**INFANT & TODDLER**
**CONNECTION OF VIRGINIA**
VICC RETREAT
SUMMARY REPORT
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Prepared by:
Solutions
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The opinions, observations and recommendations expressed in this
Summary Report are those of the Consultants,
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and do not necessarily represent the opinions or recommendations of the
Virginia Departments of
Mental Health, Mental Retardation and Substance Abuse Services
(DMHMRSAS), Health (VDH) and/or Medical Assistance Services (DMAS)

As always, it was a pleasure to work with the VICC and
to assist in the continuous process of improvement so essential
to a robust and successful Part C system.

# VIRGINIA INTERAGENCY COORDINATING COUNCIL (VICC) RETREAT CONSULTANT SUMMARY REPORT

## Background

The VICC members participated in an October Retreat which focused on the following six (6) outcomes:

- Understand the opportunities and challenges related to the change of Lead Agency for Part C and specifically to the VICC;
- Understand the potential impact of the Early Intervention Medicaid Initiative upon Part C system components;
- Review the VICC's accomplishments since the December 2006 Retreat;
- Determine the primary "clients" of the VICC;
- Identify the strengths and needs of the VICC as it is currently configured; and
- Confirm up to three (3) priorities for the VICC focus for the next 18-24 months.

The Consultant, Sue Mackey Andrews from SOLUTIONS Consulting Group, LLC, led the VICC members in an activity to identify what they wanted to accomplish during the day together:

- A plan and objectives for the VICC;
- Priorities to address issues of change and concerns, including funding and infrastructure needs;
- Share a sense of the transition to Virginia Department of Health (VDH) and what that means to the VICC;
- Discuss and reach a consensus regarding the "big picture";
- The role of the VICC related to the transition including new relationships with VDH and sister agencies;
- Prioritization related to funding and infrastructure;
- Better sense of how to spend time at the VICC meetings and to make efforts by the VICC the most effective;
- Increasing accomplishments;
- Determine the power of the VICC and the relationship with the Governor;
- Communication; and
- Look at where the VICC currently is.

The VICC also heard from Dr. David E. Suttle, Director of the Office of Family Health Services for the VDH, about the VDH's commitment to Part C and the linkages between their prenatal, infant and home visiting programs and prevention initiatives.

Sue discussed the need for the VICC to update the Mission Statement while stressing the responsibilities of the VICC. She encouraged the VICC to define "who" they advise and assist, and to consider updating their vision to be one more focused on assuring the sound implementation, evaluation and improvement of the Virginia Part C system statewide.

Due to the variety of VICC member representation on local interagency coordinating councils or their affiliation as a provider, there is often a tendency for members to focus on their constituent issues rather than upon the statewide system as a whole – which is really the job of the VICC.

Sue noted that the VICC mission statement is outdated. She suggested consideration of the following language. She noted that the VICC needs to determine how they "assure" that the implementation, evaluation and identified improvements occur.

> To advise and assist ***the Lead Agency*** in the planning of the comprehensive system of early intervention services defined in the Individuals with Disabilities Education Act and to assure the implementation, evaluation **and identified improvements** of the coordinated, statewide, interagency, interdisciplinary system of services which enhances the capacity of families to meet the needs of their infants and toddlers with disabilities.

Sue made the following points and posed the following questions for VICC consideration:

- The role of the VICC is to advise and assist.
    - "Advise" is defined as counsel, recommend, give an opinion, warn, inform and make aware.
    - "Assist" is defined as help out, aid, lend a hand, support and back.
- There is a need for all VICC members to be at the "table."
    - The appointments to the VICC need to be filled with current, active appointments; otherwise, the decisions made by the VICC may be subject to external criticism or dismissal.
    - All members need to accept their role and agency representatives need to understand their agency's role.
- VICC members are appointed by the Governor and are a voice for their constituency at the VICC table – but need to have an eye on the statewide system, not their individuality locality or constituent issues as a singular item.
    - Whose voice are members representing when they speak?
    - What hats do members wear? How many hats do people wear?

- How will the VICC know which "hat" is talking when the members are speaking?
  - Members need to take responsibility to acknowledging which voice they are using, when
- How do members know they are speaking for their constituency and taking information back to them?
  - *There needs to be a process for getting information to and from* *each* *constituency on a regular basis.*
    - *This is especially true for family representatives – where there are tremendous barriers in truly representing the universe of family members given the difficulty in contacting, informing and soliciting opinions and experience in a comprehensive manner.*
  - *All voices should be heard and responded to with the same velocity and volume by the VICC.*

- There is an obligation of VICC members to inform their constituency AND also to support the decisions of the State Lead Agency.
  - Actual, timely and accurate data is needed by the VICC in order to understand the issues and make viable recommendations to the Lead Agency, in its role to "advise and assist."
  - There should be an understanding by the VICC of why decisions have been made by the Lead Agency.
- It was recommended by the Consultant that consideration be given to including a VICC member from the Department of Corrections possibly the Juvenile Justice System.
  - There is a link to the juvenile justice system and early intervention and school readiness.
- VICC Roles vis a vis the Federal regulations:
  - The VICC is charged with assisting the Lead Agency in the resolution of disputes regarding other state agencies.
  - The VICC may advise and assist the Lead Agency and the State educational agency regarding the provision of appropriate services for children aged birth to five.
  - Prevention is also a component of the work of the VICC regarding advising appropriate agencies with respect to the integration of services for infants and toddlers with disabilities and at-risk infants and toddlers and their families, regardless of whether at-risk infants and toddlers are eligible for early intervention services.
  - There is also a financial focus for the VICC through advising and assisting the Lead Agency in identifying sources of fiscal and other support and the assignment of financial responsibility to the appropriate agency.

    - Promotion of the interagency agreements is also a responsibility of the VICC.
    - Responsibility for the VICC to advise and assist in the areas of preparation and amendment of applications and transition were discussed.
        - Additionally, the annual report to the Governor and the Secretary on the status of early intervention was emphasized.
            - Currently, this is a report prepared for OSEP and is assembled by the Part C staff – and not the VICC.
            - It is impersonal and limited in terms of its utility for public awareness, engaging new stakeholders, or informing the General Assembly.
        - The report requirement of the VICC was viewed as a potential marketing tool to Legislators and to the general public.
            - VICC members shared samples of other state annual reports, which vary considerably and often are a short but informative piece with data on #s of children served, funds across all sources spent, individual family or stakeholder stories, etc.
    - The Part C system has been under the "microscope" for a number of years, with a variety of stakeholder groups and reports generated by different sources which essentially continue to agree and result in similar recommendations.

The following points were emphasized by the Consultant as major responsibilities and tasks for the VICC to consider developing with the Lead Agency:

- Interagency Financial Responsibility
    - Specifically HOW does the Lead Agency ensure the assignment and maintenance of interagency financial responsibility?
    - Specifically HOW does the Lead Agency ensure the assignment and maintenance of the federal finance requirements, including non-supplanting, maintenance of effort, payor of last resort?
    - How are these data reported to the VICC – in what format, frequency, how is data verified and what is the protocol when data are challenged?
    - What specifically is the VICC's role in "advise and assist" to the Lead Agency with respect to interagency financial responsibility?

- Fiscal Controls
  - Specifically HOW does the Lead Agency ensure Part C funds are used in accordance with State and Federal requirements?
  - How is this information reported to the VICC – in what format, frequency, how is data verified and what is the protocol when data are challenged?
  - What specifically is the VICC's role in "advise and assist" to the Lead Agency with respect to financial information, reporting and management?
- Service Provision Arrangements
  - Specifically HOW does the Lead Agency ensure the provision of Part C services?
  - How are these data reported to the VICC – in what format, frequency, how is data verified and what is the protocol when data are challenged?
  - What specifically is the VICC's role in "advise and assist" to the Lead Agency with respect to service delivery issues?

Further discussion focused on how to address the responsibilities of the VICC. **The creation of subcommittees was offered as a potential solution. Other constituents could also be included on the subcommittees while not VICC members. This would be a way to engage more perspectives in the deliberations of the VICC, and also prepare potential new members for the VICC.**

The following opportunities, challenges and realities in the Part C System were identified:

- <u>Financing the Part C System</u>

  - State agencies have been directed by the Governor to develop budgets representing 5%, 10% and 15% cuts. It is unlikely that Part C will be able to avoid a direct impact of this reduction order.
  - Federal funding allocation decreased for Virginia due to the reduction in state population.
    - The Federal Government expects that the Part C System will be supported with dollars other than federal dollars.
  - There is evidence that local dollars contributed to the system are declining.
    - Maintenance of effort and nonsupplanting requirements continue to be an issue.
    - Analysis since 2003 by SOLUTIONS Consulting Group, LLC appears to indicate that the potential impact of the infusion of state funds has been negated by the retraction of local funds.

- Data collection on third party reimbursements, family fees, co-pays, as well as local contributions, has been inadequate and incomplete over the years. Recent attempts to collect these data illustrate that some of the Local Lead Agencies do not have these data nor do they demonstrate the willingness to collect and report these data in a timely, complete and accurate manner.

- Impact of the additional state funds:
  - State dollars for Part C represent the largest infusion of state dollars into the system that Sue has seen in any state, at any one time.

***Why is this an important statement?***

Sue discussed the fact that there wasn't a proportionate increase in the number of children served, using the December 1 Child Count. The Commonwealth has historically used the annualized count of children served in their state reports. Sue noted that using the annualized count must also be balanced by reporting several key data that were identified in the 2007 System of Payments (SOP) Report. The Child Count is the number of children served that is collected across states, and used to report progress to Congress. It represents the total number of children in service on an average day throughout the year. When using the annualized number, careful attention and recognition must be given to qualifying this statement by the following excerpt from the SOP Report (page 34):

> *Average Age of Referral*
> *We also reviewed data related to the "average age of referrals" which, from 2000 through 2006, indicated a fairly "flat" pattern of the average age of referral for the Commonwealth as a whole (16.39 months in 2001 as compared to 16.21 months in 2006). Incomplete data for 2007 indicate the average age of referral at 15.46 months for the Commonwealth. The range of average age of referral for 2006 ranged from 13.05 months (Cumberland Mountain) to 18.97 months (Goochland-Powhattan).*
>
> *Table 8 displays these data by the localities for each of these years.*
> *Of those localities with >200 referrals for 2006, Prince William County and Fairfax-Falls Church report the lowest average age of referral at 14.64 months and 14.77 months respectfully for Fiscal Year 2006. Eleven (11) of these 20 localities report average age of referral higher than the state average of 16.21 months.*
>
> *These data indicate pretty serious problems for the Commonwealth as a whole in locating and identifying children <12 months, as required in OSEP Indicator Five. Given that Part B/ECSE assumes responsibility for services for children at age 2, this means that a majority of the children in the*

*Commonwealth's Part C system are served for less than 8.5 months before exiting from the system.*

The significance of these data is expanded when we view the percentage of referrals which result in eligibility and an IFSP. Data in ITOTS, collected for the System of Payments Report, revealed that more than 50% of the total referrals are either ineligible or the family declines to participate. This decline may occur even if the child is eligible. Because of the sequence in which the Part C service pathway in the Commonwealth currently works, there are substantial resources used prior to eligibility determination in "testing" children.

Despite the infusion of state funds, a concurrent increase in child enrollment has not been realized. The chart on page 10 (updated since the VICC Retreat) illustrates the relationship of financial data to enrollment. This chart provides information for 2002-2008 related to the December 1 count and system funding. Sue made the following points:

- An increase in children enrolled was seen in 2005-2007.
- The infusion of $1,000,000 in "bubble" money in 2005 was identified as one-time funding but resulted in some systems hiring employees for which they would receive no further funding.
- Some service coordination was covered by targeted case management.
- The one-time funds has created a disparity over the years.
- State infrastructure needs were not addressed.
- Local dollars, insurance, family cost share, other state funds, contributions, etc. are not included in the chart but represent approximately 50% of the dollars in the system.

Data collected during the 2003-04 Cost Study conducted by SOLUTIONS Consulting Group, LLC collected data from 24 providers and 15 Local Lead Agencies, indicated an additional $12,453,877 in "locally generated revenue" from a variety of sources including local lead agency contributions, Medicaid and other third party resources.

Extrapolated, it is likely that $20 million dollars, from these resources is realistic to add to the state and federal fund total prior to the infusion of the additional state funds.

Data collected from the Local Lead Agencies for the General Assembly Report for FY 2008 indicates a total of $13,295,823 constituted "locally generated revenue." These data are incomplete as many Local Lead Agencies were unable to report revenue from third party resources (e.g., Medicaid, private insurance, family fees and co-pays) which are collected by

individual providers and are not reported to the Local Lead Agency. Again, there is evidence that local dollars contributed to the system are declining.

If we consider all of these data from an integrated perspective, the current short-fall experienced by the Part C system and anticipated for 2009-2010 strongly indicates that it is caused by a retraction of Local Lead Agency contributions to Part C.

Many Local Lead Agencies have put into place to manage local budgets are contrary to the Part C federal regulations. These actions have placed the Commonwealth in significant jeopardy when one considers the potential for family/child due process complaints, systemic complaints or class action suit and the financial impact to the Commonwealth for compensatory services and possible legal fees.

| Fund Source: | 2002* | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|---|
| Federal | $5,509,883 | $7,388,178 | $ 8,701,314 | $9,919,704 | $8,419,704 | $8,287,152 | $8,473,236 | $8,457,479 |
| State | $125,000 | $125,000 | $125,000 | $875,000 | $3,127,606 | $6,562,185 | $7,203,365 | $7,280,219 |
| Supplemental Funds | $878,130 | $2,455,961 | $1,000,000 | $2,250,000 | $93,246 | $675,908 | $1,499,198 | $82,178 |
| Total | $6,513,013 | $9,969,139 | $9,826,314 | $13,044,704 | $11,640,556 | $15,525,245 | $17,175,799 | $15,819,876 |
| % Increase/Decrease | | 53.06% | -1.43% | 32.75% | -10.76% | 33.37% | 10.63% | -7.89% |
| Family Fee/Co-pay | Unknown | Unknown | Unknown | Unknown | Unknown | Unknown | $322,915 | |
| Medicaid | Unknown | Unknown | Unknown | Unknown | Unknown | Unknown | $1,095,727 | |
| TCM | Unknown | Unknown | Unknown | Unknown | Unknown | Unknown | $1,538,805 | |
| Private Insurance | Unknown | Unknown | Unknown | Unknown | Unknown | Unknown | $1,049,697 | |
| Grants, Gifts, etc. | Unknown | Unknown | Unknown | Unknown | Unknown | Unknown | $293,697 | |
| Other/Unknown | Unknown | Unknown | Unknown | Unknown | Unknown | Unknown | $624,754 | |
| Local Contribution | Unknown | Unknown | Unknown | Unknown | Unknown | Unknown | $8,370,228 | |
| TOTAL | | | | | | | $30,471,622 | |
| Dec. 1 Child Count | 4087 | 4204 | 4178 | 4335 | 4652 | 5052 | | |
| % Increase/Decrease | | 2.86% | -0.62% | 3.76% | 7.31% | 8.60% | | |
| | | | | | | | | |
| *This year represents a 9-month allocation. | | | | | | | | |

- <u>The Virginia System of Payments Report</u>

This Report, developed using a stakeholder process, was published in June 2007 by SOLUTIONS Consulting Group, LLC and confirmed serious issues with the Commonwealth's "Ability to Pay" system in that it is not uniformly applied, fees are not uniformly collected, and there is no relationship between the utilization of private insurance and family cost. A series of recommendations, anticipated to be phased in over two years, were produced which included:

  - major changes in the System of Payments structure to move this to an annual fee for all services;
  - major enhancements in Medicaid reimbursement including increasing reimbursement to cover all Part c required functions and to include all Part C services under a new Medicaid EI Initiative;
  - major changes, as requested by the Lead Agency, in the way in which Federal and State funds are allocated to the localities; and
  - significant modifications were needed in the Part C Service Pathway to reflect compliance with Federal regulations, effective use of all resources and a more family-friendly, streamlined approach to responding to child eligibility and enrollment.

This report, along with the 2004 Cost Study, is posted on the Infant & Toddler Connection web site. It is also important to cite that earlier work completed by a stakeholder group in 2004, not performed by SOLUTIONS Consulting Group, LLC, revealed some of the same findings as SOLUTIONS has made through our work and also came to similar if not the same conclusions related to systems redesign and efficiencies.

- <u>The Early Intervention Medicaid Initiative/System Transformation</u>

Considerable work has been done between the Part C System and DMAS to articulate a State Plan Amendment and rate methodology which expands Medicaid to include all Part C services, and includes reimbursement based upon cost which includes "associated costs." A major problem with the way in which "associated costs" are managed by the Local Lead Agencies is that not all Local Lead Agencies pay "associated costs" and there are varying ways in which providers are paid, some of which may be in conflict with Federal and State Medicaid regulations, as well as the IDEA requirements related to payor of last resort.

Sue was able to report to the VICC that conversations with the Centers for Medicare and Medicaid Services (CMS), the Department of Medical

Assistance Services (DMAS) and Part C have been very positive and the initiative is moving ahead. Key points to this initiative are:

- A developmental therapy chapter will be included by DMAS which will provide the opportunity to include more providers in the Part C system.
- The rate methodology will allow for a career ladder and will be budget neutral.
- All providers will be enrolled and credentialed through the Part C State Office.
- Specific training will be required.
- Monitoring will need to expand to include <u>all</u> programs and services.
- The changes will require a change in currently used forms.
- DMAS has requested that Part C promulgate regulations regarding the changes.
    - Part C is exploring the option of "Fast Tracking" the regulations.
    - The Office of the Attorney General has question the authority of the Dept. to promulgate the regulations.
    - The regulations may have to been done through VDH (in anticipation of moving Part C to VDH as lead agency) due to the inability to transfer the regulations from the Department to VDH.

- <u>Change in State Lead Agency for Part C</u>

It is anticipated that Part C will relocate to VDH as its Lead Agency, resulting in a variety of substantial benefits – including, but not limited to:

- The initiatives bring a variety of early childhood initiatives and services together, including those with special needs under Governor Kaine's commitment to include "all" children in his Early Childhood/School Readiness initiative;
- Increased direct partnership with prenatal, infant and home visiting programs and services operated by VDH which are anticipated to:
    - Increase viable referrals,
    - Increase earlier referrals,
    - Provide expansion of the provider network through the coordination between these VDH programs and Part C,
    - Greater data linkages and opportunities to establish and maintain a comprehensive continuum of care for the Commonwealth's most vulnerable citizens, and

    - Infrastructure partnerships with respect to training, case management, services, administrative responsibilities including monitoring, etc. at the state level.
  - The change in lead agency will not affect the current Local Lead Agency (LLA) designations and should be transparent to all stakeholders and families.

The Commonwealth's Part C system state office currently operates with the support of approximately $1.4 million dollars in Federal funds. The VICC agreed that the Part C infrastructure operation is grossly underfunded and not adequate to meet the Federal requirements related to monitoring, provision of training needed and required, technical assistance, etc.

In preparation for this transition, the following activities are underway:

  - Changes will be made with the Infant & Toddler 0n-line Tracking System (ITOTS).
    - The data system from Alaska has been looked at and determined that it would meet Virginia's needs with some Virginia-specific changes being made by VA once the transaction is complete.
    - Alaska has agreed to allow Virginia to acquire their Part C system at no charge.

An interagency agreement is being developed between DMHMRSAS and VDH related to the transition. The transition to the VDH is anticipated to occur no later than July 01, 2009, with no changes anticipated in Local Lead Agencies.

<u>The VICC members then listed benefits of moving to the VDH as the State Lead Agency.</u>

They include the following:

- Will help to bring health care programs to the Part C table all across the state;
- Reaches a broader spectrum of the population;
- VDH addresses prevention;
- An increased opportunity to find families through the connection with VDH programs;
- A more seamless system;
- Consolidates children's programs;
- Increased Child Find;
- The name of the agency has a better connotation for Part C;
- Makes more sense for referral sources;

- VDH looks at diagnosis and not rehabilitation;
- The move aligns with Part C; and
- This has never been done before with VDH.  Start with a clean slate and perspective!

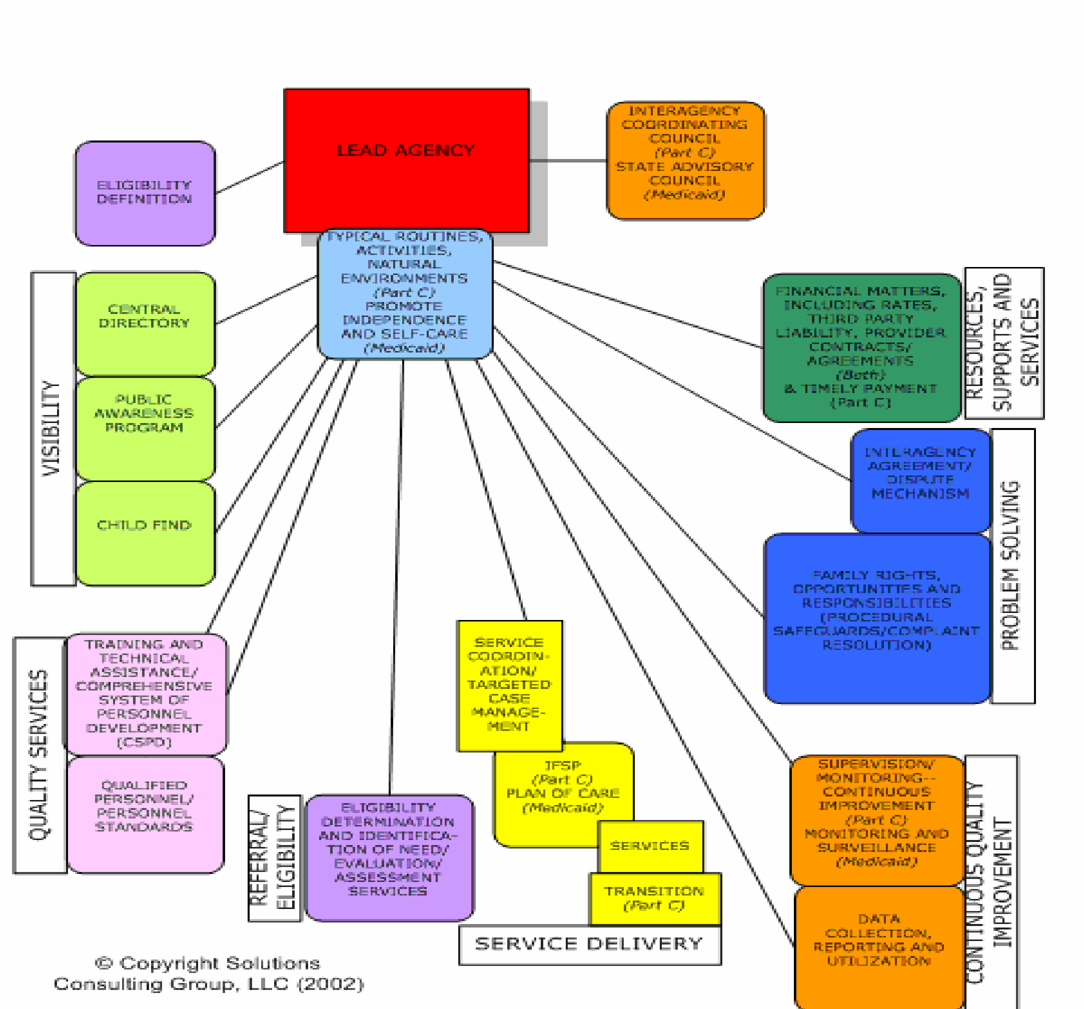
Minuses or concerns associated with the move to VDH as the State Lead Agency were then discussed.

Comments included:

- The connection with DMHMRSAS;
- Community Services Board advocacy;
    - Continued support is needed.
    - Do not want to experience a decrease in local funding.
- The potential exist for the perception of a loss of focus during the transition;
- Local downsizing of VDH;
    - Lead agencies do not have to change.  This has been a misperception by some.
- Fear of the unknown;
- Funding cuts; and
- Perception of the medical model due to the location in "health."

Further discussion stressed the need for communication.  It was acknowledged that partnerships and relationships at the local level need to be strengthened. There was some concern expressed about the transition happening at the same time that budget cuts occurring.

Sue then addressed the components of a quality early childhood system.




These components are all linked together and represent the following:

- A Lead Agency;
- State and/or Local Interagency Coordinating Councils;
- Resources, Supports and Services;
    - Financial matters
    - There are 35 resources that are expected to contribute to Part C systems.
    - There is a need for an equitable and timely system of funding local systems.

- The office of Special Education Programs (OSEP) will be doing fiscal verification visits.
  - OSEP will be looking at the payor of last resort, maintenance of effort and supplanting.
- The Part C infrastructure is under-funded.

- Problem Solving;
  - Interagency agreement/dispute mechanism
  - Family and provider rights
- Continuous Quality Improvement;
  - Supervision/monitoring
  - Data collection, reporting and utilization
- Service Delivery;
- Referral/Eligibility;
- Quality Services;
  - Training and technical assistance
    - There is a need for training using various formats.
  - Personnel Standards
    - Virginia must address the federal requirement for a Comprehensive System of Personnel Development (CSPD).
- Visibility;
  - Resource and referral
  - Public Awareness
  - Child Find.

<u>Additional discussion that followed included</u>:

- Information is not readily available regarding the exact local dollars and Medicaid dollars in the system for the years 2005-2008.
- What type of recourse will there be by OSEP if supplanting has occurred or maintenance of effort was not followed?
- There are not sufficient dollars allocated for infrastructure.
- What currently is available as a CSPD?
  - There is a Governor's Initiative around personnel development.
- Knowledge of the Federal Requirements is needed in order for the VICC to do their business.

<u>Further discussion occurred related to data and dollars in the system including</u>:

- What do the data tell us?
  - A lot of dollars were added to the system in contrast to the increase in the number of children served.
- What did the money pay for?

- As a system, we must be able to show efficiencies related to what the dollars will do and then be accountable.
- The system must be able to defend that additional funding is needed.
- How does Virginia compare to other states in cost per child?
    - Care must be taken in comparisons due to many variables.
- The need exists to know all of the dollars in the system.
- Equitable access and equitable distribution to all systems is required.
- The Fiscal Assurance Requirements need to be looked at by the VICC.

1. **The benefits of moving Part C to VDH include the following**:

- Clear dual focus on promoting the health and educational opportunities for young children. ("Entering School Healthy and Ready to Learn")
- Decrease in parallel systems (outreach, publicity, data collection) and multiple locations for programs serving nearly the same early childhood populations.
- Earlier enrollment of infants at-risk for developmental delays due to improved efficiency of intra-agency referrals between VDH Newborn Screening for all newborns and Part C screening and assessment services.
- Increased enrollment in Part C through routine screening by VDH programs serving women of child-bearing age and children ages 0-3. Reaching more numbers would be an indication of an effective state program. Virginia is not reaching the projected number needing services.
- Opportunity for developing a cohesive infant and toddler continuum of care. One partnership example discussed was that the Child Development Clinics, Care Connection and Part C could utilized state funds more efficiently, possibly increasing the timely evaluation and serving additional children through decreased duplication.
- Increased revenue-generation for the state through federal Medicaid funds (billing for services and Administrative claiming) Part C will be billing through EPSDT, which will open up services for more infants and toddlers.
- Development of one data collection system for evaluation and tracking which would incorporate birth certificate data, WIC data, and as well as EPSDT data through DMAS.
- Standardization of the rates paid by different programs across the state to providers for similar services.
- Congruency with health promotion and family involvement in concert with Bright Futures' six core concepts (Partnership among family, child and provider, Communication, Health Promotion/Injury Prevention, Health Education, Time Management and Advocacy)

**2. Benefits for Families and Young Children (ages 0-3 years)**

- Families may be more willing to engage in and to participate with an entity focused on the promotion of healthy child development from birth to age 3.
- Local health departments are familiar to parents of young children.
- Families may be open to earlier intervention with children who are at risk for developmental delay because they are already enrolled in, know of or have used previously VDH services for children and parents (birth certificates, Newborn Screening, hearing screening, immunizations, family planning, WIC, and possibly dental care).
- Health department staff members (nurse practitioners, nurses, LPNs, nutritionists, clerks) are accustomed to spending time on parent education and care plan development.

**3. Benefits for Local Providers**

- There is a network of family and pediatric providers and hospitals serving young children are already connected to the local health department for certain data reporting, newborn screening, service referrals, case management services and training.
- Provides enhanced clarity for providers of where to refer, rather than concern about making an incorrect referral.
- VDH has opportunities in its delivery of routine early childhood services to screen for developmental delays.

Sue also noted that at least 40 state Part C systems were housed in the Health Department and that this trend has been growing nationally for more than the last decade.

**VICC members then discussed upcoming changes and the need for changes.**
The following issues were addressed:

- The culture will be different at VDH including the language and jargon used and the priorities.
- Consideration must be given for adding new members to the VICC possibly including:
    - Juvenile Justice;
    - Moving forward on the appointment of the representative for homeless children;
    - Pediatric therapists;
    - Systems evaluation representation;
    - Kathy Glazer;

- Partners from the Governor's Initiatives;
  - Business community representation; and
  - The insurance industry, specifically health plans.
  - It was noted that some representatives may not necessarily be on the VICC but could serve on committees as resources.
    - Some states have a Health Advisory Group in this role.

- **Who are the "clients" of the VICC?**
  - The primary clients are the children and their families. The focus of the VICC must occur through this lens.
    - The VICC is responsible for the broad Part C system, and not for any particular stakeholder group. Their primary allegiance should be for families and children.
  - Secondary clients include:
    - The State Lead Agency;
    - Tax payers and all citizens;
    - State agencies through their representatives;
    - The Governor and the General Assembly;
    - Service providers;
    - OSEP; and
    - CoCoA.

- **There is a need to redefine the committees of the VICC and provide a job description to guide their work.**
  - Are there existing stakeholder groups that address issues where the VICC can participate and then report back?
    - This was previously identified by the VICC.
  - Committees that are needed include:
    - CSPD-Currently there are members working with the Integrated Training Collaborative;
    - Public Awareness;
    - Membership-On a short-term basis; and
    - Infrastructure.

**In order to identify the top priorities for the VICC focus for the next 18-24 months, members identified a list of priorities.** They included:

- A communication plan;
- CSPD including compliance and the Medicaid Initiative;
- Infrastructure;
- Transition to VDH;
- Compliance with OSEP;

- Research of the data and development of a clearer picture;
- Meeting the needs of the children and families;
- Assuring adequate resources including funds and personnel;
- Supporting the Medicaid Initiative; and
- Clarifying transition information.

**The following were identified as the top three priorities for the focus of the VICC for the next 18-24 months, with committees being formed:**

- Data Research Committee: All VICC members will be asked to look at the provided data to understand the numbers and the dollars.
    - Questions and comments will be submitted to the Committee within one week related to the data
    - Two to three days of meetings will then be scheduled for committee members. Current infrastructure and infrastructure needs will be included.
    - A FAQ will be developed which will likely take 2-3 weeks.
    - The Committee will present information at the November 12, 2008 meeting. Further questions and discussion will occur.
        - Members-Mary Lou Hutton, Phyllis Mondak and Ginny Heuple along with input from Mary Ann Discenza.
- Communication Plan Committee: Agenda item for the October VICC meeting.
        - Members- Joanne Boise, Mary Ann Discenza, Debra Holloway, Delegate Valentine.
- Comprehensive System of Personnel Development/Medicaid Initiative Committee:
    - Understand the Medicaid Initiative and the implications on CSPD.
    - Look at drafts of regulations from Part C. Information for December 10th VICC meeting.
        - Members-Delly Greenberg, Eva Thorp, Mary Lou Hutton, Debra Holloway, Phyllis Mondak.

It was determined that the Steering Committee will address membership.

VICC members agreed that January 2009 would be an appropriate time for another VICC Retreat based on the following:

- New members should have been appointed and be serving.
- The transition will be moving forward.
- The Medicaid Initiative will be moving forward.
- VICC can address and plan the future work.

## *VICC Member Attendance*

**<u>VICC Members in Attendance</u>**

Frederick Beaman
Joanne Boise
Delly Greenberg
Virginia Heuple
Mary Lou Hutton
Dr. Colleen Kraft
Rev. Brenda Laws
Phyllis Mondak
Sheila Nelson
Sharon Osborne
Leslie Hutcheson Prince
Dr. Eva Thorp
Delegate Shannon Valentine

**<u>ICC Members Not in Attendance</u>**

Corinne Garland
Dina Kirby
Martha Kurgans
Lyndell Lewis
Laura Miller
Jacqueline Fagan Myal
Jeannie Odachowski
Glen Slonneger
Yolanda Tennyson
Sandra Binns Whitaker
Tammy Whitlock