care Association with the tools and processes to identify opportunities and threats that exist within the State Healthcare environment. We understand that through this process, the Mid-Atlantic Association of Community Health Centers (MACHC) will work with the Federally Qualified Health Centers to analyze broad state and market issues and/or trends and develop specific strategies and actions that can result in increased access to preventative and primary care to underserved communities.

As part of this endeavor, we commit the following individual to act as the central point of contact with MACHC throughout this initiative.

Name _____

Title _____

Email _____

Phone _____

Sincerely,

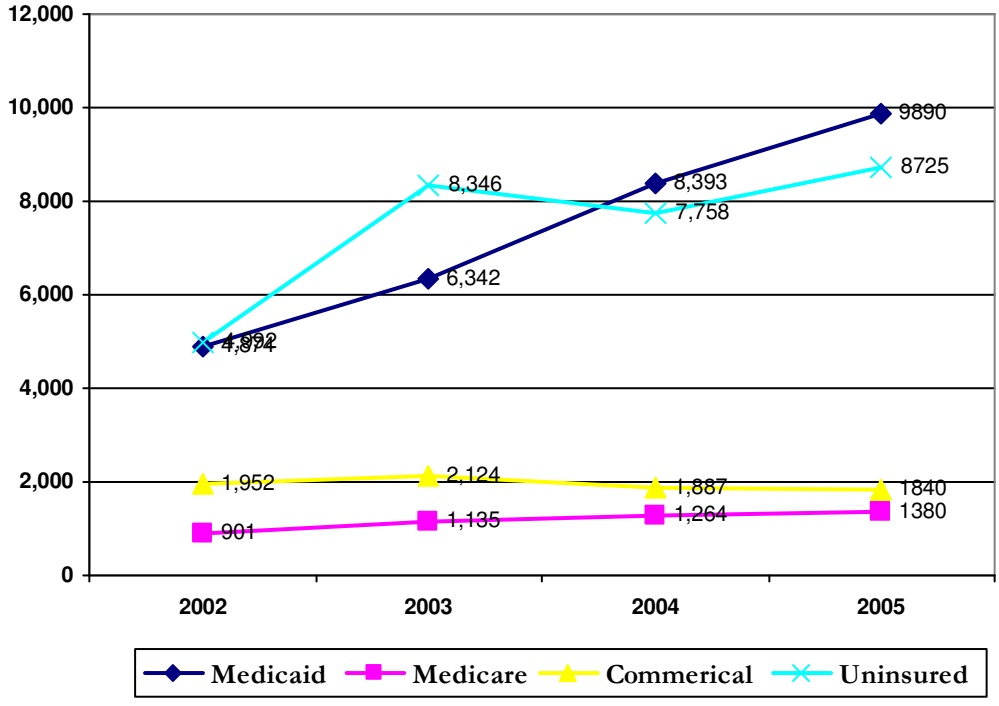
APPENDIX ITEM 2

Delaware's FQHCs saw a 70.1% increase in patients from 2002 to 2005, adding 9,059 patients since 2002. The largest increase in patients occurred in Medicaid (+5,016)) and Uninsured patients (3,803).

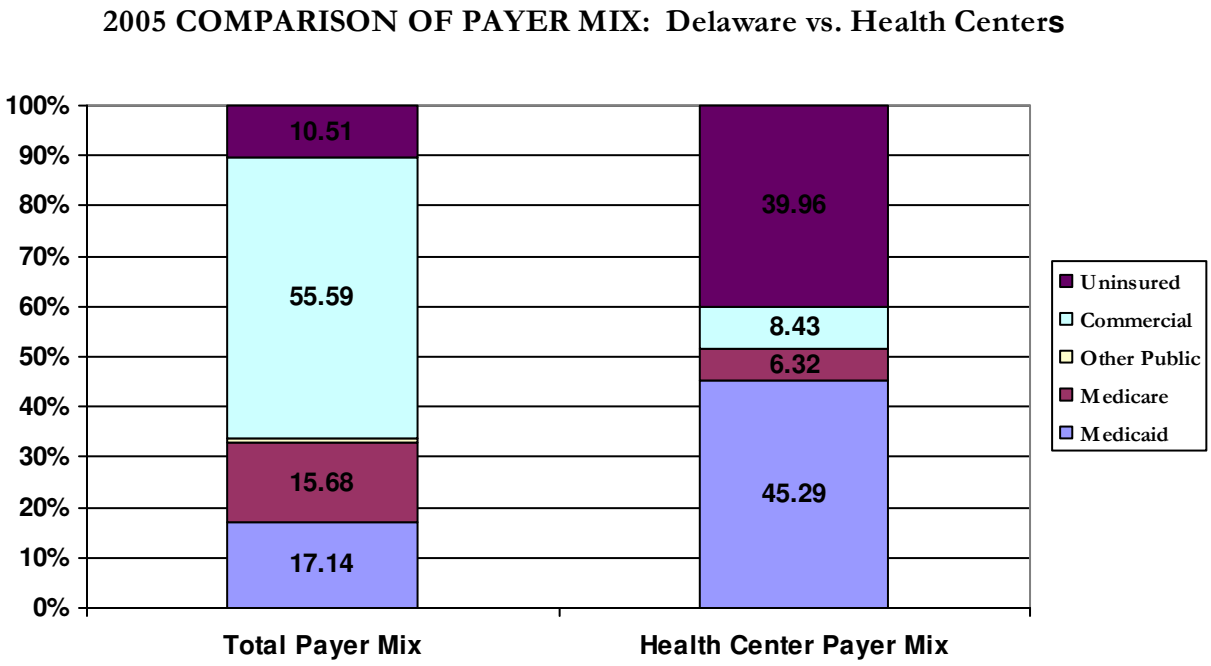
HEALTH CENTER PERCENT CHANGE IN PATIENTS

	2002-2003	2003-2004	2004-2005
Health Center Patient Increases	42.4%	6.1%	13.1%

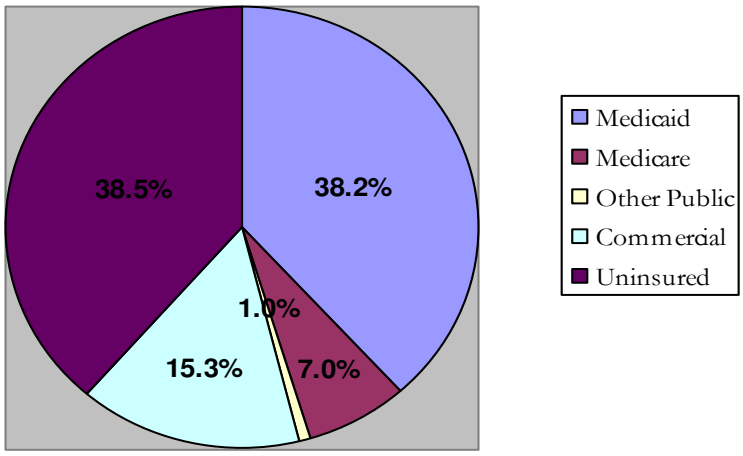
CHANGE IN HEALTH CENTER PATIENTS BY PAYMENT COHORT: 2002-2005



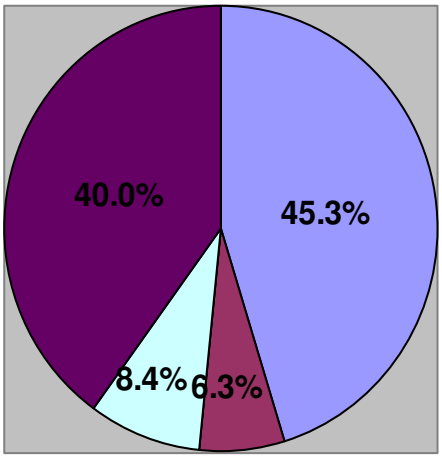
APPENDIX ITEM 2



2002 Delaware Health Center Payer-Mix



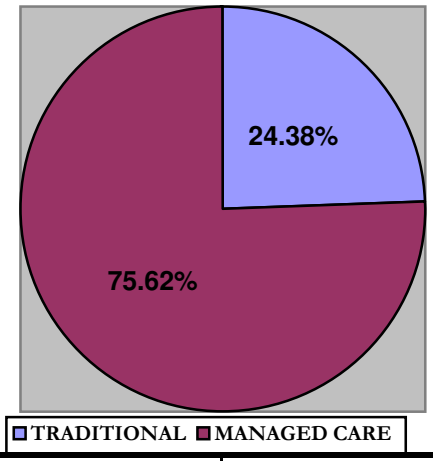
2005 Delaware Health Center Payer-Mix



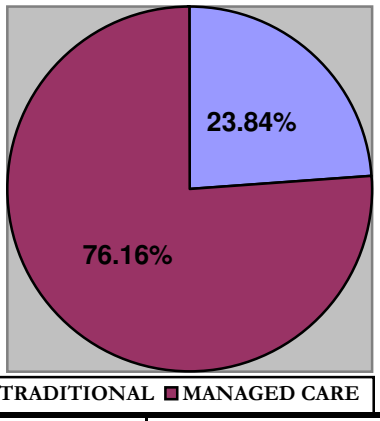
APPENDIX ITEM 2

The following pie charts show the percentage of people enrolled in Delaware's Medicaid program by Traditional versus Managed Care plans and SCHIP and Delaware's Health Center patients by the same break down for the years 2002 and 2005. Actual enrollment and patient numbers are also provided.

2002 DELAWARE MEDICAID: Enrollment in Traditional vs. Managed Care

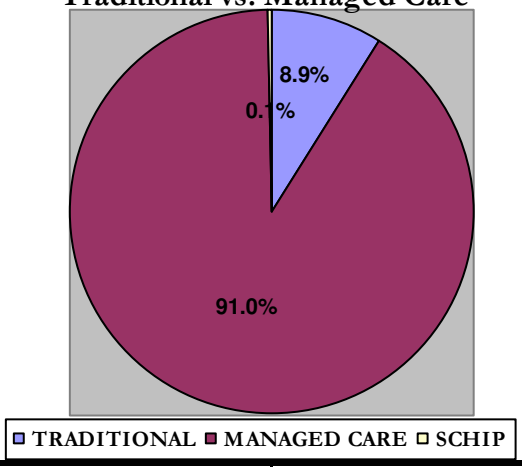


2005 DELAWARE MEDICAID: Enrollment in Traditional vs. Managed Care

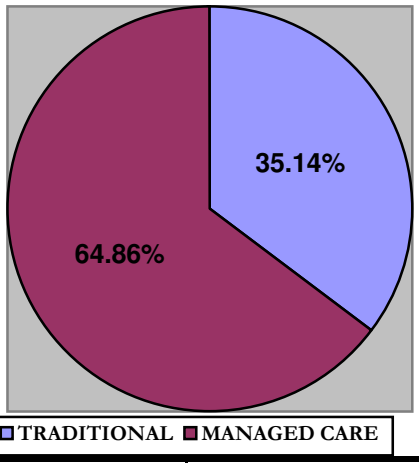


DELAWARE ENROLLMENT	2002	2005	2002-2005 Percent Change
Traditional	30,433	33,419	9.8%
Managed Care	94,395	106,783	13.1%
SCHIP	4,082	4,360	6.8%
TOTAL	128,910	144,562	12.1%

2002 DELAWARE HEALTH CENTER MEDICAID: Patients in Traditional vs. Managed Care



2005 DELAWARE HEALTH CENTERS MEDICAID: Patients in Traditional vs. Managed Care

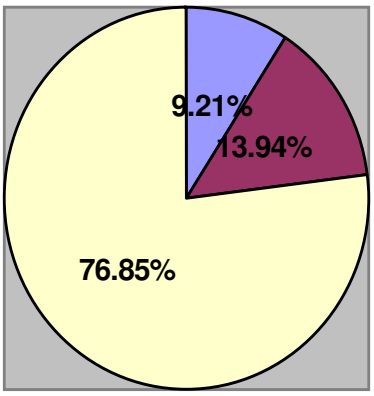


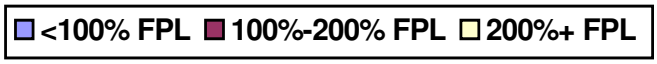
DELAWARE HEALTH CENTERS	2002	2005	2002-2005 Percent Change
Traditional	433	3,475	703%
Managed Care	4,434	6,415	44.6%
SCHIP	7	0	-100%
TOTAL	4,874	9,890	103%

APPENDIX ITEM 2

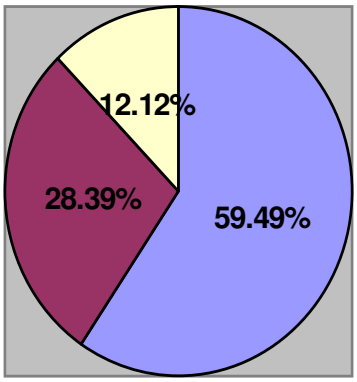
The pie-charts below show the population of Delaware and Health Center patients by Federal Poverty Level for 2005.

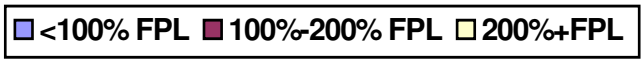
Delaware





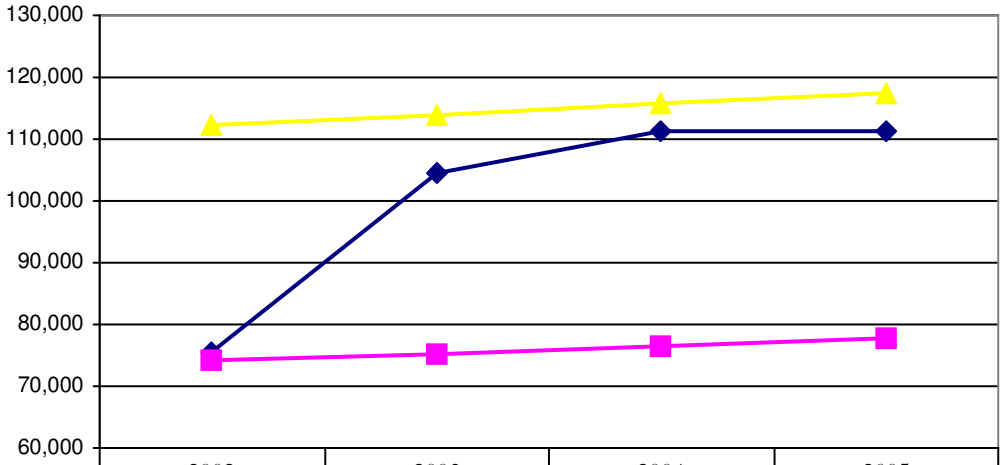
FQHCs





	DELAWARE	HEALTH CENTERS
<100% FPL	77,648	10,929
100% -200% FPL	117,556	5,217
200%+FPL	648,320	2,227
Unknown	n/a	3,462

DELAWARE UNINSURED, POOR AND NEAR POOR: 2002-1005



	2002	2003	2004	2005
Uninsured	75,604	104,629	111,321	111,321
</=100% FPL	74,172	75,282	76,409	77,648
101%-200% FPL	112,294	113,975	115,681	117,556

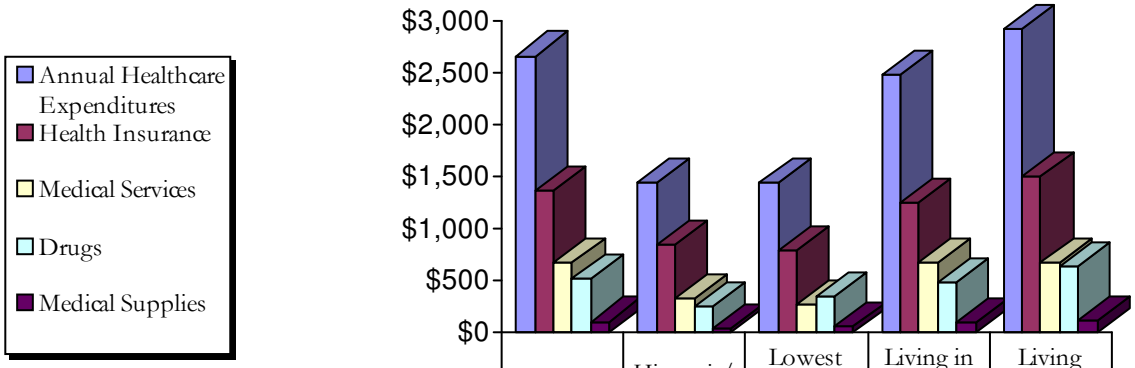
APPENDIX ITEM 2

The average health center patient in Delaware is likely to have the following characteristics.
(Based upon 2005 UDS)

Gender:	Female
Age:	Between the ages of 25-44 years old.
Race/Ethnicity:	Hispanic/Latina
FQHC Location:	New Castle
Income:	At most 150% of the Federal Poverty Level (FPL), but likely to be 100% or below the FPL
Insurance Status	Uninsured

The following graph shows national consumer expenditure data on health care services for 2005. Cross tabulation of data was not possible, therefore a comparison is given of expenditures based upon the total population, and demographic characteristics of Delaware's health centers average patient.

2005 Consumer Expenditure Survey: Health Care Expenditures



	Total	Hispanic/ Latino	Lowest 20% Income	Living in Urban Area*	Living Outside an Urban
Annual Healthcare Expenditures	$2,664	$1,448	$1,448	$2,484	$2,919
Health Insurance	$1,361	$841	$780	$1,252	$1,497
Medical Services	$677	$321	$266	$672	$665
Drugs	$521	$244	$351	$474	$639
Medical Supplies	$105	$43	$51	$87	$118

*Data for Urban Areas is based upon urban populations with less than 100,000 persons.

Facts on Latina's Access to Quality Care

31% of Latino women lack a regular health care provider.
Latinas are less likely than other women to receive important screenings such as blood cholesterol, blood pressure, and clinical breast exams.
More than half of Latina women do not have dental coverage (54%) or coverage for vision care (58%).
Nearly 1 in 5 Latina women delay medical care because of transportation problems.

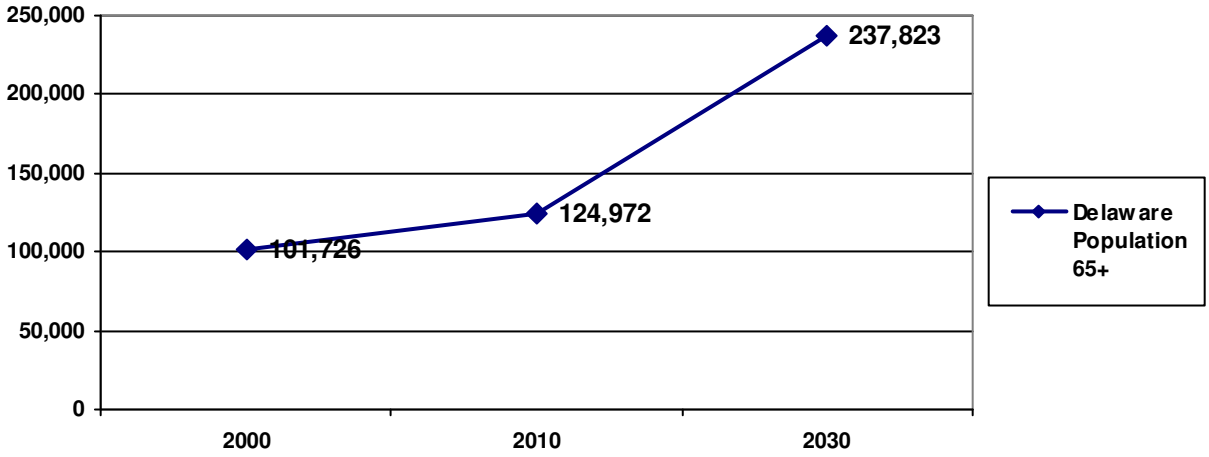
APPENDIX ITEM 2

2005 Delaware Facts and Figures for the Population age 65 and Older

Population:	106,791
Households:	68,040
Gender:	44% Male, 56% Female
Median Age:	74 years
Race and Ethnicity:	86.1% White
	11.8% Black/African America
	1.5% Hispanic/Latino
Language:	6.8% Speak a language other than English
Disability:	35.7% of persons 65 and older in Delaware have a disability
Mean Income:	$37,873
Poverty Level:	7.2% are below Federal Poverty Level (FPL)
	9.0% are between 100%-149% FPL
	83.7% are 150% or higher of the FPL
Rank:	19th among U.S. states for the percentage of the population aged 65 and over.
*Percentage reporting difficulty in obtaining care:	2.5%
*Percentage reporting delayed care due to cost:	6.1%
**Percentage of population with supplemental insurance:	86.6%

* Data is only for people enrolled in Medicare, year 2002.
** Date is only for people enrolled in Medicare, year 2004.

DELAWARE POPULATION AGE 65 and OLDER:
PROJECTIONS 2000-2030



PERCENTAGE OF DELWARE'S POPULATION THAT IS 65 YEARS AND

2000	2010	2030	Population percent change: 2000 to 2030
13%	14.1%	23.5%	134%

APPENDIX ITEM 2

Percentage of Population Age 65 and Older who reported having the following Chronic Conditions

	Heart Disease	Hypertension	Stroke	Asthma	Any Cancer	Diabetes	Arthritis	Chronic Bronchitis
Total	31.7	51.9	9.2	8.9	206.6	17	49.9	6
White	33.4	50.5	9	8.8	22.6	15.4	50.2	6.2
Black	24.1	67.6	10.3	9.5	11.8	26.6	52.2	5
Hispanic/Latino	23.7	49.3	9.7	8.8	9.4	24.5	44.8	5.5

APPENDIX ITEM 3

STAKEHOLDERS

The following are the offices and organizations that were included in the final stakeholder list targeted for interviews. The list is ordered by section and listed from highest to lowest, the priority of each as determined by the FQHC surveys. Brief descriptions of the organizations or offices are provided.

Policy

The Office of Delaware Representative Mike Castle: Representative Mike Castle was the former Deputy Attorney General, state legislator, Lieutenant Governor and two-term Governor of Delaware. Representative Mike Castle is currently serving his eighth term as Delaware's lone Member in the House of Representatives.

The Office of Delaware Lt. Governor John Carney: The Lt. Governor serves as the President of the State Senate, Chairman of the Health Care Commission and co-chairs the state task for on health disparities. Currently the Lt. Governor is in his second term and will likely run for governor during the next gubernatorial campaign.

The Office of Delaware Senator Tom Carper: Senator Tom Carper has previously served as a Congressional Representative for five terms, then Delaware state governor for two terms. In his current position as a state senator, he also serves as a deputy whip and . vice-chairman of the Democratic Leadership Council. His committee assignments include the Special Committee on Aging which deals with important items such as Social Security and Medicare.

The Office of Delaware Governor Ruth Ann Minner: Governor Minner is currently in her second term as governor, having been first elected in 2001. She publicizes her issue areas to include improving health care and fighting cancer in Delaware. To date, the governor has allocated $37.5 million on education, treatments, preventions, screenings and monitoring of cancer in the state.

Office of State Senator Patty Blevins: Senator Blevins was first elected to the state senate in 1990. She was the former Chair of the Senate Health and Social Services Committee and since 2006, serves as the Senate Majority Whip. Senator Blevins still sits on the Health and Social Services Committee.

Office of Senator Margaret Rose Henry: Senator Henry was first elected to the state legislator in 1994. She is the new Chair of the Senate Health and Social Services Committee, the committee which reviews all new legislation regarding health policy and issues. In addition, Senator Henry is on the Joint Finance Committee.

Office of Representative Bethany Hall-Long: Representative Hall-Long is from Middleton, Delaware. She was first elected in 2002 and currently sites on four committees including the House Health and Human Development Committee.

Office of Representative Pamela Maier: Pamela Maier is the representative from Drummond Hill, Delaware. She was first elected to the State General Assembly in 1994. Representative Maier currently serves on the House Health and Human Development Committee and is an alternate on both the House Joint Finance and Appropriations committees.

Office of Representative Teresa Schooley: Representative Schooley represents Newark, Delaware and was elected in 2004. She sits on the House Health and Human Development Committee. In her professional work, Representative Schooley is also the Director of Delaware's KIDS COUNT, the leading organization collecting and publishing data on social, economic, heath, and educational indicators for children in Delaware.

APPENDIX ITEM 3

State Public Health and Social Service Offices

Division of Public Health: The Division of Public Health's mission is to protect and enhance the health of the people of Delaware by:

- · Working together with others
- · Addressing issues that affect the health of Delawareans
- · Keeping track of the state's health
- · Promoting positive lifestyles
- · Responding to critical health issues and disasters;
- · Promoting the availability of health services

Directly under the Director's office are the Office on Minority Health and the Office of Workforce Development.

Division of Medicaid and Medical Assistance: The mission of the Division of Medicaid & Medical Assistance is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner. This is the division that works with federally qualified health centers to develop contracts for Medicaid and SCHIP reimbursements.

Division of Substance Abuse and Mental Health: The Delaware Division of Substance Abuse & Mental Health (DSAMH) provides short-term counseling and intensive services, treatment and referrals to help troubled Delawareans and their families conquer addictions and deal with mental health issues. Services for problems related to the use of alcohol and drugs, gambling and mental health are available throughout the state. In addition this office provides alcohol and drug abuse prevention services targeting high-risk and underserved populations in the state.

Office of Minority Health: Located within the Division of Public Health, the main functions of this Office are to advise public health, social services and the governor's office in policy issues that affect minority health. In practice this translates into working directly with communities, providers and community based organizations to bolster capacity for health promotion, disease prevention and to work in communities directly with minority groups.

Division of Services for Aging and Adults with Physical Disabilities: The Delaware Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) carries out a broad range of activities to assist older persons and adults with physical disabilities. The Division operates a number of programs, including the Adult Protective Services Program, the Community Services Program, the Delaware Medicare Fraud Alert Program, the and Delaware Money Management Program. In addition, the Division provides services such as information and assistance, caregiver support, and health promotion. Finally, the Division advocates on behalf of older persons and adults with physical disabilities to create a broader awareness of the needs of these populations within Delaware.

Local Public Health and Social Service Agencies *(*not ranked)

Northern Health Services, Division of Public Health: Serves New Castle County residents.

Southern Health Services, Division of Public Health: Serves Sussex and Kent County residents.

The regional Northern and Southern Health Services offices provides clinical services to children and adults for select public health issues including but not limited to lead testing, children's immunizations, sexually transmitted diseases and HIV testing and treatment, tuberculosis screening, treatment and management, breast and cervical cancer screenings. Services provided are primarily focused on infant and maternal health, and communicable disease. Each of the regional divisions maintains several service locations throughout the state.

Wilmington Health Planning Council: The Wilmington Health Planning Council was established in 2001 to develop a plan for the City of Wilmington to improve the health of its residents. The council has since identified seven priority areas in which to focus its efforts:

Access to preventative care,

APPENDIX ITEM 3

Chronic disease prevention and early detection,
HIV/AIDS,
Mental Health,
Responsible sexual behavior: Teen Pregnancy Prevention,
Substance abuse,
Violence prevention.

Hospitals

Hospitals in the state have historically been helpful to health centers in placing residents into practice at the centers and with the facilitation of referrals. Proximity to health centers plays a key role in the relationship to health centers, therefore no hospital is ranked. Each of the hospitals below operates an emergency department. Patient service areas for each of the hospitals are provided in Appendix 1.

Bay*health* Medical Center: Bay*health* Medical Center was established in 1997 with the merger of Kent General Hospital and Milford Memorial Hospital. Bay*health* is the second largest healthcare system in the state. In additional to maintaining the two original hospitals, Kent General Hospital located in Dover, DE and Milford Memorial Hospital in Milford, DE, Bay*health* operates several outpatient and medical walk-in facilities throughout central Delaware.

Beebe Medical Center: Beebe Medical Center is a not-for-profit community medical center located in Lewes, Delaware, a beach community in east Sussex County.

Christiana Care Health System: Christiana Care Health System is the largest healthcare system in Delaware. It has two hospitals locations; in Wilmington and in Newark, in additional to several outpatient medical facilities throughout the state and one transitional care facility. Christina Care also operates on its main hospital campus the Helen F. Graham Cancer Center, Center for Heart and Vascular Health, and the Women's health program which delivers over 7,000 babies a year. Christiana Care is also a teaching hospital with residents in sixteen different fields including family physicians, dentistry, internal medicine and pharmacy.

Nanticoke Memorial Hospital: Nanticoke Memorial Hospital is located in Seaford, Delaware, in western Sussex county. Nanticoke's hospital and extended medical facilities and services are under the corporate title of Nanticoke Health Services. Nanticoke Health Services operates four medical centers, including one in Georgetown, Delaware which offers space to La Red Health Center.

St. Francis Hospital: Located in Wilmington, St. Francis Hospital is part of the Catholic Health East, the largest Catholic healthcare system on the east coast. The hospital is a not-for-profit entity, employing 682 medical staff. Furthermore, the hospital operates Center of Hope, the St. Clare Medical Outreach Program (mobile outreach van) providing medical services to the uninsured. Another program offered is Tiny Steps, dedicated to providing prenatal and postpartum care to low-income women. St. Francis has a Family Practice residency program.

Chambers of Commerce (not ranked)

Delaware State Chamber of Commerce: The Delaware State Chamber of Commerce is the largest business membership and advocacy organization in the state. The mission of the Chamber is to *"promote an economic climate that strengthens the competitiveness of Delaware businesses and benefits citizens of the state."* Main services areas the chamber provides to its members are legislative advocacy, publications, small business programs, and professional networking opportunities.

Central Delaware Chamber of Commerce: The purpose of the Central Delaware Chamber of Commerce as stated on their website is " to advance the balanced economic development of Central Delaware by promoting civic, industrial, commercial, agri-business and social interests of the community, and by strengthening the freedom of private business to operate competitively for profit with minimal governmental regulation." They are a membership based organization which offers networking opportunities, group discounts.

Georgetown Chamber of Commerce: The Georgetown Chamber of Commerce has nearly 400 members.

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The organization hosts monthly networking events, advertising and promotional opportunities to its members.

Related Organizations

Delaware Healthcare Association: The association is a statewide trade and membership group serving hospitals, health systems, and related health care organizations. From the organizations website, *"The primary role of the Association is to serve as a leader in the promotion of effective change in health services through collaboration and consensus building on health care issues at the State and Federal levels."* This work is accomplished via lobbying and policy work, as well as linkages to healthcare professional resources. Each of the hospitals included in this assessment are members of the association.

Medical Society of Delaware: This is a membership based organization serving physicians and the medical community in Delaware. The organization does much of its work in the area of policy, legislation and advocacy on behalf of its members.

United Way of Delaware: This mission of the United Way of Delaware is *"To maximize the community's resources to improve the quality of life for Delawareans*". United Ways across the country operate as a fundraising organization and clearing house of donations to not-for-profit membership organizations. Two health centers are members of the United Way of Delaware.

Delaware Public Policy Institute (note not part of original stakeholder list): The Delaware Policy Institute is an affiliated organization of the Delaware State Chamber of Commerce. The mission of the organization is "to conduct research and encourage the study and discussion of public policy issues affecting the citizens of Delaware. The Institute identifies emerging issues that drive Delaware's future public policy agenda." Recently, they have held meetings on increasing access to the uninsured in Delaware and will soon be holding talks on insurance solutions to access issues.

APPENDIX ITEM 4

Summations and Recommendations from Stakeholder Groups

Policy

MACHC was able to interview only two of the policy stakeholders identified as priorities. This was seen as a result of two functions, first and primary was timing of the interviews and the federal and state legislative sessions. Second, poor recognition of MACHC and or the health centers by policy makers staff seemed to be a barrier to reaching policy stakeholders. Policy stakeholders interviewed were very familiar with the roles of the health centers and supportive of their work.

- MACHC strongly recommends that the health centers become more recognizable to legislators and to their staff.
- Health centers should be both a resource of information to their policy makers and in turn use their policy makers as a resource.
- State policy makers often have dual professional roles. Health centers should capitalize on opportunities that may exist with policymakers

State Public Health and Social Service Offices

While the state public health and social services offices were very familiar with the health centers, the differentiation in perceptions in the health centers service capacity and visibility needs to be addressed. Several of the informants provided their own recommendations to the health centers. Recommendations made by key informants are.

- Be visible and involved in your communities, including the interfaith groups, commerce, and other health institutions,
- Work with other health centers more to form a better system of care,
- Be vigilant of the Governor's priority areas and be prepared to respond,
- Develop competitive proposals to RFP,
- Take part in commissions, councils, and town hall meetings, acting as a resource to these groups.

Local Public Health and Social Service Agencies

Overall, local health officials see health centers as partners in public health. However, among the local public health officials, there was a clear differentiation between health centers and their perceived capabilities, services, and activity in the public health community. Not all health centers were viewed as being equal in this area, a perception that affected current working relationships and likely future collaborations. Recommendations based upon interviews with these stakeholders are;

- Increase health center visibility in local and state public health committees and organizations on a regular basis.
- Identify dynamic spoke persons from your health centers to create and foster relationships with local public health offices and to promote health centers within those agencies.
- Don't assume that the health centers work or services are well known in the public health community, become the health center champions.
- Seek partnerships and support with the public health offices on issues germane to both your organizations and theirs. There are opportunities for growth, enhancements and collaborative problem solving.

Hospitals

The hospitals in Delaware had an overall very positive view of the health centers, albeit limited in scope. Health centers should consider ways in which to expand their current relationships with hospitals to go beyond the scope of OB-Gyn care.

- Educate hospital partners on the full breadth of services health centers are able to offer your patients. Capitalize on health center's quality-care services and enabling services they are able to provide.

- Explore new opportunities with hospitals to increase patient base, improve health center payer-mix, and retain more patients that enhance the bottom-line.
- Hospitals will be more open to working relationships with FQHCs in areas where they see the FQHCs alleviating patient strain, but not where FQHCs would be seen as competitors. FQHCs need to look for and negotiate win-win situations with Hospitals.

Chambers of Commerce

Overall, knowledge level of FQHCs among this group was moderate, as was their general perceptions of what health centers role was in the community. Health centers should examine their current affiliations to determine if they are capitalizing on these relationships fully. Given that one of the primary goals of chambers of commerce is to facilitate networking and recognition of businesses in the community and state, health centers that have the goal of increasing their profile and recognition in the community at-large would do well to work with the chamber of commerce to assist in this area. There is significant opportunity with this group to educate and become more active.

- Don't assume that an organization knows who you are based on your past relationships or affiliations. Furthermore, don't assume these organizations are championing for your interests.
- Health centers should look at ways to increase their profiles in their community and the state at large utilizing the chamber of commerce existing networking structures.
- Health centers should investigate potential opportunities to provide services that meet the needs of the small business community and other collaborations that chambers of commerce could help to facilitate.

Related Organizations

Knowledge of FQHCs among this group varied significantly. There are significant coinciding interests among these organizations and the health centers. Furthermore these organizations do a good deal of work in the areas of policy and are linked to potential funding organizations.

- Health centers should work to educate these organizations about the unique roles they play in their communities and with serving the uninsured and the underserved.
- Health centers should investigate ways to be involved in policy discussions on the uninsured and underserved involving these organizations.
- Health centers should look at ways to maximize collaborations with these organizations on mutual areas of interests and in areas where resources could be leveraged to the health centers advantage.