

VIRGINIA INTERAGENCY COORDINATING COUNCIL
Draft MEETING MINUTES
Henrico Area Mental Health, Mental Retardation & Substance Abuse East Center
Richmond, Virginia
September 13, 2006

The Chair of the Virginia Interagency Coordinating Council (VICC), Brenda Laws, called the meeting to order at 9:35 a.m. Karen Durst then called the roll. Eighteen (18) VICC members were present. (Please see the attendance sheet following the minutes).

Ms. Patti Davidson, from the Department of Medical Assistance Services (DMAS), spoke to the VICC members regarding Managed Care. She provided the following information:

- Most Medicaid enrollees are required to receive their medical care through managed care programs;
- Individuals are initially enrolled in regular Medicaid and if they meet the criteria for managed care, they have approximately one month to select a Medallion Primary Care Provider (PCP) or Managed Care Organization (MCO);
- There are six Health Maintenance Organizations (HMOs);
- Part C services are covered but must meet the definition of medical necessity;
- HMOs determine their own definition of medical necessity;
- Rates are set by the HMOs;
- Network evaluations have been completed to ensure that there are an adequate number of providers;
 - There is no requirement that providers be part of the Part C system;
- Few complaints have been received; and
- Individuals can make complaints through their legislators, DMAS Help-Lines, or through the Managed Care Website;
 - As much information as possible regarding the specific complaint must be provided.

Discussion then occurred among VICC members and the audience members. The following concerns were expressed:

- Problems exist with the MCOs based on physician reports;
 - These include:
 - There is no continuity;
 - Parents are confused;
 - The ten percent increase that was legislatively mandated has not been seen;
 - Fewer and fewer providers are available;
 - The number of pediatricians accepting Medicaid is only about 44%; and
 - There are too many people to work with when addressing concerns.
- Differences exist in the medical model of services and Part C services;
- DMAS has no involvement regarding the rates that are set by the HMOs;

- The number of providers available do not meet the existing needs;
- There needs to be an avenue for voicing concerns related to systemic issues;
- Providers are dropping out because of the low reimbursement rates;
- Information on the role of the providers needs to be included in the contracts with HMOs related to Part C referrals;
- Question on the availability of Spanish translations as well as translations in other languages;
- Information is needed on the systemic issues that are occurring around the state;
- Information is needed on exceptions;
 - It was previously determined that Part C children were exempt if their needs could not be met;
 - The process is very involved and needs to be looked at; and
 - Not all systems are aware that this exception exists.

DMAS representatives responded that they had not been told that children were not getting the services that they needed. They stated that specific information is needed. It was suggested that a meeting be scheduled between DMAS and Part C staff and that the issue of the MCO contract be included in the discussion.

Dr. Colleen Kraft suggested that a subcommittee of the VICC be established to look at the issues. It was suggested that as a first step, information be gathered related to the systemic issues that are occurring. The following individuals volunteered to serve on the committee: Dr. Eva Thorp, Dr. Colleen Kraft, Delly Greenberg; Rick Beaman; Allan Phillips and Beth Tolley. It was suggested that regional representation be included to ensure that all concerns were identified. The timeline for the committee is to begin gathering the information immediately and report back at the next VICC meeting.

Sanford Hostetter and Kathi Honeycutt from the Department of Mental Health, Mental Retardation and Substance Abuse Service's (DMHMRSAS) Information Technology Systems (ITS) then presented information regarding changes to the Infant & Toddler On-line Tracking System (ITOTS). The system is being moved into the Department effective February 28, 2007.

The following issues were identified as reasons for changing the ITOTS system:

- ITOTS does not have adequate reporting capabilities;
- The process is fragmented;
- The technology provides minimal support to local providers and coordinators;
- There is the recognition that not all of the data is needed;
- The current ITOTS software vendor was unable to adequately support the Part C technology requirements; and
- There are sources of data that are not being tapped into.

Sanford Hostetter reported that the goal for changing the ITOTS system is to provide the needed support for providers, local systems and the Part C office. In looking at the current status of the system, the question was asked as to what is needed, why and by

whom. The initial in-house move of the ITOTS system will not significantly modify the process. Modification of the system is more complicated and will require time.

Security is an issue that must be addressed. It was sited that some localities share their log-on information and when an individual leaves the system they still have that information. Changes need to be tracked. Information needs to be provided to the Department when individuals leave jobs and changes occur.

It was shared by Sanford Hostetter that there are a broad range of opinions among local programs as to how the Department should address data acquisition for reporting. He cited the following as “Guiding Principles”:

- Require only minimally necessary data;
- Existing data should be utilized and should be practical and economical;
- Streamline data reporting; and
- Identify opportunities to utilize technology to enhance services.

The future activities for ITOTS include:

- Moving the ITOTS system in-house;
- Continuing the analysis on improvements;
- Refining the ITOTS system; and
- Refining the software.

The presentation concluded with the following final thoughts:

- ITS is committed to helping solve problems within the ITOTS system;
- A systematic process to review and determine how to address new data requirements will be included;
- Everyone is a stakeholder;
- Funding depends on data reporting;
- The effectiveness of the system is important; and
- The “electronic health record” will impact ITOTS and Part C within the next five years.
 - The “health record” was clarified, as being a summary while a “medical record” is very detailed.

A comment was offered regarding the need to eliminate dual reporting requirements. Sanford Hostetter added that the Department wants to accomplish this and that it is an expensive proposition. He shared that there are currently eight different software vendors among the Community Services Boards and many more software versions.

Glen Slonneger shared that he wanted to ensure there was not a misconception that the ITOTS system was not providing useful information to the field. He stated that the system was designed many years ago for usefulness and that the issue of using available data was reviewed at that time. It was shared that a request was made on a yearly basis to bring ITOTS into the Department but that many complexities existed. It was reported that one-time funding is now being used regarding the in-house move.

Sanford Hostetter reported that there is “front-end” work that needs to be done to avoid a major risk. The following discussion occurred:

- We must look at opinion versus fact;
 - A federal requirement exists related to reporting data; and
 - There is a risk of the loss of funding if that data is not provided.
- There is a need to hire staff and a cost associated with that;
- There is a need for training;
- Not all reports will be available when the initial in-house move occurs
 - Reports will be added as needed; and
- The use of an on-line IFSP has not been determined.

The audience members were then introduced with public comment to follow. (Please see a list of audience members following the minutes).

Sherry Winn, the System Manager for the Infant & Toddler Connection of Piedmont, spoke of behalf of the Steering Committee of the Virginia Council Coordinator’s Association, CoCoA. The following italicized information is verbatim from the written report provided:

CoCoA Steering Committee
Public Comments to the VICC
September 13, 2006

My name is Sherry Winn, System Manager for Piedmont. I am speaking on behalf of the CoCoA Steering Committee.

We want to continue to express our appreciation for the opportunity to openly communicate with staff from the Part C Office after the VICC meetings. This meeting allows all of us, on behalf of Virginia’s youngest citizens, to share ideas, discuss concerns, and collaborate to strengthen services.

Besides continuation of the meetings with System Managers following the VICC meeting, we are also very appreciative that the field was asked for representatives to sit on some new committees, specifically the IFSP, Funding Formula and ITOTs Committees. We hope that the committees will begin work soon. CoCoA has a networking system that will allow feedback and input from all local systems through the designated CoCoA representatives on each of the committees.

As you are aware, there continue to be personnel shortages. We commend the Integrated Training Collaborative for establishing on the web site a job opportunity section and for including on the Collaborative representatives from Virginia’s universities that prepare students to work in the field of early intervention. We know that this link is important because, over time, it helps our State universities become more aware of our personnel needs. We anticipate there will continue to be acute personnel shortages, especially in some regions of the state, and we worry that these shortages will impact service access and compliance.

We recently received instructions regarding the implementation of the Family Survey, an activity identified on the State Performance Plan. We look forward to working with the State Part C office to gather this data required. We have questions about the process, but anticipate and certainly hope the information from the data will help to move Virginia's Early Intervention system forward.

We appreciate this opportunity to offer comments during this public comment period of the VICC.

Beth Tolley also provided public comment. The following italicized information is verbatim from the written report provided:

Northwestern CSB is no longer serving as the local lead agency for the Infant & Toddler Connection of Shenandoah Valley. Beginning this month, James Madison University will be the new local lead agency.

I would like to take this time to thank Allan Phillips, Debbie Billodeaux, Susan Sigler and Laurie Cunningham for their assistance during the transition of lead agencies. Debbie, Susan and Laurie provided intakes, evaluation and assessments, IFSP meetings and/or intervention for seven children in Shenandoah Valley which helped decrease the backlog of referrals and intervention that has occurred with the transition and the loss of many of the providers in the local system.

Paula Miller also provided public comment. The following italicized information is verbatim from the written report provided.

My name is Paula Miller. I'm a resident of Fairfax County with my husband Glenn and our four boys.

I stand before you as the president of Virginia Smiles, which is a 501c3 organization to provide information and education to families of children born with a cleft lip and palate, and to educate providers and the public about cleft palate, and I am here today on behalf of all families in Virginia of infants born with a cleft palate.

On a personal note, in 2000, my son Michael, an identical twin, was born with a unilateral cleft lip and palate, and entered Early Intervention Services at age 8 weeks and continued until his third birthday. He qualified for services because of his diagnosis of being malnourished and Failing to Thrive, which was a direct result of his severe feeding challenges because of the cleft palate, and a potentially deadly combination of severe reflux. My son's situation is more common than you think. Our family really appreciated the Early Intervention Services—it was the Early Intervention speech therapist who detected that Michael's palate wasn't functioning properly even after his first palate repair, and she even came with us to the craniofacial team visits—which really made us believe that all entities of Michael's repair team were really working together for the benefit of Michael—Talk about family-centered care!

In January, the CDC reported that orofacial clefting is the most common birth defect, more than downs syndrome, more than cerebral palsy or any other neurotubal defect, occurring 1 in 547 instances. Today, 10 states in our nation automatically qualify infants born with a cleft palate for Early Intervention Services, including West Virginia, North Carolina, and Delaware. Unfortunately, at this point, Virginia is not one of those states. Many more states qualify these infants under a POHI, or potentially or otherwise health impaired clause.

I'm here today to urge this committee to move "cleft palate" from the risk side of eligibility for services to the "automatic entry" side.

All infants born with a cleft palate require immediate intervention from birth for the following reasons:

When an infant is born in Virginia with a cleft palate,

One-Many infants born with a cleft palate are later being readmitted to hospitals for malnourishment/failure to thrive, and other feeding challenges such as gagging and choking, which ends up being a bigger cost to our society in terms of health care.

Two-Infants born with a cleft lip and palate require a series of surgeries before their first birthday, which affect the way they eat, swallow, make sounds, develop speech, and use the large motor muscles of their arms.

Three-Parents are not adequately taught how to feed their infants.

Four-Parent given the wrong info, told that nursing is okay.

Five-Parents are not told about their choices for nipples/bottles/or even craniofacial teams,

This is all because of the gross lack of knowledge and education about cleft palate on the part of the birthing hospitals, even in northern Virginia, where budgets for health care seem to be unlimited.

Medical professionals in birthing hospitals of Virginia have no idea what a craniofacial team is, what options parents have for repair methods, craniofacial teams, feeders, nipples, bottles made specially for infants with a cleft palate, or even how to use them.

-These families, who are already facing a great deal of anxiety about their infant's future, are robbed of their feeling of confidence, sense of accomplishment, capacity to feed and care for their infants born with a cleft palate, especially if this is a first child, the parent doesn't speak English.

The Services of Virginia's Infant Toddler Connection are critical to these infants for the following reasons:

One-The majority of infants born with a cleft palate also have a cleft lip and face a series of surgeries before their first birthday, which affects their feeding methods, their large motor muscle activity as a result of being restrained, and their chance at normal development for speech. Those born with a cleft palate only have a high percentage of having various syndromes, such as Pierre Robin that can only be detected by through regular attention from a provider, including an occupational or speech therapist. They also have a high risk of hearing loss. The earlier these things are detected in infants born with a cleft palate, the better—that's what Early Intervention Services are all about, right?

Two-Oral motor activities are important to these infants to stimulate the oral muscles.

Three-Occupational Therapy is important to these infants to stimulate their arm muscles after having been restrained for several weeks postop, in addition to oral and feeding therapy.

Four-Speech and occupational therapy is important for their very challenging feeding issues. Their feeding methods change several times during their first year of life because of their surgeries.

Five-Social service Support is necessary for the family so they know what their options are for care, resources, and support, as well as parent networking and education to increase their confidence to care for their child, and increase their involvement within the community.

Families of infants born with a cleft palate need intervention to gain the knowledge, skills, abilities, and confidence to feed their infants.

Infants born with a cleft palate need intervention so they can thrive as much as possible, and learn how to take in nourishment without expending too many calories, and be given a chance to develop speech at a normal pace, or if not, have these delays be detected as early as possible so that intervention can help.

The Early Intervention services of the Infant Toddler Connection help these families quickly establish family and patient centered care, which the Cleft Palate Foundation has been advocating for at least the last five years.

Please move the cleft palate diagnosis from the risk factor side column to the automatic eligibility side of the column.

Every infant born with a cleft palate in Virginia has the basic right to eat and to get nourishment, and grow and thrive, and attain developmental goals.

It is with great hope that the Commonwealth of Virginia become one of 11 states that support the rights and challenges of infants born with a cleft palate.

It is with great hope that the Commonwealth of Virginia won't allow infants born with a cleft palate to risk developmental delays due to lack of the necessary services in their first months of life.

By opening up the doors to allow cleft palate in there, you are actually avoiding more work down the road, more hardship, and costs not just to the family, but to our society as well.

It is with much hope that this change be established as soon as possible so that going forward all families of infants in Virginia born with a cleft palate will receive the services they need to grow and thrive.

Other States that recognize Cleft Palate as automatic entry for IT services:

<i>West Virginia</i>	<i>Iowa</i>
<i>North Carolina</i>	<i>New Mexico</i>
<i>Florida</i>	<i>Nevada</i>
<i>Ohio</i>	<i>Rhode Island</i>
<i>Texas</i>	<i>Delaware</i>

Discussion then occurred in response to Paula Miller's public comment and the possibility of making changes to include cleft lip and palate under the conditions for eligibility for Part C services. The following comments were made:

- Could cleft lip and palate be included under "atypical" for eligibility;
- Cleft lip and palate are included as a Title V qualifier and encouragement was received to add this under Part C eligibility;
- Many localities find children with cleft lip and palate eligible under "atypical" due to feeding issues;
- Should this issue be discussed at regional meetings; and
- A timeline is needed for this to be addressed.

Dr. Collen Kraft made a motion for VICC to ask Part C to look at the issue of including cleft lip and palate for automatic eligibility for Part C services. Sharon Osbourne seconded the motion. The motion was approved. Ginny Heuple agreed to serve on a work group related to this issue if one was established.

Shirley Ricks stated that she would talk with Mary Ann Discenza regarding looking at the process of adding cleft lip and palate to the eligibility list for Part C services. She offered to do this within the next 30 days. She also raised the question as to whether education is needed regarding cleft lip and palate.

VICC members shared that there needs to be a mechanism for reporting information back to the membership and for providing input and making contributions to the Part C system. It was suggested that this be included as a topic for the upcoming VICC retreat.

Shirley Ricks then provided the Part C Update.

She shared that the approved state budget included approximately \$8,000,000 over the biennium, for Part C. Most of the funds have been allocated to local systems for direct services. The amount of \$500,000 has been reserved for emergencies such as a need for one-time additional funds for localities.

The Virginia Association of Community Services Boards (VACSB) will be asking for additional funding in the upcoming year. This will be based on growth in the Part C system of approximately 8% yearly and the need for increased services. The child count for SFY 2006 was reported to be almost 10,000.

Infrastructure needs were also identified. Shirley Ricks shared that as the system has continued to grow, the new funds have been allocated for direct services. Dr. Eva Thorp asked if there was anything that VICC could do to assist with asking for funding for the infrastructure. Shirley Ricks responded that it would be helpful for individuals to speak with their legislators and stress the need for funds for the infrastructure. Support would be appreciated from local system managers and families.

Shirley Ricks also shared that Mary Anne White and Bonnie Grifa were invited and recently presented at OSEP's National Conference on Monitoring. The conference was

held in Denver, Colorado. The presentation was included as part of the plenary session to approximately 480 individuals. Data verification was the topic and three states, including Virginia, were invited to be part of a panel discussion.

Mary Anne White and Bonnie Grifa then presented information on monitoring and supervision. The following information was shared:

- Local system managers have recently completed record reviews;
 - The chart review process was piloted with four local systems.
- Part C staff will be verifying the information during upcoming site visits which will occur beginning October 01, 2006 and concluding around the middle of November 2006.
 - Verification will include ITOTS data and data from the record reviews;
 - If errors are found, systems will have to complete a corrective action plan (CAP) if the percentage of accuracy is under 93%;
 - Further drill-down will occur as needed;
 - Localities will have up to one year from identification of the issue to come into compliance.
- Staff will also be looking at quarterly verification forms at each site;
 - This helps to ensure that systems are providing oversight to their systems regarding accuracy.
- This information will be used for reporting to OSEP on the State Performance Plan;
 - The report to OSEP is due February 02, 2007;
 - OSEP will be looking at how the state performed overall;
 - OSEP is requiring public reporting of the data;
 - This will occur in February;
 - The public report process has not been finalized but information will be included on the website with other reporting sites to be determined.
- Monitoring staff will report on the findings to VICC at a special meeting to be scheduled the end of November.

Phyllis Mondak shared that Part B of the Department of Education is also required to do public reporting. Some information is currently on their website but the finalized process for reporting is still to be determined. She shared that the law also requires that local systems report the information in the locality and that accountability is the focus. OSEP is asking the question as to whether the data is being used to support decision-making.

Further discussion involved collaboration with the Department's Information Technology System staff. It was reported that an internal workgroup has been formed. It is hoped that eventually local systems will not have to do chart reviews but that all data needed for reporting will be available through the ITOTS system.

Discussion occurred as to scheduling a special VICC meeting on November 28, 2006 from 9:30-3:00. This will provide an opportunity for reporting on monitoring and

supervision and the findings from the verification visits. The first hour of the meeting will be set aside for other VICC business.

Cori Hill then presented information on the Integrated Training Collaborative (ITC). She shared that a new-trainer's orientation was held in August for eight participants who will be assisting with Kaleidoscope I trainings. Two Kaleidoscope I trainings have been scheduled for Staunton and Manassas. The Staunton training is scheduled for September and October and the Manassas training for October and November. The new trainers will attend as observers. A training for Kaleidoscope II has also been scheduled for November 30-December 01, 2006.

Cori Hill further shared that the Conference Committee has been working on the plans for the upcoming Celebrating Connections 2007 conference. In response to past feedback regarding the conference location being in Roanoke, the committee requested input from local system managers regarding other potential locations. Few responses were received and those received included the options of Williamsburg, Portsmouth and Charlottesville. The committee explored those options looking at both the pros and cons.

It was reported that the locations that were submitted for consideration either were unable to provide the amount of space needed for the conference or were cost prohibitive. Cori Hill shared that the Hotel Roanoke did not charge for hotel space use and that food costs were only \$39 per person, including afternoon refreshments. This was related to a grant and the hotel's partnership with Virginia Tech. She stated that the committee had not contacted the Hotel Roanoke for this upcoming conference.

Discussion occurred and the following points were made:

- Hotel Roanoke should be contacted in order to present a cost comparison;
- Some localities have expressed that Roanoke is too far to travel and the cost is too great to send their teams;
- People need to know how much money is being saved through the use of the Hotel Roanoke as the conference site;
- It is a good reflection on the committee that consideration is being given to other sites but fiscal responsibility must also be considered;
- Cost is a big factor if families are being encouraged to attend;
- Consideration should be given to parent participation and offering a family-friendly conference; and
- There has been no call for papers, as of yet.

Shirley Ricks stated that the committee had done their work in exploring alternate conference sites and that the Hotel Roanoke was the most feasible. The committee will move forward in checking with the Hotel Roanoke regarding costs and scheduling the conference.

Cori Hill further reported on the following:

- There are currently two new individuals starting the process of becoming early intervention assistants; and

- The ITC is working collaboratively with the Department of Education on their Priority Project.

Debra Holloway, Manager of the Family Involvement Project, then gave the Family Report. The following italicized information is verbatim from the written report provided:

Project staff continues to be active participants on the VICC steering Committee, Management Team, Integrative Training Collaborative, Virginia Integrated Network of Family Organizations (VA-INFO), Ability to Pay Workgroup, GSEG, Hearing Workgroup, Child and Family Services Advisory Group and local and regional council meetings. Carol Hagen, Northern Virginia Region Representative, and Missy Colley, Tidewater Region Parent Representative, have been working hard attending regional and local activities in order to increase availability provide support and resources to families who have children in Early Intervention. The FIP will be requesting resumes this month in order to hire a part-time parent representative for the Roanoke Region.

The project continues to conduct PTP trainings 2 were held this summer. I attended and conducted a workshop titled: "Parent involvement and how families can become more involved in the Early Intervention system" at the VA-INFO Conference. The Family Involvement Project hosted its first "retreat" bringing together all local parent representatives in the commonwealth together to set goals and talk about issues. We also met again recently to address issues and develop new ideas to provide support to families. The group is in the process of developing a parent notebook and also working on a transition notebook to assist families. Project staff Missy Colley attended a conference in Colorado to learn more about the "Guide By Your Side" program. This program provides non-biased information and support for families who have children who are deaf or hard of hearing. I also had the opportunity to speak to residents at MCV about Early Intervention and about how physicians could be supportive and helpful to a family who has a child who is or could be eligible to receive services.

Project staff continues to host the ARCFIP list serve with 261 members.

VICC member, Frederick Beaman, commended the Family Involvement's Northern Virginia Family Representative, Carol Hagen, on her contributions to the early intervention system.

Chair, Brenda Laws, then facilitated the discussion of VICC business. It was reported that the names of three VICC members have been presented to the Governor's office for reappointment. They are Dina Kirby, Virginia Heuple, and Mary Lou Hutton. The VICC is still in need of a legislative representative as that seat expires on September 30, 2006. A request was made for suggestions of Legislators that may be interested in serving on the VICC.

Discussion then centered on plans for a VICC retreat. The previous retreat focused on history, future direction, committees, and getting to know one another. The National Early Childhood Technical Assistance Center assisted with that retreat. It was suggested

that since VICC would be meeting November 28, 2006 for a special meeting, that the original VICC date of December 13, 2006 be used for the retreat. The orientation for newer members that had been previously discussed could be incorporated into the retreat.

Members agreed that the retreat would be held December 13, 2006 from 9:30-3:00 at a location to be arranged. The following individuals agreed to serve on a planning committee: Phyllis Mondak, Frederick Beaman, and Debra Holloway. The use of a facilitator will be explored.

Agency reports were then given. They are as follows.

Department for the Blind and Vision Impaired: Glenn Slonneger

- The annual conference of the Department for the Blind and Vision Impaired will be held November 15-17, 2006 in Hampton at the Holiday Inn Hotel and Conference Center.
 - Sessions will be available of interest to both parents and providers related to early intervention.

Department for the Deaf & Hard of Hearing: No Report.

Department of Education: Phyllis Mondak

- Federal Part B regulations were published in the Federal Register in August;
 - DOE will be updating state regulations.
- Work is continuing related to the State Performance Plan; and
- The transition document is being updated.

Department of Medical Assistance Services (DMAS): No Report.

Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS): Shirley Ricks

- HJR 96 encourages the Board and Department of Education and the Board and Department of Mental Health, Mental Retardation and Substance Abuse Services and other relevant entities to take certain actions to improve the education and treatment of individuals with autism spectrum disorders.
 - A workgroup is being formed to address the issue;
 - The workgroup will explore what the issues are related to training and what can be done to improve training opportunities;
 - The resolution relates to individuals birth-21 years of age; and
 - Funding is not included with the resolution.
 - A status report must be provided in December;

Department of Social Services: No Report.

State Corporation Commission: No Report.

Virginia Department of Health (VDH): Pat Dewey

- A Guide-by-Your-Side program has been developed to provide first line contact to parents of newly identified children with hearing loss;
 - The program was developed based on a similar program from Wisconsin’s Early Hearing Detection and Intervention Program;
 - MCHB EHDI Grant funds will be used to fund the program;
 - The program will be managed through a contract with the Partnership for People with Disabilities; and
 - Twenty-four applications were received to serve as guides;
 - Interviews will be conducted soon.
- Through the provision of federal grants, on-line courses will be available related to working with the deaf and hard of hearing;
- SKI-HI follow-up training was provided; and
- InSITE: Training will be provided related to the deaf and blind population through a contract with the Partnership for People with Disabilities.

Virginia Office for Protection & Advocacy: No Report.

The development of the agenda for the November 28, 2006 VICC meeting was then addressed. Discussion included:

- Follow-up Report of the Medicaid Committee;
- ATP Update; and
- Report on the Eligibility Status for Cleft Lip/Cleft Palate.

The meeting was adjourned at 12:30 PM.

Attendance

VICC Members

Frederick Beaman
Pat Dewey
Corinne Garland
Delly Greenberg
Virginia Heuple
Mary Lou Hutton
Dr. Collen Kraft
Rev. Brenda Laws
Lyndell Lewis
Laura Miller
Phyllis Mondak
Sheila Nelson
Jeanie Odachowski
Sharon Osborne
Shirley Ricks
Glen Slonneger
Dr. Eva Thorp
Tammy Whitlock

Part C Staff

Beverly Crouse
Karen Durst
Bonita Grifa
Cori Hill
David Mills
Beth Tolley
Mary Anne White

System Managers

Kim Beabeau
Debbie Billodeaux
Cindy Burgess
Sandra Church
Brenda Crockett-McGee
Elizabeth Faulk
Marilyn Hoexter
Allan Phillips
Kathy Phillips
Kathy Pierson
Jane Prince
Susan Shaw
Alison Standring
Kim Taylor
Wanda Walker
Sherry Winn
Lynn Wolfe

Parents

Paula Gorman
Carol Hagen
Debra Holloway
Paula Miller

Others

Cindy
Patti Davidson
Mary Margaret Harrison
Kathi Honeycutt
Sanford Hostetter