

**DELAWARE HEALTH CARE COMMISSION
MAY 7, 2009
DELDOT ADMINISTRATION BUILDING
FARMINGTON-FELTON CONFERENCE ROOM
DOVER
MINUTES**

Action Item

Commission Members Present: Theodore W. Becker, Jr., Acting Chair; Lisa C. Barkley, MD, A. Richard Heffron; Rita Landgraf, Secretary, Delaware Health and Social Services; Janice E. Nevin, MD, MPH; Dennis Rochford, and Fred Townsend.

Members Absent: John C. Carney, Jr., Chair; Gary Pfeiffer, Secretary of Finance; Vivian Rapposelli, Secretary, Services for Children, Youth and Their Families; and Karen Weldin Stewart, Insurance Commissioner.

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

CALL TO ORDER

The meeting was called to order at 9:10 AM by Ted W. Becker, Jr., Acting Chairman.

MEETING MINUTES OF MARCH 5, 2009

Fred Townsend made a motion to accept the March 5, meeting minutes. Dennis Rochford seconded the motion. After a voice vote, the motion carried.

UNINSURED ACTION PLAN

Update: Community Health Care Access Program (CHAP)

Ted Becker, Chair of the CHAP Oversight Workgroup, reported Request for Proposals (RFPs) for the *Community* based and *Hospital* based *Outreach Programs* was released. The deadline for vendor submission was May 5. All existing providers applied but there were no new applicants.

Over the past year, efforts to coordinate CHAP and Screening for Life have been ongoing, culminating in release of an Eligibility and Enrollment RFP (with an additional deliverable requiring assistance in coordinating and gearing up for blending the two programs during FY '10). Proposals are due to the Commission office May 19.

The CHAP Oversight Workgroup will report provider recommendations to the Commission at the June DHCC meeting.

Action

The March 5, 2009 meeting minutes were approved.

CHAP Oversight Workgroup reported Request for Proposals (RFPs) for the *Community* based and *Hospital* based *Outreach Programs* was released.

The CHAP Oversight Workgroup will report provider recommendations to the Commission at

In April, an event at Henrietta Johnson Medical Center highlighted accomplishments of the *Healthy Delawareans Today and Tomorrow* activities, to which CHAP was an essential contributor. Senator Tom Carper, Congressman Michael Castle and Governor Jack Markell attended and presented proclamations promoting healthy Delawareans.

Healthy Delawareans has been underscored by Delaware holding it's first *Bike Summit* at the end of April. Governor Markell attended and signed the proclamation, *Complete the Streets*; with Senator Carper and Congressman Castle there providing additional encouragement to promote health.

On April 23, at Delaware Technical and Community College, Stanton Campus, the Voluntary Initiative Program (VIP) launched a pilot program for CHAP patients and income eligible Delawareans to receive prescription medications through Welvista, a mail order pharmacy. This event received press coverage in the News Journal. Medicines are donated by Astra-Zeneca and other pharmaceutical manufacturers.

Betsy Wheeler reported that the Covering Kids and Families (CKF) coalition holds an annual event to recognize individuals in the field of community health and public policy. This year's theme was long standing dedication and consistent commitment. Paula Roy, Dr. James Gill, Joann Hasse and Edward Ratledge were recognized for their contributions.

The U.S. Health Resources and Services Administration has announced a new grant entitled, *State Health Access Program*, whereby states could receive \$2 to \$5 million a year over 5 years for programs to expand health care coverage to targeted populations, such as children and small business employees or \$7 to \$10 million dollars a year for comprehensive coverage initiatives. This is a follow up program to the old State Planning Grant, from which Delaware received funds over a 5 year period. The Planning Grant funded the work Dr. Jonathan Gruber has done for the Commission.

Paula Roy said she and Betsy Wheeler participated in a conference call for interested applicants. Ms. Wheeler added the key difference in this grant is that the strategy be specific and identifiable. The Commission will pursue applying for a grant.

the June DHCC meeting.

The Voluntary Initiative Program (VIP) launched a pilot program for CHAP patients and income eligible Delawareans to receive prescription medications through Welvista

Covering Kids and Families (CKF) recognized Paula Roy, Dr. James Gill, Joann Hasse and Edward Ratledge for their dedication and consistent commitment in the field of community health and public policy.

Presentation: CHAP Evaluation – Dr. James Gill

1. Health Status Evaluation

In previous years, two main methods used to obtain data for CHAP, the CHAP Evaluation of the program's impact on patient health and health outcomes: 1.) health risk assessment and, 2.) chart reviews. Both ways were resource intensive and yielded a relatively small volume of records for measurable results.

In FY 2009, Dr. Gill explored the use of electronic data through DHIN and electronic medical records (EMR) from Federally Qualified Health Centers and VIP providers as a data source for evaluation activities.

2. Infant Mortality and Birth Outcome Evaluation

Infant mortality data for CHAP enrollees at La Red Health Center was analyzed to determine if it is possible to evaluate the impact of CHAP on prenatal care and birth outcomes. Data gathering had limitations, such as:

- although it was assumed that the first prenatal visit to LaRed was the patient's first prenatal visit, it is actually unknown whether there had been a prenatal visit at another location,
- LaRed provides pre-natal care at the health center, but births occur in hospitals and it is difficult to obtain birth outcome data from them,
- CHAP/LaRed data is descriptive only and there is no good comparison group.

Health Status Baseline and Follow-up Survey Data Results

Baseline data was collected from 15 – 30 CHAP enrollees per month from persons who were high risk and completed baseline survey from August 1, 2008 to April 7, 2009.

A baseline survey and 4 month follow-up was recorded for 117 enrollees with one or more high risk condition:

- 48 enrollees with diabetes
- 82 enrollees with hypertension
- 31 enrollees with asthma

(enrollees may have more than one condition)

Interview questions to measure health status and quality of care were administered by the CHAP/VIP nurse. The nurse collects data at intake and again 4 months later during a follow-up interview. The result is a response rate of over 75 percent.

Dr. James Gill presented the FY 09 CHAP Evaluation with a focus on reviewing electronic data.

Baseline data was compared to 4 month follow-up survey data
Follow-up surveys recorded for 36 enrollees with one or more high risk condition

- 19 enrollees with diabetes
- 23 enrollees with hypertension
- 11 enrollees with asthma

Patient Interview Baseline and Follow-up Survey Data

Results indicate:

- Some improvement in immunizations for diabetics
- Slight improvement in eating habits and provider visits for hypertensive patients (self-reporting)
- Improvements in asthma symptoms, urgent care visits

Results consistent with previous evaluations

- Despite a consistent high turnover rate in the program, an improved quality of care has been demonstrated over 5 years of evaluations

Next Steps

Continue to explore data sources for future CHAP evaluations

- Conduct additional meetings with DHIN and EMR users
- Potential use of patient queries and EMR reports
- Consider use of Infant Mortality Program data for larger evaluation in coming year
- Need a source of comparison data

Continue patient interview data evaluations on limited basis

Discussion

Dr. Janet Nevin asked how the CHAP patient prenatal data at La Red compared to data for the State. Dr. Gill answered that he did not have information for comparison. La Red only has the data if the first prenatal visit was at La Red but not if the first visit was elsewhere. The goal is for the first prenatal visit to take place in the first trimester.

Dr. Nevin wanted to know if data on race and ethnicity was collected? Dr. Gill said upwards of 90 percent of the patients are Hispanic.

Dr. Nevin thought the issue of working with other big projects that are looking at outcomes is important; not just infant mortality but the cancer folks have a lot of great outcome data. If we could more consistently use CHAP as a variable as other programs do evaluations, Dr. Gill would have access to a bigger end and comparison data.

Review and Action: House Bill 85

House Bill 85 implements recommendations of the Delaware Health Care Commission and its Small Business Health Insurance Committee to reform rating rules for small employer group health insurance. A comprehensive review of the current law revealed that it is complicated, difficult to understand, and does not achieve the goal of making premiums more predictable from year to year. The bill compresses rate variations between high risk and low risk groups, reduces rating factors from seven to three, limits annual increases and decreases due to changes in health status to 15 percent, and prohibits the sale of 'stop-loss' coverage in the small group market.

Paula Roy recalled previous work within the Small Business Insurance Committee revealed dissatisfaction with current laws governing the sale and purchase of health insurance in the small group market. Delaware law defines small groups as those ranging from 1 to 50 people.

The current law was put in place in the early 1990's, based on model legislation developed by the National Association of Insurance Commissioners, and was intended to address problems of rate stability, predictability and the overall availability of health insurance for small firms.

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

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

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

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One overall problem uncovered during the most recent analysis was that the current law is complicated, difficult to understand and difficult to enforce.

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

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

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

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

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

3. Problem: Groups of One

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

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

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

Recommendation:

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

5. Potential Problem: "Virtual" self-insurance with stop loss coverage

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

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

1. There were still high variations in the high risk groups, who paid a much higher premium (five times more than the low risk group).
2. Multiple rating factors, combined with a relatively high rating band

Discussion

Dennis Rochford asked why the Committee thought "virtual" self-insurance with stop loss coverage was a bad idea? Why take an option off the table if a small business is willing to pay \$10,000.00 annually for each employee?

Fred Townsend added one concern might be that stop loss insurance providers might not be there if a large claim is submitted.

Mr. Townsend asked Linda Nemes from the Insurance Commissioner's Office if the stop loss policy framework will limit someone's access to a provider. Ms. Nemes cautioned that stop loss insurance is subject to an entirely different set of regulations and small employers would not have the same protections offered in Chapter 72 in accessing coverage under stop loss insurance.

Mr. Townsend understood the advantages of narrower bands, or ratings, but said the key point is, that bringing the top band down, the bottom band goes up, meaning more expensive premiums for healthier people. This could create disincentives for some smaller employers from renewing their policies. At some point, this could create a much healthier small employer pool to insure, and this may cause the rates to go up.

Action

Richard Heffron made a motion that the Delaware Health Care Commission support House Bill 85. Fred Townsend seconded and the motion carried.

Mr. Rochford said points of discussion from the Commission should be presented to the Legislature. Mr. Becker reiterated those points would be: 1.) concern over virtual insurance and 2.) all the questions raised by the Commissioners.

Review and Action: Options for Health Reform in Delaware: Impacts on Insurance Coverage and Government Cost -

Jonathan Gruber, PhD

Dr. Gruber asked if his report could be presented to the Commission today via telephone. The Commission is interested in having Dr. Gruber present his report in person. In order to have Dr. Gruber to come to Delaware for the June 4 meeting, his contract must be extended.

Action

Dr. Nevin made a motion to extend Dr. Gruber’s contract which was seconded by Dr. Lisa Barkley. After a voice vote the motion carried.

INFORMATION AND TECHNOLOGY

Update: Delaware Health Information Network – Prue Albright

DHIN is in Beta testing with the search query function. If testing continues to proceed without problems during May, in June current practices will be re-trained and new practices will come on board.

Gina Perez, executive director of DHIN, has:

- been appointed to the National HIT Standards Committee statutorily created by the ARRA (federal stimulus legislation).
- provided testimony to a congressional committee charged with defining “meaningful use” of health information technology under the ARRA—the basis for ARRA HIT spending.
- participated in Nationwide Health Information Network: shaping the national approach to health information technology (HIT)
- sits on the American Health Information Management Association (AHIMA) State Level Health Information Exchange Steering Committee

Successes:

- DHIN is the only health information exchange in the country with two national reference laboratories contributing data and financing: LabCorp and Quest Diagnostics
- Doctors Pathology Services, a local pathology provider is live with DHIN and data is starting to flow

Action

Richard Heffron made a motion that the Delaware Health Care Commission support House Bill 85. Fred Townsend seconded and the motion carried.

Action

Dr. Nevin made a motion to extend Dr. Gruber’s contract which was seconded by Dr. Lisa Barkley. After a voice vote the motion carried.

DHIN is the only health information exchange in the country with two national reference laboratories

- Discounted vendor interface rates for doctors with electronic medical records systems
- Enhanced functionality giving providers flexibility to do their work and information they need in real-time
- One standard format for all data from all sources
- Critical mass: two-thirds of patients, more than 85% of lab tests and hospitalizations
- Forty million transactions per year

contributing data and financing: LabCorp and Quest Diagnostics. DHIN does forty million transactions per year.

The Numbers:

- 648,000 patient charts
- 900 providers (by June 30th - fifty percent of the providers in the state)
- Four hospital systems with six hospitals (BayHealth Medical Center, Beebe Medical Center, Christiana Care Health System – plus St. Francis in late 2009)
- Four Federally Qualified Health Centers (Delmarva Rural Ministries, La Red Health Center, Henrietta Johnson Medical Center and Westside Family Health)
- Five hospital Emergency Departments sending data to the Division of Public Health for public health monitoring of outbreaks, such as Swine Flu
- Connectivity to 6 Electronic Medical Records (EMR) vendors currently serving over 130 physicians in 24 practices

Services:

- Secure delivery of clinical results (lab and pathology), reports (radiology) and face sheets (demographic and billing information)
- Web-based portal for those without an EMR, including auto-print for paper charting
- Direct interface into the EMR with patient record matching for those providers with EMRs

Coming in FY10:

- Patient record search – clinical history available in DHIN on a need to know basis
- Transcribed Reports
- Electronic Order Entry
- EMR Primer for those who cannot afford an EMR (ePrescribing, clinical reporting/analytics, etc.)
- Transitions of Care – Nursing Home, Home Health and Rehab
- Third Party Evaluation of DHIN

Funding

- Three sources:
 - Federal contracts – Over \$1 million per year until September 2010
 - State funding matched \$1 for \$1 with private sector

- funding from DHIN data senders
- Blue Cross Blue Shield of Delaware (BC/BS does not receive information through DHIN but sees value in it improving patient care).

...a combined total of \$4 to \$5 million annually

DHIN revenues have been provided in even thirds by the three sources.

Discussion

Paula Roy said the term, *meaningful use*, will drive who gets money from the Federal Stimulus Package. Gina being invited to testify on how to define *meaningful use* before a congressional committee speaks volumes about the DHIN's leadership.

Dr. Nevin commented one of the challenges for physicians in practice is getting the initial funding to implement connecting to DHIN. Dr. Nevin asked if there is an opportunity for DHIN to help leverage for stimulus package funding to go to those practices?

Ms. Albright answered she did not know all of the details, but there are opportunities for physicians in the stimulus package. Part of the regulation to receive funding requires physicians to be connected to a health information exchange – without DHIN there would not be a system to be truly connected and the physicians may not be eligible to collect that funding.

Mr. Rochford asked two questions: does a physician have to upload software in order to connect to DHIN and is Senate Bill 80 in direct conflict with DHIN?

Ms. Albright said DHIN is free to the physicians' offices and all that is necessary is to have high speed internet access, a Windows based system with licensed software and yes, SB 80 conflicts with DHIN and will be addressed in more detail by Ms. Roy.

Senate Bill 80

The Commission was informed that Senate Bill 80 has been introduced to create the Delaware Health Consortium, charged with implementing and operating a Statewide health information network.

Ms. Roy reported background information on Senate Bill 80, which was introduced last Thursday and assigned to the Administrative Services and Elections Committee. The Committee met yesterday and released the bill, but there are many steps ahead before the bill could potentially pass both Houses of the General Assembly.

A discussion followed and the following points were raised:

- SB 80 is in direct conflict with the Delaware Health Information Network.
- The Bill lacks clarity and appears to duplicate exactly what the DHIN has done.
- The Bill does not include any oversight from the State. Everything is placed into a private corporation run by an Oversight Board that could do pretty much whatever it wanted to.
- The years that have been spent collaborating and coming to consensus on the DHIN have been remarkable. The fact that Delaware is the only Health Information Exchange in the country suggests that it has moved much more rapidly than other states or communities.
- Delaware's DHIN legislation is held up as a model. At least seven other states have used it as a basis for their own HIE governance, following failed attempts to do health information exchange completely on a private basis.
- The State of Delaware has invested over \$6 million. Soon it will be roughly \$7 million in State funds, \$7 million in private funds, and \$7 million in federal funds. To think that the progress that has been made up to this point would just simply be handed over to a new Board of Directors operating in the private sector is disturbing.
- Wayne Smith, President and CEO of the Delaware Healthcare Association, asked to go on record that the Delaware Healthcare Association does not support SB 80. The Bill is very vague, it has direct mission overlaps with the current DHIN, and would put in place two structures within the Delaware Code trying to accomplish the same mission.
- The Delaware Healthcare Association is very pleased with the progress of DHIN and would like to see it continue exactly as it is in its current structure under the Health Care Commission.
- Although SB 80 directs the initial composition of an Oversight Board that is only the "initial" composition. After a period of time anyone could be placed on the Board.

Action

Dennis Rochford made a motion that the Commission oppose SB 80, and include in the minutes the comments made by everyone during discussion. Dr. Janice Nevin seconded the motion. Rita

Wayne Smith, President and CEO of the Delaware Healthcare Association, asked to go on record that the Delaware Healthcare Association does not support SB 80. The Bill is very vague, it has direct mission overlaps with the current DHIN, and would put in place two structures within the Delaware Code trying to accomplish the same mission.

Action

The Commission voted to support HB80 and comments from the Commission

Landgraf abstained from voting because she has not vetted the bill through her Department, as is customary. There was a voice vote. Motion carried.

to be presented to the Legislature.

OPPORTUNITIES WITH AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (Federal Stimulus Package) Medicaid/SCHIP – Rita Landgraf

Rita Landgraf introduced Frank O'Connor, DHSS point person for Medicaid, and Steve Groff, who is most familiar with the SCHIP program and Jim Wilton.

Medicaid

Frank O'Connor distributed a handout, *American Recovery and Reinvestment Act (ARRA) of 2009, Title V – State Fiscal Relief, Medicaid Fact Sheet*, which is attached to these minutes.

Because of the discussion about DHIN, Mr. O'Connor began his presentation by pointing out that the ARRA provides funds for Health Information Technology(HIT)/Electronic Health Records (EHR) through the Medicaid program as well as other programs (including Medicare and Federally Qualified Health Centers).

This is a new area for Medicaid both nationally and at the state level so there is no road map to follow and little to no in-house expertise at the Division of Medicaid and Medical Assistance (DMMA).

The Lt. Governor has assigned the Department of Technology Information (DTI) to coordinate the state's HIT/EHR activities related to stimulus funding opportunities.

Historically, Delaware receives a 50 percent federal match (FMAP) for Medicaid. There is an across the board increase of 6.2 percent for the period October 2008 – December 2010

In state fiscal year 2009 the increase results in a projected state savings of \$96.7 million (50 percent to 60.19 = 60.19 percent)

In state fiscal year 2010 the increase results in a projected state savings of \$149.8 million (61.59 percent to 61.78 percent)

Discussion

Dr. Nevin asked if, in the state, we would have the ability to reach out to those practices that we know are eligible and help them know they can do this? It would especially important to ensure Primary Care Physicians are aware of this funding. Mr. O'Connor responded that with some benchmarks (identifying Medicaid providers) it can be done.

Dr. Barkley asked if the state will have any funding to help support this opportunity. Mr. O'Connor said this money is federal and state matching funds are not necessary with this program – unusual for the Medicaid program.

Department of Technology Information Secretary James Sills and Steve Groff from DMMA, are on the DHIN Board of Directors. There is a relationship built in that could utilize DHIN for stimulus funding opportunities.

SCHIP

Steve Groff distributed the handout, *Children's Health Insurance Program Reauthorization Act of 2009 (PL111-3) Fact Sheet*, which is attached to these minutes.

Mr. Groff said if there had not been a re-authorization, the program's funding would have ended. Funding has been appropriated through FY 2013.

HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT

Update: Oral Health Planning Grant

Background

A \$200,000 grant awarded to Delaware for one year of planning activities to expand access to dental health care services and improve oral health outcomes, with a particular focus on Sussex County. The Commission is collaborating with the Division of Public Health on this planning grant.

- In December, released a Request for Proposals as a part of the Oral Health Workforce Planning Grant awarded to DE by the US Health Resources and Services Administration (HRSA).
- Proposals were due to DHCC on January 22, 2009, for which we received one response to conduct a feasibility study of three target initiatives:
 - 1) Creation of a case management program to develop a dental home for children in Medicaid and SCHIP, to improve oral health status of underserved.
 - 2) Enhancement of dental education opportunities for dental hygienists and dental residents in southern DE, to strengthen the dental workforce
 - 3) Establishment of a multi-purpose dental clinic and training facility in Sussex County, to improve access to care and expand training opportunities.

Update

- *March*

Contract negotiations and contract execution with John Snow Inc.

- *March/April*

Phase I – Began preliminary assessment, community engagement, and presentation of basic programmatic options

- Review and analysis of existing data, reports, current health issues in Sussex
- Scan of best practice models in other states and in the region (re: 3 target initiatives)
- Conduct key informant interviews with providers and key stakeholders to identify service gaps, barriers and challenges, current delivery system capacity

April 7th - 8th – John Snow Inc. in Delaware to conduct interviews with key stakeholders, and led a roundtable on oral health care access issues at the Rural Health Summit

- *April/May*

Continue interviews –April 30th through May 1st

- Convene Steering Committee on May 12th and report progress:
 - Need / Service Delivery Systems in Sussex County
 - Framework of Best Practice Options
 - Review of Key Stakeholder Interviews

Update: Workforce Summit Planning

Dr. Nevin, co-chair of the Health Workforce Development Committee, reported the Committee hoped to issue a Request For Proposals but funding was not available. Dr. Nevin, Dr. Brian Little of the DIMER Board, Paula Roy and Leah Jones held a conference call. The result was a decision to convene a one day Workforce Summit this Fall. The Summit would include stakeholders and would share pertinent research, identify current workforce activities, get local and regional expertise, and identify future needs to formulate specific recommendations to the Legislature.

OTHER BUSINESS

Update: Rural Health Summit

Barbara DeBastiani of Wheeler and Associates Management reported on the April 8, 2009, Rural Health Summit at Delaware Technical and Community College, Owens Campus, under the auspices of the Delaware Rural Health Initiative (DRHI). DRHI is a non-profit, non-partisan, grassroots organization that works to improve the health of rural Delawareans.

Over 100 people attended the Summit. There was a presentation and discussion on national/state rural trends; Delaware specific information about the downstate population and provider workforce; perspectives of local industry leaders in the fields of

recruitment and direct service delivery and an in-depth examination of the disciplines of mental health, primary care, OB/prenatal care, and oral health (roundtable discussions).

Ed Ratledge of the Center for Applied Demography and Survey Research, University of Delaware presented basic demographic data for Sussex County both now and the future.

Three Southern hospital systems were represented: Bayhealth Medical Center, Beebe Medical Center and Nanticoke Memorial Health System.

PUBLIC COMMENT

Joann Hasse, League of Women Voters, has actively been talking to people in the Administration, members of the Legislature, and the Joint Finance Committee about the proposal to change the Commission from an independent body and move it under the Division of Public Health. Ms. Hasse thinks this not cost effective and addresses a problem that doesn't exist. The Commission has done a wonderful job of providing a place for people to come together.

NEXT MEETING

The next meeting of the Delaware Health Care Commission will be held on Thursday, June 4, 2009, at 9:00 a.m. in the Farmington/Felton Conference Room on the first floor of the Department of Transportation (DelDOT) Administration Building, 800 S. Bay Road, Dover.

ADJOURN

The meeting adjourned at 11:45 a.m.

Next Meeting

The next meeting of the Delaware Health Care Commission will be held on Thursday, June 4, 2009, at 9:00 a.m. in the Farmington/Felton Conference Room on the first floor of the Department of Transportation (DelDOT) Administration Building, 800 S. Bay Road, Dover.

GUESTS

Prue Albright	Advances in Management/DHIN
Anthony Brazen, D.O.	Division of Medicaid and Medical Assistance
Judy Chaconas	DHSS/Division of Public Health
Barbara DeBastiani	Wheeler and Associates Management
Angela S. Grimes	Delaware Valley Outcomes Research
Joann Hasse	League of Women Voters
Katie Rosch Hegedus	Delaware Valley Outcomes Research
Jean Heller	Electronic Data Systems
Jonathan Kirch	American Health Association/ASA
Lolita Lopez	Westside Family Healthcare
Linda Nemes	Department of Insurance
Brian Olson	La Red Health Center
Wayne Smith	Delaware Healthcare Association
A. Butch Sims	La Red Health Center
Kay Wasno	Electronic Data Systems
Betsy Wheeler	Wheeler and Associates Management