

**DELAWARE HEALTH CARE COMMISSION
APRIL 1, 2010
DELDOT ADMINISTRATION BUILDING
FARMINGTON/FELTON CONFERENCE ROOM
DOVER
MINUTES**

Action Item

Commission Members Present: John C. Carney, Jr., Chairman; Lisa C. Barkley, MD; Theodore W. Becker, Jr.; Thomas J. Cook, Secretary of Finance; A. Richard Heffron; Rita Landgraf, Secretary, Delaware Health and Social Services; Dennis Rochford, and Fred Townsend.

Members Absent: Janice E. Nevin, MD; 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 Policy and Planning; Marlyn Marvel, Community Relations Officer; and Linda G. Johnson, Administrative Specialist.

CALL TO ORDER

The meeting was called to order at 9:05 a.m. by John Carney, Chairman.

MEETING MINUTES OF MARCH 4, 2010

Dr. Lisa Barkley made a motion to accept the March 4, 2010, meeting minutes. Ted Becker seconded the motion. There was a voice vote. Motion carried.

UNINSURED ACTION PLAN

Update: Community Healthcare Access Program (CHAP) Oversight Workgroup

Ted Becker, Chair of the CHAP Oversight Workgroup, gave the following report to the Commission.

Site Visits

All site visits, with the exception of one, were completed during March. The remaining visit had to be rescheduled because one of the people to be interviewed was hospitalized.

Key findings from site visits include:

- All health homes and hospitals report increased volume and demand for services, many pointing to the economy as a likely reason. A common theme was that many new patients had never been uninsured before.
- CHAP has become very well integrated into operations at all sites.
 - Hospitals recognize the CHAP card and offer full write-off of hospital based services, procedures and stays. In several cases they also write off any bad debt that has

Action

The minutes of the March 4, 2010 Commission meeting were approved.

All CHAP site visits, with the exception of one, were completed during March.

accrued on the CHAP enrollees' hospital account.

- Health homes code CHAP as a "payment" method, and tracking CHAP patients and services rendered is much easier. This is particularly true now that they have implemented practice management systems and electronic medical records (all FQHC's are receiving information through the DHIN).
 - Referrals to VIP for prescription assistance and referrals for specialists works smoothly.
 - Professional relationships have developed across agency and program lines – care coordinators with VIP; primary care physicians with VIP specialists.
 - Health Homes report that CHAP significantly adds value to patients, as it provides access to a greater array of services.

All partners value the care coordination and case management aspects that CHAP provides.

Integration with Astra - Zeneca/Healthy Delawareans Today and Tomorrow

Funds provided by Astra Zeneca (A-Z) help support CHAP efforts, and the CHAP funded positions and A-Z funded positions work "hand in glove." Examples are:

- Expanded hours of care coordination services into evenings and week-ends
- Follow up on screenings and chronic care management
- Total integration of job responsibilities, allowing care coordinators/patient navigators to experience full array of outreach and case management in multiple settings, including in the clinic, in administrative settings and "in the field"

Budget Cuts

There is grave concern about the proposed budget cuts. At each site visit the magnitude of the proposed cuts was discussed, and each partner was informed that they should expect follow up visits to discuss cuts in detail, and re-negotiated contracts for those who are not scheduled to respond to a Request For Proposal (RFP) this year. Most sites report that the cuts they will experience are not limited to CHAP, but also come from other sources of funding, thereby limiting their ability to absorb the cuts.

Various approaches to the proposed cuts have been examined and none offer good outcomes. Even if outreach was completely eliminated as has been discussed, the savings anticipated cannot be achieved without severe impact on program operations.

Options being examined include the following:

1. Targeted cuts – eliminating some aspects of the program, such as outreach
2. Across the board cuts – the proposal is a 22% reduction. One option is to reduce all contracts by the same amount. This will result in reduced staffing. In some cases agencies may be able to keep staff with reduced working hours. In other cases jobs will be lost. This will inevitably impact patients. Results are likely to range from not getting new patients enrolled, and therefore access to services; reduced linkage to other services (hospital services could create greater hassle factors if CHAP card not available, specialty care, prescription assistance, case management and “navigation”
3. The worst case scenario is stopping the program – either temporarily or permanently. This is not seen as being feasible, since the costs of stopping and starting again, along with the complete disruption of care, would be worse than the other two scenarios.

There is real and legitimate fear that the severity of the cuts may jeopardize the entire program. In view of the federal health reform, the long term future of CHAP has been discussed, but the key elements of reform which will result in more people having coverage will not occur until 2014. In the immediate short term, there is clearly a need for serving the CHAP population

There is real and legitimate fear that the severity of the cuts may jeopardize CHAP.

The CHAP Oversight Workgroup will continue these discussions and expect to have more concrete proposals ready in May. However, the Request For Proposals for health home services has not yet been released. May 10 has been slated as the response due date.

Discussion

Chairman John Carney said the \$250,000.00 enhancement to CHAP's funding from the State has only been in place for the past couple of years. Mr. Carney asked what changes were made to CHAP by the enhancement of additional funding?

Betsy Wheeler said that the funds provided for the addition of the Health Risk Assessment process and the following of patients with chronic disease.

Mr. Carney would like to see how the enhanced funding was included in the providers' contracts. With health care reform, more people will have health insurance and will be paying customers, which will provide other revenue.

While the health care reform bill has a huge funding amount for Federally Qualified Health Centers (FQHCs), Alec McKinney pointed out that funding for the FQHCs is very targeted. It does not supplant other funds and is not allowed to be used for what a health center might want or need.

Ms. Wheeler said that none of the options for scaling back are good ones. In some scenarios, the CHAP Oversight Workgroup discussed cutting full time equivalent (FTE) positions devoted to CHAP.

Rita Landgraf asked if any inroads have been made with the blending of CHAP and Screening For Life (SFL)? That blending would involve a revenue stream from Public Health to CHAP.

Mr. Becker answered the timelines of CHAP and SFL did not coincide last year and the initial start-up would require additional funding that was not available.

It is anticipated that the RFP for CHAP health homes will be released April 10 with a due date of May 10.

Cover the Uninsured

Paula Roy said March 17 began the 2010 "Cover the Uninsured" week, sponsored and initiated by the Robert Wood Johnson Foundation. Delmarva Rural Ministries hosted the seventh annual recognition event on Friday, March 19, 2010 in its Administrative Building.

Community Service Awards were presented to Dr. Vicenta Marquez for her work at Hope Medical Clinic; Delmarva Rural Ministries for the Kent Community Health Center and Bayhealth Medical Center for its voluntary Ambulatory Surgical Access Program.

In April 2008, Astra-Zeneca began devoting an entire month to "Cover the Uninsured." Today is the beginning of its 2010 "Cover the Uninsured" month.

RESEARCH AND POLICY DEVELOPMENT

Update: Delawareans Without Health Insurance Report

Ms Roy said this year, the "Delawareans Without Health Insurance Report" will include sections that should help the Commission understand health reform, with some analysis of the legislation, the likely impact on Delaware's uninsured, access issues in Delaware in general, and offer comments on how access may change and basic workforce issues.

A draft of the report is expected in May.

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INFORMATION AND TECHNOLOGY

Update: Delaware Health Information Network (DHIN) Progress

Gina Perez presented an update on the activities and progress of the Delaware Health Information Network (DHIN).

DHIN enrollment increased from 166 live practices on February 26, 2010 to 183 live practices as of March 31, 2010.

Twenty four practices are currently in the pipeline, with the enrollment form complete and awaiting set-up and training. Seventeen of the 24 practices are associated with either the Medical Group of Christiana or the Beebe Physician Network and the training is being coordinated centrally.

More than 811,000 unique patients are represented in the Master Patient Index.

DHIN has enrolled 61 percent of providers actively practicing medicine in Delaware, a nearly 10 percent increase over the previous month.

The number of practices signed off increased by 5 to 37

Practice Status by County is:

Practice Status	New Castle	Kent	Sussex	Total
Live	81	39	26	146
Signed Off	13	11	13	17
Total DHIN Practices	94	50	39	183

DHIN has been working with all of the stakeholders on scope planning for the next fiscal year, finalizing contracts for the technology, including work associated with the HIE State Cooperative Agreement.

There is a lot of activity with the DHIN Finance Workgroup, with a meeting scheduled in April. Two sub-groups are looking at sustainability from standpoints of payers and data senders - how DHIN can institutionalize a different approach to fees associated with participation in DHIN.

A Bond Bill hearing is scheduled on April 28. One million dollars was requested for DHIN in the Commission's budget request, which was not included in the Governor's Recommended Budget. DHIN will be presenting to the Bond Bill Committee its continued need for those funds.

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Based on agreements from years ago, private funds require a State fund match. There are also matching fund requirements under the Health Information Exchange Cooperative Agreement.

The DHIN has been awarded \$4.68 million in federal American Reinvestment and Recovery Act (ARRA) funds under the State Health Information Exchange Cooperative Agreement program. The funds will be distributed over four years.

Among the new activities the grant will support are:

- connectivity to Medicaid
- connectivity to the Division of Public Health
 - immunization registry
 - public health laboratory
- connectivity to Division of Substance Abuse and Mental Health
 - connectivity to Department of Services for Children, Youth and Their Families
 - claims processing

DHIN Sunset Review

Another hearing between DHIN and the Sunset Review Committee is scheduled for April 14.

DHIN Audit

It is believed the audit process is winding down. Pre-exit interviews have been held with three representatives from the State Auditor's Office. The auditors had gathered incorrect information and the interviews provided an opportunity for correction. An exit meeting is scheduled on April 8. DHCC and DHIN staff will have an opportunity to review the Auditor's report and respond within 10 days if are corrections necessary. Responses will be adopted verbatim in the report with no editing.

Dennis Rochford inquired about the status of the DHIN governance legislation.

Ms. Roy responded that the Legislature will not take action until the Sunset process resolves itself. That commitment was made by the Sunset Review Committee and sponsors of the legislation have also made that commitment to the Senate leadership.

HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT Oral Health Infrastructure Enhancement Feasibility Analysis - Alec McKinney, John Snow, Inc.

A draft final report on the Oral Health Infrastructure Enhancement Feasibility Analysis was distributed to Commissioners for review and Alec McKinney gave a presentation of key findings and recommendations.

Another hearing between DHIN and the Sunset Review Committee is scheduled for April 14.

DHCC and DHIN staff will have an opportunity to review the Auditor's report and respond within 10 days if are corrections necessary. Responses will be adopted verbatim in the report with no editing.

Alec McKinney gave a presentation of key findings and recommendations of the Oral Health Infrastructure Enhancement Feasibility Analysis.

Guiding principles were:

- the need for a coordinated systematic approach
- focus on the most vulnerable
- pragmatic response that is inclusive of all stakeholders
- builds capacity and strengthens workforce
- involves the private sector overtime
- aware of provider concern and business realities.

Multi-Purpose Clinic

- Develop an access point for comprehensive primary care dentistry, particularly for low income uninsured adults and Medicaid insured children.
- Develop a venue for dental workforce training, particularly for dentists, dental hygienists, and dental assistants.

Possible options:

- free dental clinic
- not-for-profit, publicly subsidized clinic (non FQHC, quasi public authority)
- full service public health dental clinic
- FQHC/private dentist partnership
- full service school based clinics
- federally qualified health center with on site dental services
- dental residency program

Recommendations

- support LaRed Community Health Center (designated FQHC) with its ongoing efforts to establish primary dental care operations
- LaRed could work with various stakeholders to implement training activities starting in years three or four
 - community based residency program in collaboration with Sussex County hospital(s)
 - dental hygienist training site with Del Tech hygiene program student residents of Kent and Sussex Counties
 - dental assistant training site with Sussex County vocational schools

Training Workforce Development Initiatives

- Address dental providers shortage downstate by developing 'home grown' eligible dentists
- Expand current and future dental capacity (.5 FTE Residency Director, two dental residents)
- Facilitate better access and care in hospital emergency departments
- Promote greater involvement of private dentists

Possible Options

- general practice residency (GPR)
 - satellite of existing GPR
 - academic institution based
 - hospital based
 - community based
- AEGD
 - less intensive community based model
- dental externships

Recommendations

- general practice residency sponsored by Sussex County hospital with community based clinical co-sponsor
 - Beebe, Bayhealth or Nanticoke Hospital would be primary applicant (could be collaborative effort between two or more hospitals)
 - LaRed would be clinical co-sponsor
 - Wilmington based GPR would play supportive role
 - Sussex/Kent County private dentists and medical doctors could play supportive role

Downstate Expansion of Del Tech Dental Hygiene Program

- Address dental hygiene provider shortage downstate by developing 'home grown' eligible hygienists
- Expand future dental capacity by allowing dentists to maximize their capacity
- Solidify new and/or strengthen existing practical/clinic training Opportunities to augment/replace Dover Air Force Base (DAFB)

Possible Options

- didactic training expansion
 - expand Del Tech Community College (DTCC) Terry Campus (Dover) extension of hygiene program
 - develop new DTCC Owens Campus (Georgetown) extension of hygiene program
- practical/clinic training site
 - develop training operations at LaRed
 - explore targeted training opportunities at the Stockley Center

Recommendations

- solidify relations with DAFB and develop contingency plans should site be unavailable
- confirm demand for hygienists in Sussex County – anecdotal evidence suggests that graduating hygienists are experiencing difficulty securing employment.
- explore loan repayment for hygienists, particularly for students from Sussex County
- explore training opportunities at Stockley Center
- develop clinical training program at LaRed after its operations

- are solidified to augment DAFB
- assuming demand for hygienists is confirmed:
 - expand the number of slots for students from the DTCC Terry Campus Extension, particularly for students from Sussex County
 - continue to explore the expansion of DTCC hygiene program to DTCC Owens Campus

Case Management Program

- Promote preventive care among populations at high risk for more costly dental needs
- Facilitate access for high need Medicaid eligible children and uninsured adults by providing identification, education, screening, enabling services, and treatment referral services
- Reduce missed appointments to support viable business model for the provision of dental care

Possible Options

- Publically sponsored efforts
 - school based programs (elementary school, Head Start and Early Head Start)
 - statewide publicly funded program (Medicaid or Public Health delivered)
 - electronic population based case management system (Medicaid or Public Health managed)
- Privately sponsored efforts
 - pediatrician's office
 - primary care clinics (FQHCs)

Recommendations

- work with LaRed to case manage existing medical patients to obtain dental care
- once established, work with the Public Health clinics, area schools and other organizations (as appropriate) to case manage children
 - coordinate respective outreach within area schools
 - collaborate to assist in providing treatment to high need children and facilitating a dental home for ongoing preventive care
- develop statewide or regional case management program targeting Medicaid eligible children in high need areas operated by DPH or Medicaid
 - program operated out of public health clinic, mobile dental van, and/or other community based venues

Would require significant state funding that is currently not available

Strategic Focus

In dental clinics (DPH, LaRed or private), dental assistants can be used for clinical care as well as case management, providing flexibility in operations

At LaRed, facilitate access of existing patients, include schools and other venues incrementally (Head Start, WIC, pediatricians, etc.)

At LaRed, even distribution of adults and children

Most successful case management programs provide hands on assistance, reach clients where they congregate, and match demand with supply

Discussion

Dr. Barkley asked if LaRed were to obtain HRSA funding, how many years would it last? Much of LaRed's funding in the report comes from grants and Dr. Barkley is concerned about sustainability.

Mr. McKinney answered that the HRSA Workforce Development grant is for three years; however, HRSA Expansion grant funding, which LaRed applied for, basically does not go away.

Delaware's Medicaid reimbursement for dental care is probably the most generous in the country and there is great revenue opportunity for sites that serve children.

The Delaware State Dental Society and DIDER have been very supportive of this project.

Rita Landgraf asked if people who have no funding whatsoever will still get served without payment?

Mr. McKinney said no. Providers are not required to provide service without pay for oral health care.

Ms. Landgraf recommended the report be amended to reflect that the sliding fee scale indicate a minimum payment of \$50.00. The dental sliding fee scale is unlike the medical sliding fee scale, which is almost down to zero payment.

Ms. Roy said there was the opportunity to apply for implementation grant funding but the requirement to apply came while the planning process was still in place. The Division of Public Health successfully applied for that implementation funding so there is some funding to proceed but it will not pay for everything. Some components can go forward.

The Delaware State Dental Society and DIDER have been very supportive of this project.

Ms. Landgraf recommended the report be amended to reflect that the sliding fee scale indicate a minimum payment of \$50.00.

Gregory McClure, DMD, MPH, Dental Director, Division of Public Health, commented that the planning grant was for one year. The Division of Public Health applied for the implementation phase grant about halfway through. There was an unexpected opportunity to apply for another grant, which the Division of Public Health has applied for, that could be used to upgrade activities; however, it requires a forty percent State match.

Action

Mr. Becker made a motion to approve the report pending review of the document by the Commission. Dr. Barkley seconded the motion. After a voice vote, the motion carried.

Update: Delaware Health Science Alliance Partnership – Dr. Lisa Barkley

A meeting was held with Dr. Kathy Matt, Dean of the College of Health Sciences at the University of Delaware, and director of the Delaware Health Sciences Alliance as a follow up to Dean Matt's presentation to the Health Care Commission in January.

Dr. Barkley reminded Commissioners that the Delaware Health Science Alliance will be a multi-faceted initiative that primarily focuses on education, but will include elements of research, training in the health sciences with the goal of training health professionals, fostering research, particularly translational research and providing leadership in the improvement of health and health services to all Delawareans.

Although the initial Alliance partners are the University of Delaware, Nemours, Christiana Care and Thomas Jefferson University, Dr. Matt envisions incorporating as many partners as feasible as the work of the Alliance unfolds.

As discussed at the Commission meeting in January, a logical first new partner is the Delaware Health Care Commission. The Commission's history in research, its commitment to health professional workforce development and DIMER and DIDER hold the potential to bring a broad and deep knowledge base together with Alliance partners who can execute recommendations.

Key themes which emerged from the discussion include the following:

Workforce of the Future

Tomorrow's workforce will look and act differently from today's workforce, and future generations will relate to the workplace differently than generations in the current workforce. Furthermore, the aging population will require new and innovative ways to both train and deliver health care services in the years ahead.

Action

The Oral Health Infrastructure Enhancement Feasibility Analysis Report was approved pending review by the Commission.

Building on existing research

The Commission has invested in research on workforce issues which can be of value to the Alliance and its current and future partners. Examples include:

- Allied Health Professional report
- Educational Pipeline report
- Nursing reports
- Supply and Demand on Mental Health Professionals in partnership with Division of Public Health, and reports on Primary Care Physicians and Dentists in Delaware.

Building on existing programs and knowledge

DIMER, DIDER and State Loan Repayment programs are critical partners in helping the Alliance succeed.

Applying best practices to meet current and future needs of Delaware

Applying knowledge of best practices assures training to help improve health care services in Delaware. Specific examples include incorporating principles of a patient centered medical home and training for rural settings

Recommendations

It is recommended that the Commission provide policy guidance upon which the Alliance can base its specific activities. In short, the Alliance can help execute recommendations arising from the Commission's policy work.

Specific next steps:

- Look at existing data; identify resources (grants, etc) to analyze existing data, synthesize it and identify critical gaps and needs for additional research.
- Reconstitute the Health Workforce Development Committee to oversee the data analysis work and provide policy guidance for the Alliance
- Gather information and research on generational and population differences and its impact on training health professionals for the future . What are students asking for? How do we specifically train professionals to meet rural health needs? How do we train to meet needs of aging population? How do we maximize advantages of best practices, such as the patient centered medical home?
- Conduct an inventory of how we are currently educating people to meet our needs and identify gaps

Commission approval is sought to proceed with the plan outlined. Specifically, it would be important to reconstitute the Health Workforce Committee to begin these discussions. Among other things, funding sources to implement these ideas should be

explored, beginning with a kick-off conference. Dr. Barkley believes that the Health Science Alliance will look to the Commission as well as the Workforce Committee to provide policy guidance for its work. This action will assure that activities are coordinated.

Action

Dr. Barkley made a motion to reformulate the Health Workforce Committee to work with the Health Science Alliance, addressing workforce issues throughout the state. Fred Townsend seconded the motion. There was a voice vote. Motion carried.

OTHER BUSINESS

Delaware Health Care Commission Statute Review Committee

Fred Townsend reported the Delaware Health Care Commission Statute Review Committee met on Tuesday, March 30th and began with an overview of the history of the Commission and the statute that was enacted in 1990. That discussion was led by Marc Niedzelski, the Commission's Deputy Attorney General from the Attorney General's Office.

Mr. Niedzelski gave his impressions of the current federal legislation and how that might dovetail with the statute review process.

The subsidiary nature of DIMER, DIDER and DHIN was discussed- the fact that they are advisory, not executory and that is a function of the makeup of their Boards. Members are not appointed entirely by the Governor. By that virtue, those Boards need to have a "home," or would need to be reconstituted pursuant to legislation. Mr. Townsend believes that would not be realistic. The opposing viewpoint would be that they benefit a great deal from the broad makeup of their members. Any future home to these organizations would need to be vetted and we should get input from them. Mr. Townsend believes it is going to take input from a broader group than those who attend the Committee meetings. The Committee does not want to present legislation to the General Assembly at this time. The Committee needs more time to thoroughly analyze options for updating the statute. In addition, enactment of current legislation regarding the DHIN's governance is generally viewed as a more urgent priority than updating the Commission's statute. Having two pieces of legislation could be potentially confusing.

The balance of the meeting was devoted to an analysis of the statute. The current statute contains a section that is referred to as "*Findings*," which is more typically seen in the form of "*Whereas*" clauses that do not get adopted into the Code in a typical bill. Those *Whereas* clauses generally reflect what has moved the drafters of the legislation to present changes to the Code. The *Findings* in the current statute are generally out of date

Action

Commissioners approved reformulation of the Health Workforce Committee to work with the Health Science Alliance, addressing workforce issues throughout the state.

or obsolete. When a new statute is drafted, it should not contain *Findings* clauses. It may contain a few *Whereas* clauses that describe what has been done in the past and why new legislation is desired.

Federal Health Reform

Mr. Carney would like to have a high level expert present information on the federal health care reform legislation to the Commission.

Rita Landraf recommended Missy Hughes from Governor Markell's Washington, DC office as an ideal person to give a presentation.

PUBLIC COMMENT

Dr. Robert Frelick said it is important to learn how to get people to want preventive care. It is important to recognize that this is part of the problem.

Dr. JoAnn Fields asked for clarification about the requirement that the State establish a high risk pool within 90 days of passage of the health care reform legislation.

Linda Nemes, a representative from the Department of Insurance, answered that the Federal Health and Human Services Secretary has 90 days to establish the pool. Then it goes to the state and the state has six months to set up. She explained there are a couple of ways to go with the pool. One way is to have a private insurer set up or establish an actual pool.

NEXT MEETING

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

ADJOURN

The meeting adjourned at 11:00 a.m.

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Next Meeting

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GUESTS

Shannon Backus
Butch Briggs
Judith Chaconas

Barbara DeBastiani
Dr. JoAnn Fields
Dr. Robert Frelich
Debbie Gottschalk
Joann Hasse
Barbara Jackson
Jonathan Kirch
George Meldrum
Linda Nemes
Sheila Nutter
Brian Olson
Gina Perez
Rosa Rivera
Lillian Ronnberg
Wayne Smith
Jose Tieso
Betsy Wheeler

Delmarva Rural Ministries
LaRed Health Center
DHSS/Division of Public Health/Bureau of Health
Planning Management
Wheeler and Associates

Medical Society of Delaware
Delaware Health and Social Services
League of Women Voters
Hewlett Packard
American Heart Association/ASA
Nemours
Department of Insurance
Hewlett Packard
LaRed Health Center
Advances in Management/DHIN
Henrietta Johnson Medical Center
Hewlett Packard
Delaware Healthcare Association
Hewlett Packard
Wheeler and Associates/CHAP