" WORKING WITH YOU TO FIND THE RIGHT SOLUTION"

FAX TRANSMITTAL LEAD SHEET
CAP FAX# (703) 756-0975

DATE: ______________ TIME: ______________

TO: Rosalyn Miller for Ms Rasco

FAX #: 456-2878

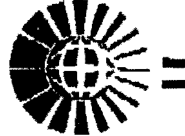
FROM: Dinah Cohen

PHONE #: 703-756-0976

MESSAGE: Clear hard copy of the letter is in the mail. Pls fax bio and feel free to call if you have any questions.

Thanks!
Dinah Cohen

TOTAL NUMBER OF PAGES INCLUDING COVER SHEET: 2



CAP OFFICE
DEFENSE MEDICAL SYSTEMS SUPPORT CENTER
5109 LEESBURG PIKE, SUITE 502
FALLS CHURCH, VA 22041-3201

Perspectives on Employment of Persons with Disabilities is sponsored by: ■ Department of Defense/Department of the Navy ■ Department of Labor ■ Department of State ■ Department of Veterans Affairs ■ Equal Employment Opportunity Commission ■ Office of Personnel Management ■ President's Committee on Employment of People with Disabilities ■ Public Health Service

Ms Carol Rasco
Assistant to the President for Domestic Policy
The White House
1600 Pennsylvania Ave, NW
Washington, D.C. 20500

Dear Ms. Rasco:

This letter is to confirm your participation as a keynote speaker at our conference on "Perspectives on Employment of Persons with Disabilities" to be held on December 8-10, 1993. The conference will open with keynote speakers on December 8th at 8:30 a.m. at the Bethesda Hyatt Regency, Bethesda, Maryland. You are scheduled to speak at 8:45-9:10 a.m. Mr. Justin Dart, Chairman of the President's Committee on Employment of People with Disabilities will follow you on the schedule.

Your presence would be an outstanding contribution to the conference's success. As a leader on domestic policies for this administration, and your personal commitment, you will bring a unique perspective to current issues.

We would be honored if you were able to take time from your busy schedule to join us for the entire conference. If you have any questions concerning the conference, please feel free to call me on (703) 756-0976 at the Defense Medical Systems Support Center. I would also appreciate a copy of your bio to be faxed to me at (703) 756-0975.

I speak for the entire Planning Committee when I say that we look forward to your presentation on Wednesday, December 8, 1993.

Sincerely,

Dinah F. B. Cohen
Conference Planning Committee

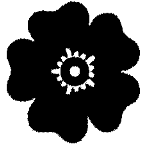
① Speech Only ram
② please send agenda & program attached
③ No Q+A ram

copy of PVA / Easter Seal Society / NASCE attached

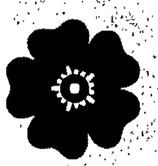
The 12th Annual
Perspectives on
Employment of
Persons With
Disabilities
Conference

December 8-10, 1993
Bethesda, Maryland

Attendees



Speakers



Planning Committee

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December 8-10, 1993

Perspectives on Employment of Persons with Disabilities

Perspectives on Employment of Persons with Disabilities is sponsored by:
The Access Board ■ Department of Defense ■ Department of Labor ■ Department of State ■ Department of Veterans Affairs ■ National Institute on Drug Abuse ■ Office of Personnel Management ■ President's Committee on Employment of People with Disabilities ■ Public Health Service

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Facts About Health Care

- One of every four of us will lose our health coverage sometime in the next two years.
- Insurance companies pick and choose whom they cover. If you change jobs, move, or get sick, they can drop you.
- Insurance companies charge small businesses as much as 35% more than big business.
- Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have almost no choice today.
- Twenty-five cents out of every dollar on a hospital bill goes to bureaucracy and paperwork -- not patient care.
- Health care fraud costs all of us at least $80 billion a year. That's a dime of every dollar we spend on health care.
- Our nation's health costs have nearly quadrupled since 1980. If we do nothing, your family's health care costs will double by the year 2000.
- The number of hospital administrators is increasing four times faster than the number of doctors.

Health Security: The Principles

__Security__. Every American will receive a Health Security Card that guarantees you a comprehensive package of benefits that can never be taken away. If you lose your job, move, or get sick, you're covered. That's not true today.

__Savings__. To control health care costs we're going to spend smarter and make health plans compete for your business. We're going to cap how fast your health premiums can go up, eliminate wasteful spending, and crack down on fraud.

__Quality__. We're going to provide free preventive care, give you the information you need to choose, and invest in training more family doctors. We'll make what's best about American health care better.

__Choice__. We're going to preserve your right to choose your doctor. Many people, in fact, will have increased choices, including a traditional fee-for-service plan that too many of us are denied.

__Simplicity__. We're going to streamline the paperwork that's choking you and your doctors and nurses. Simplifying forms and cutting back on regulations will give doctors more time to spend caring for you.

__Responsibility__. Everyone should contribute to health care. Right now, we __all__ pay for those who don't take responsibility. It's time to say: "No one should get a free ride."

Besides individual professionals and advocates I have also learned and experienced that organizations have tended to feel they must first and foremost go after a piece they can call their own, their own place in the sun so to speak. I say, we must come together as individuals and organizations to seize special moments when our collective voices can make a real difference for the people we love, the people we serve, for all people. And so, if we're going to put PEOPLE first, what is the real action step other than internalizing the phrase, giving it real meaning?

The Clinton Administration led with an economic package that addressed the health of our economy....we are NOW saying to the American people - join with us in looking at the health of people and together we can make a difference. Yes, you should join in the dialogue and make certain we will serve people appropriately, fully within this plan. But first and foremost, let's seize the moment, join our voices and hard work by looking at those things ALL people need within a health plan and stand together on what people - all people - first require.

These are principles upon which I hope you will join us with insistence. The reform, the transformation of our health system to one of security for ALL people is an action step that could change the whole outlook on the economic consequences & employment of people w/ disability within a short period of time if we can come together and work hard for those things upon which we can all agree and not allow ourselves to fracture this debate beyond success with an approach that only focuses on the areas of disagreement.

And so I ask you to join us...I ask you to leave here and resolve to approach tomorrow differently, ~~Hokey as it may sound,~~ take a real action step when you return to your place of work, take some memento of today - your nametag, your program, a business card you exchange --- put it in a tickler file three months ahead, place it there with two questions: (1) Is health care reform further along due to efforts I have made? (2) What am I doing daily that actually empowers further one person with a disability? Sept 29 PVA -

Each of us must have the courage to always be changing, to recognize mistakes, to abandon what doesn't work, to challenge ourselves to do better. Concern for people- all people with their own hopes/dreams/potentials- must start at the top - but it can't end there. We must empower clients or customers, parents, friends, advocates, neighborhoods, communities and voluntary organizations across this great nation to do what our people need. The President can and will take the lead but only you can complete the task. We will work with you. We won't always succeed, and we won't always be able to do everything that you - and we - would want.

But I can promise you this....we will never relent in our effort to give every person a chance to develop fully. Because at the end of Bill Clinton's second term, at the dawn of the third millennium, I want to be able to say to Hamp Rasco and Mary-Margaret Rasco and to all the children of America ---with a clear conscience and a full heart....I did my best. And I want all of you at this meeting to join me in being able to look at one another and say: We did our best to empower all people We did our best to give everyone something to do someone to love something to hope for."

Thank you very much.

You like me have probably attended many a meeting - whether long or short - where the stunning facts and overwhelming statistics you will hear today have been presented in piecemeal form.... I remember attending the White House Conference on Handicapped Individuals in 1977 in this town...reams of paper were generated, many hopes were raised and good intentions were overflowing....but far too little time was spent throughout that long, grassroots preparatory process in looking at what could be done to harness all those hopes toward significant changes and again, we left DC and what happened? Exactly what I regret I have seen throughout these twenty years I've concentrated on issues related to disabilities occurred....splinter groups were so busy looking at small pieces of issues within that 2000+ set of recommendations that significant movement was not evident. Programs have continued to grow in number, barriers have been erected to an even greater degree between programs, job placements for people with disabilities have not grown as they should, health care is still a problem, housing needs aren't adequately addressed. Let me hasten to add there are significant successes, yes, and I don't want to minimize them but we can do better, we CAN do better and more importantly, we MUST do better.

ACTION STEP: We must each internalize a phrase that was a slogan I came to dream about in the last two years: Putting People First. It just says PEOPLE, not people with economic needs, people with disabilities, people with allergies, people with educational funds lacking, people with teenagers in the family.....simply PEOPLE first. We have done too little of that in our ever growing array of programs to meet the needs of all the categories of people we classify....and now we find that people are lost in the process and instead we are within our service delivery systems putting PIECES of people first....one agency serves this little piece of a person, another serves another little piece and so forth. I am sometimes astonished when I look back at the number of forms I have filled out for my son and always the same questions over and over, the large numbers of caseworkers we've seen, all looking at him at a slightly different angle - and I often FOUND and FIND myself wondering - do any of them really know him as a whole person - and I know for sure few of the professionals with whom we have worked saw us a family UNIT...all were extremely well meaning but seldom was there a person with whom we worked that saw Hamp as a PERSON first. And I've often wondered if it is simply coincidence that the people I remember as BEST -regardless of their professional field/status -serving Hamp were first and foremost self-esteem builders? I believe what this piecemeal approach ultimately does to individuals is compound the disability by which they have been labelled. This is not to say we don't need specialized and/or individualized approaches but it does mean we need to recognize places of similarity/ programs commonly needed by all if we are going to act on the types of things I daresay you will need to act upon when you leave here today.

REMARKS BY CAROL H. RASCO

PARALYZED VETERANS OF AMERICA
Wednesday, September 29, 1993

Thank you. I commend the ~~Paralyzed Veterans of America~~ Planning Comm. & the organ. you represent for your leadership in organizing this conference. I have ~~not~~ only once before found myself before this type audience, an audience where the focus is primarily on the needs of adult age individuals with disabilities. Preparing for my visit with you today has given me an opportunity to learn more about ~~your organization and to review the summary of your fine publication on The Economic Consequences of Traumatic Spinal Cord Injury.~~ this annual symposium. In looking at your agenda & the participant roster book I am again reminded of your impressive agenda & the fact it is the 12th annual that feds can collaborate! ~~I also have not often found myself in the position of being somewhat star-struck, but there is no other way to describe what I feel as I stand here before all of you today. As I reviewed the roster of participants expected here today, I saw names of individuals that have looked back at me from pieces I have read and studied or names that belong to speakers to whom I have listened over the last twenty years; I saw names and/or initials of organizations that have consistently provided leadership and services to me and my family as well as friends and acquaintances.~~ For you see, I come to you not as someone who is all knowing in the field of service to and with persons with disabilities...I come to you primarily as the mother of Hamp Rasco, the friend of many families and individuals with disabilities. I come to you with gratitude for your ongoing belief in the worth of every individual and your commitment to empowering each individual to develop to her/his full potential. And therein lies the point at which I also become the person known as the Domestic Policy Advisor within the White House because the underlying theme as we approach domestic issues is that matter of providing the environment/the necessary tools/the opportunity for that empowerment process to unfold.

What do I mean I come to you as a mother of Hampton or Hamp as he is known to his family and friends? Relate birth, institutional choices, status today. Insert addison

After carefully reviewing your agenda with the expert presentations you will have and recognizing this is a special opportunity to spend a few moments with you, it became clear to me that I should open this morning session of the conference with a call to action. You have before you ~~today~~ over the next 2 1/2 days an agenda that ~~will crystallize~~ brings together for you in ~~one day~~ this short time the very best in the body of information you will find assembled anywhere on the ~~ECONOMIC CONSEQUENCES OF~~ Employ. of Persons [illegible] DISABILITIES. If you then leave here ~~today~~ and don't change anything about the way you are doing business, ~~today~~ this sym will have been for naught....but instead you have the opportunity to say, I AM GOING TO LEAVE HERE ~~TONIGHT~~ and I WILL APPROACH MY WORK DIFFERENTLY ~~TOMORROW and~~ each day thereafter...and it is no fair to say I WILL SIMPLY THINK DIFFERENTLY....WE MUST ACT DIFFERENTLY.

As I further thought about this morning & wondered what I might really add — You have so much to teach me as my Sen turns 26 enters the world of work

Number 3: Something to hope for....My daughter who didn't want to miss a day of the eighth grade today has many hopes and I both thrive in that gleam of hope in her eyes constantly look for ways to nurture and keep that sparkle present....help me, help our administration look for ways to create that hope for all citizens of this great country. Health security frees up a family for hopes and dreams, safer streets help free children to look at what education can be for them....but untreated ear infections, uncorrected vision problems, lack of immunizations, school buildings in AMERICA where children must wear their coats in order to be warm enough to even begin to pay attention...and we wonder where hope has gone?

In the Enterprise Zone legislation we have an opportunity to test our real commitment to reinvention....will we truthfully recognize the need for integration of human development and

nature...none of the other things we seek to do will ever take us where we need to go."

No, it can't be done by government PROGRAMS in the traditional sense but we in government need help in thinking through how we best stimulate this process of individual, family and community healing and growth, that is where real reinvention must occur.

I am reminded inwardly on a constant basis of what an elderly physical therapist who had dedicated her life to young disabled children told me early in my son's life...she said, "Carol, I don't know a lot of philosophy or theory about programs for children like Hamp, but I think the best thing I can tell you as a parent is to remember the words of Joseph Addison, an essayist, poet "Everyone must have

Something to do

Someone to love

Something to hope for."

And how right she was and is in the case of not only Hamp, but people with whom I've worked with and worked for....and so at each age of life in our quest to reinvent how we approach the ~~problems of the urban poor~~ [programs for people w/ disabilities] we must ask

What do they have to do? If a young child, what is the preschool program available? Can they play, dance, sing, and soar? If a child, is school relevant? Is school safe? ~~I was struck this morning as I went to my door to get the paper. My daughter, in an attempt to make SURE I didn't forget to~~

Until our communities get as fired up about our schools as we/they do about athletic teams, car manufacturing plant locations, Olympic sites, etc. we won't have a good answer to the question: What have we given the children – young and adolescent to DO?

And for adults: What do they have to do? What kinds of work? Is it stimulating? Is it relevant?

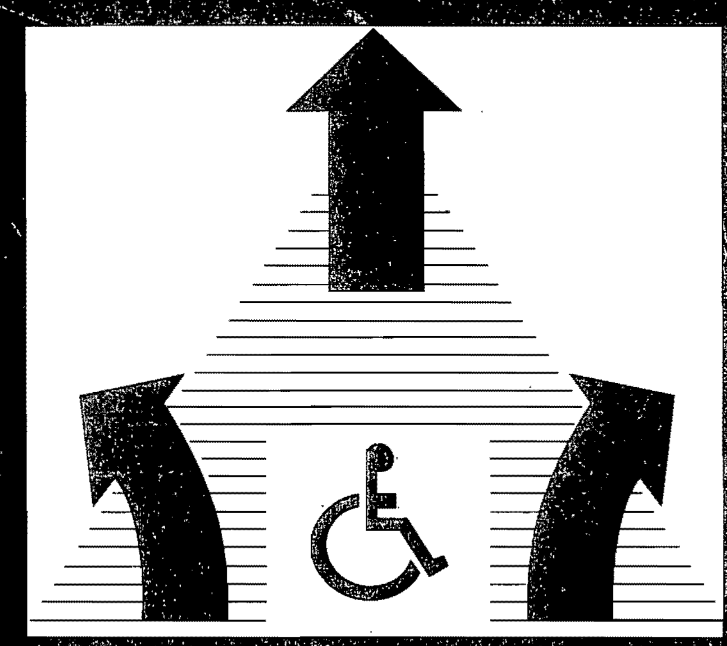
Number 2: Someone to love...and we all know that before you can love another, you must love yourself. ~~Think about children's faces you've seen in urban poor neighborhoods, adults you've passed on those streets....do they have much to love about themselves? Many don't and therefore we can't truthfully expect the love to flow outward.~~ As for adults It is As the Pres. has said – WORK gives structure & meaning to our lives.

Perspectives on Employment of Persons with Disabilities

Hyatt Regency Bethesda

Bethesda, Maryland

December 8-10, 1993



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PERSPECTIVES ON EMPLOYMENT OF PERSONS WITH DISABILITIES
1993 CONFERENCE EVALUATION FORM

(RATING SYSTEM: 5=EXCELLENT, 3=OK, 1=POOR)

OVERALL CONFERENCE EVALUATION:

a. Overall Rating	5	4	3	2	1

GENERAL SESSIONS:

a. Keynote Speaker I (8 December - Carol Rasco)	5	4	3	2	1
b. Keynote Speaker II (8 December - Justin Dart)	5	4	3	2	1
c. First Luncheon Speaker (8 December - Richard Pimentel)	5	4	3	2	1
d. General Session (9 December - Raymond Kurzweil)	5	4	3	2	1
e. Second Luncheon Speaker (9 December - Bill Graham)	5	4	3	2	1
f. Brunch Speaker (10 December - John Kemp)	5	4	3	2	1

WORKSHOPS:

a. Accessible Formats	5	4	3	2	1
b. Ask the Experts	5	4	3	2	1
c. Critical Factors in Recruitment,Interviewing & Placement	5	4	3	2	1
d. Deaf Issues - A Report on the Dallas Forum	5	4	3	2	1
e. Dealing with the Resistant Manager	5	4	3	2	1
f. Developing a Resource Network	5	4	3	2	1
g. Disability Rights in the Federal Sector	5	4	3	2	1
h. Employment of Disabled Veterans	5	4	3	2	1
i. Employment of People with Chemical Sensitivities	5	4	3	2	1
j. Employment of People with Mental Retardation	5	4	3	2	1
k. Employment of People with Psychiatric Disabilities	5	4	3	2	1
l. Film and Video Exhibition	5	4	3	2	1
m. Managing Emp. w/ HIV/AIDS Along the Continuum of Disease	5	4	3	2	1
n. Performance Based and Conduct Based Adverse Actions	5	4	3	2	1
o. Program and Facility Access for Work Places and Child Care Settings	5	4	3	2	1
p. Project ABLE	5	4	3	2	1
q. Readers, Interpreters and Personal Assistants	5	4	3	2	1
r. Reasonable Accommodation	5	4	3	2	1
s. Returning the Injured Employee to Work	5	4	3	2	1
t. Shattering Attitudinal Barriers to Employees with Disabilities	5	4	3	2	1
u. Substance Abuse Issues in the Workplace	5	4	3	2	1
v. Workers' Comp./Disability Retirement: The Fed. Process	5	4	3	2	1

MEALS:

a. First Luncheon (8 December)	5	4	3	2	1
b. Second Luncheon (9 December)	5	4	3	2	1
c. Brunch (10 December)	5	4	3	2	1

CONFERENCE ADMINISTRATION:

a. Hotel Facilities	5	4	3	2	1
b. Hotel Accommodations (If you stayed in the hotel)	5	4	3	2	1
c. Pre-conference registration process	5	4	3	2	1
d. Overall management of the conference	5	4	3	2	1

SEE OTHER SIDE

What topics would you like to see covered next year that were not covered this year?

What would like to see changed to improve next year's Conference?

Please comment on any items from the reverse side that you rated as either a 1 or 2.

List the 3 key factors that you feel affect programs for the employment of people with disabilities in the federal government. **(A summary of these factors will be presented to the senior management of the Office of Personnel Management-OPM)**

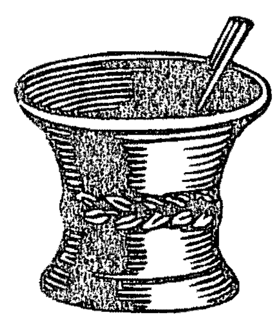
Additional Comments:

PLEASE LEAVE IN EVALUATIONS BOX OR MAIL TO:

Paul Meyer
PCEPD
1331 F St., N.W. 3rd Floor
Washington, DC 20004

HEALTH CARE PROVIDERS ASSOCIATION DELAWARE

ANNUAL DINNER



November 30, 1993
Holiday Inn, Downtown
Wilmington, Delaware

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P.O. Box 10770
Wilmington, DE 19850-0770
1-800-MEDLAB-1

10 REASONS

HEALTH CARE COSTS WILL CONTINUE TO RISE

PRESENTED BY

Edward F. X. Hughes, M.D., M.P.H.
Director
Center for Health Services and Policy Research
Professor
J. L. Kellogg Graduate School of Management
Northwest University

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Delaware folder

MEMORANDUM FOR CAROL RASCO

FROM: Kathi Way

DATE: November 22, 1993

RE: Delaware Trip, November 30

$94.00

ITINERARY

10:35 AM	LEAVE UNION STATION — Train #86
12:04 PM	ARRIVE WILMINGTON
12:30 PM	ARRIVE MBNA BANK/BUFFET LUNCH AND OVERVIEW
1:15 PM	TOUR MBNA/BENEDICTINE SCHOOL WORKSITE
2:15 PM	TOUR BENEDICTINE SCHOOL RESIDENCY PROGRAM
3:00 PM	LEAVE MBNA TRAVEL TO WILMINGTON
4:00 PM	MEET WITH GOVERNOR CARPER AND DE HEALTH CARE COMMISSION
5:00 PM	HEALTH CARE PROVIDERS RECEPTION/DINNER
9:~~30~~ 32 PM	LEAVE WILMINGTON TRAIN STATION — Train #129
~~11:00~~ 10:59 PM	ARRIVE UNION STATION

BACKGROUND ON THE HEALTH CARE PROVIDERS PRESENTATION

ATTENDANCE: About 300 people are expected to attend.

PRESENTATION: The Health Care Providers are expecting about 20-30 minutes on the general principles of the Clinton Health Care Plan. In addition to that information, I think this might be a good occasion to talk a little about the achievements of the Administration to date. I believe our report card looks pretty good and it is never a bad idea to remind folks of the accomplishments. The agenda calls for a few questions and answers at the end. I don't expect they will be too detailed. If we have any handouts on the plan we could distribute those to the group also.

1280 S. Governors Ave.
Dover, Delaware 19901
302-735-3600
1-800-874-2500
FAX 302-735-3609

HEALTH CARE PROVIDERS ASSOCIATION of DELAWARE

October 19, 1993

Ms. Kathi Way
Special Assistant to the President for Domestic Policy
218 Old Executive Office Building
Washington, DC 20500

Dear Kathi,

Thank you for working with me on the Health Care Providers Association of Delaware annual dinner. As we discussed, the date was changed to November 30, 1993. The event will be held in Wilmington at the Downtown Holiday Inn located at 700 King Street.

We have extended an invitation to the First Lady and hope that her schedule will allow her to participate at the dinner. This will be an outstanding opportunity for her to speak to Governor Thomas Carper, the legislators, the Delaware Health Care Commission, the provider community of Delaware, and the press. Where else but in Delaware could you get all of these people in one room to listen to the Clinton health care reform plan. I am excited knowing that Carol Rasco will definitely be with us to share her views on the Clinton plan. Your description of Ms. Rasco and the knowledge of her involvement in the health care package leads me to agree, she will be dynamite in Delaware.

Our schedule for November 30, 1993 is as follows.

4:00 p.m.	displays
5:00 p.m.	cocktails
6:30 p.m.	dinner
7:30 p.m.	program

Hillary Rodham Clinton and/or Carol Rasco will lead the evening's program. Dr. Jeffrey Fisher, author of Rx 2000, will be the next speaker followed by a short panel discussion moderated by Edward F. X. Hughes, M. D., M. P. H.. I am enclosing back ground material on Dr. Hughes and Dr. Fisher. Each speaker will have 30 - 40 minutes and the panel discussion will be for 30 minutes.

SUMMARY OF ACTIVITIES

DELAWARE HEALTH CARE COMMISSION

March, 1993 - November, 1993

In March, 1993 Governor Thomas R. Carper issued the charge to the Delaware Health Care Commission to design a comprehensive plan for reforming the state's health care system. This, in addition to firm commitment to on-going projects have given the Commission a multi-pronged approach to improving the delivery of health care to Delawareans.

Comprehensive Reform
The Commission has retained Health Systems Research to assist in the development of a broad architecture for a reformed health care system. Thus far the Commission has determined that it wishes to pursue a market-based system which builds upon the existing structure. To this end the Commission seeks a plan which builds on providing insurance through the workplace, but has left the question of mandates open for the time being.

Engquist & Pelrine have been retained to design a Medicaid managed care proposal, with the thought that the revamped program would become a government program through which the non-working uninsured could obtain coverage.

The Commission is completing its work in a series of workshops, supplemented by focus group sessions conducted by HSR. Two focus group sessions have already occurred -(1) Kent and Sussex County representatives and (2) advocates. Additional sessions are scheduled with representatives of business and the insurance industry and providers.

In addition the Commission will hear presentations from the Medical Society of Delaware and DelaCare (Ernie Dannemann).

A schedule of meetings is included for further reference.

Pilot Projects
The Commission has funded two pilot projects which are designed to test whether government can effectively create incentives for more employers to offer coverage to employees. This plan recognizes that approximately two-thirds of Delaware's uninsured have some attachment to the workplace.

The Delaware Health Plan Consortium - a conglomeration of the Association of Delaware Hospitals, Blue Cross and Blue Shield and Principal Health Care has nearly completed licensing requirements, and we anticipate an official kick-off announcement in mid-December. This fact is not yet for public consumption.

Nanticoke Memorial Hospital in Seaford seems to be making progress as well. Nanticoke's plan is to market a managed care program to local employers which emphasizes primary care through increased use of mid-level professionals and a wellness program. Tertiary care will be provided at Johns' Hopkins

Voluntary Initiative Program
The Medical Society of Delaware reports that since the program's inception in March over 1300 referrals have been made. It may be of particular interest to you to note that in October over 40 referrals were made to the new Nemours clinic in Dover -- despite the fact that the clinic wasn't officially operating until the first of November. Clearly a need is being met.

The Commission has agreed to fund an independent evaluation study to be conducted by Dr. James Gill of the Medical Center of Delaware.

Nemours Foundation Children's Clinics
Four children's clinics are now up and operating: Northeast State Service Center; Philadelphia Pike; Penn Mart Shopping Center and Dover. The next opening is expected to be the Lancaster Avenue site. The only hold up on the Georgetown site is finding a pediatrician. The Institute has formed a Community Advisory Committee to foster good communications between the Nemours Foundation and the community served by the clinics.

"Matrix" Project
The Commission was directed to undertake a study of the structure, financing and delivery of services to children for the purpose of identifying duplications of effort and gaps in service. The charge came from the Delaware General Assembly in the FY 94 Budget Act epilogue. A similar charge was issued to the Interagency Resources Management Committee through a Senate Joint Resolution (#16). We have collaborated with the IRMC and anticipate completing this project by June 1. The Commission has retained the Center for Assessment and Policy Development to assist in this effort. (Patrick McCarthy). This project can be regarded as building upon the work begun by the now-defunct Healthy Children's Committee.

Infant Mortality and Health Access grants
The Commission awarded $400,000 to community organizations to provide seed money for programs designed to combat infant mortality or expand access to primary health care. Most programs concentrate on prenatal care and teen pregnancy. One noteworthy program is a program sponsored by the Delaware Ecumenical Council which will provide start-up funds for a transportation system to provide access to medical services for indigent and underserved populations in the state. The program's initial focus will be Sussex County.

SPECIAL REPORT

Proposed Health Care Reform Plan for Delaware

The Medical Society of Delaware, working with representatives from the various specialty societies, has developed a Health Care Reform Plan for the state, which we believe will enhance an already excellent health care delivery system in our state. We further believe that this proposal, by providing for universal health insurance coverage and access to health care at appropriate times and in appropriate settings, will improve the health care system in the state by restoring value to the system and by improving the health care statistics for the state, particularly in areas of pediatric care and infant mortality.

While the plan's major focus is to assure health care insurance coverage for everyone in the state, it is our belief that a legislative and health insurance mechanism for providing access to appropriate care at appropriate times is not sufficient and that any plan must also establish incentives for individuals to pursue healthy lifestyles and the most efficient courses of treatment.

It is our conclusion that there are three major levels of activity which must occur for health care in Delaware to be appropriately reformed. These include the establishment of new legislation, health care policy and financing mechanisms. The legislation required is extensive and must occur at both the national and state levels. Health care policy must be established by nongovernmental agencies, again at both the federal and state levels. These agencies, by being private in nature, would tend to be driven by the public good rather than governmental budgetary targets. At the federal level, we envision a national health care board with substantial representation by practicing physicians and other health care providers. At the state level, we envision the perpetuation of the Delaware Health Care Commission enhanced by greater representation of practicing physicians and other health care providers.

With regard to financing, we envision that all individuals must have their health care financed at similar levels so that community rate premiums would be available to pay for health insurance coverage of all state residents.

Legislation

In terms of the specifics of the necessary legislation at the federal level, there would be a need for a universal mandate for the provision of health insurance coverage with contributions made by employers, individuals and the states. There would be amendments necessary to existing statutes such as ERISA and the antitrust laws. Also needed would be legislation to reform the medical liability system nationwide, provide funding for nationwide medical information systems (MIS), provide funding to establish a nationwide electronic intermediary, and provide enhanced funding for primary care physician education at the federal level.

At the state level, there would need to be major insurance reform to support this program, and there would need to be medical liability reform to comply with the federal standards mentioned above. There would need to be legislation to provide funding for primary care physician education at the state level so that regional shortages could be corrected as quickly as possible.

Policy

In terms of policy, we envision the federal health board would establish the basic benefit plan and would establish community rate premiums which would vary by region, thus setting the region's health care budget. This board would oversee national outcomes research based on information gathered by the MIS.

At the state level, we envision the Delaware Health Care Commission's role with regard to health care policy expanding. The Health Care Commission would determine whether state health care policy should be established for the entire state, or whether regional differences within the state would dictate that health care policy would be more appropriately determined on a county-by-county basis. To ensure that the health plans offered in Delaware comply with national standards, the Health Care Commission will be responsible for evaluating all plans and certifying compliance. We envision the Health Care Commission establishing clinical pathways based on outcomes research from data accumulated through the MIS, and we further envision the Delaware Health Care Commission monitoring the quality of and access to health care throughout the state. This monitoring of quality and access would include monitoring of patient and provider satisfaction.

Financing

In terms of financing, we envision an employer mandate where employers would be responsible for a given percentage of the community premium for each full-time equivalent employee, thus including both full-time and part-time employees in the mandate. We envision employers, while they would not be responsible for paying for dependent coverage, would be required to contract with plans that would make dependent coverage available.

We envision the federal government incorporating all of its existing funding of health care coverage through community rate premiums. This would include all Medicare patients, the federal government's contribution to Medicaid, the federal employee health benefits plan, VA, CHAMPUS, Congress, etc., to all be covered through similar community rate premiums.

We envision the state government's financial role to be that of its current 50 percent contribution to Medicaid, that the state would be responsible for premiums for uninsured individuals below 200 percent of the poverty level and that the state would also be responsible for the employee contribution for health insurance for those employees under 200 percent of the poverty level, as well as for any coinsurances for these individuals.

For example, employees over 200 percent of the poverty level would be responsible for paying the balance of the community rate premium for their coverage through employer withholdings. These employees would also be responsible for paying any co-pays or deductibles included in the plan. Unemployed individuals over 200 percent of the poverty level would be responsible for the entire community rate premium, as well as any copayments and coinsurances.

Delivery System

We envision the delivery system at the outset of this plan to be very much as it currently exists. However, since each insurer would receive (and be required to accept) the same community rate premium, insurers would compete not on the basis of price, but rather on the basis of quality and efficiency. Thus, we would envision a growth in managed care plans within the State and an enhancement in the integration among health care providers so that over time, health care in the state would be delivered more and more efficiently, thus containing health care cost in the State.

We envision a variety of health care plans being available, but would mandate, through health insurance reforms, that there be at least one indemnity plan available to all employees and individuals and that HMO, PPO and PHO plans all be required to offer an off-panel benefit. This provision would protect the freedom of choice of physicians and hospitals for Delawareans, while allowing for the continuity of the would be required to offer a basic benefit package as defined by the national health care board

The Society's recommended basic benefit plan follows. The Society has chosen not to adress long term care coverage as part of the basic benefit plan, and would defer any consideration in this regard to the national level. We strongly recommend that workers compen-sationa dn auto health health benefits be incorporated as part of the basic health coverage in order to eliminate the "double coverage" that currently exists.

The detailed elements of the Health Care Reform Plan as we propose it, as well as a schematic flowchart to demonstrate how the program would be implemented and organized, follow this report. We anticipate the plan would be phased in, but the transition should not be done in such a way as to jeopardize patient care or exacerbate cost shifting.

In summary, we believe that through responsible initiatives at the federal and state levels the current excellent health care delivery system in Delaware can be enhanced and improved so that all citizens of the state would have health insurance coverage and have access to appropriate health care at appropriate times and in appropriate settings.

The Medical Society of Delaware looks forward to working with other organizations in the State, as well as with the state and national governments to achieve the realization of this plan.

Principles of Health Care Reform

As adopted by the Ad Hoc Reform Committee September 8, 1993

- Universal access to health insurance coverage and health care in appropriate settings
    - Employer mandated basic benefit plan for employee coverage
    - State mandated coverage for unemployed, self-employed and others below some percentage of the poverty level (e.g., 200 percent)
    - Individual mandated coverage for those above poverty level not covered by employer
    - Premium value of benefits in excess of basic benefit plan to be taxed as ordinary income
    - Insurer mandate to provide basic benefit plan irrespective of employer group or class
- Insurance market reforms
    - All delawareans included in single community rating pool (option: community-rate by county)
    - Community rating to include Medicare, Medicaid, commercial insurers; optimally, would include VA, Congress, CHAMPUS, and other federal programs
    - Elimination of pre-existing condition exclusions
    - Elimination of erisa exemption
    - Workers comp and auto health benefits to be incorporated in basic health coverage
    - Insurers mandated to cover any subscribers at the community rate
    - Patient incentives to lower costs
    - Incentive may fund deductibles or long-term care
    - Incentive may fund health IRAs
    - Limits on copays and deductibles
    - Regulation of utilization review agents by insurance department
- Freedom of choice
    - Patient choice of physician and hospital through selection of insurance cover-

age (i.e., at least one indemnity plan to be offered and all other plans to have an "off panel" benefit at a reasonable additional cost with freedom to select physician or hospital of choice.) This will allow patients to continue under current care with current providers.

- Eliminate micro-management
  - Basic benefit package to include preventive care, office visits and drugs and dental coverage; will be subject to copayments and coinsurances (coinsurances covered by the state for those below a certain percentage of poverty level)
  - Clinical pathways/diagnosis-based resource utilization
- Uniform electronic intermediary
  - Smart card for transmission of billing and benefit data
  - Uniform claims processing
- Medical information systems (mis)
  - Assist in establishing clinical pathways
  - Avoid unnecessary/duplicative care
  - Outcomes research to aid in development of clinical pathways at the state level
- Global budget as established by community rate premium
  - Sufficient to support basic benefit package
  - Annual updates keyed to demographics, inflation and outcomes research
- Malpractice relief
  - Clinical pathways as irrefutable presumption of standard of care
  - Caps on noneconomic damages
  - Abolish joint and several liability
  - Require certificate of merit prior to filing of malpractice claims
  - More toward alternative dispute resolution
- Antitrust relief
  - To allow for expansion of peer review activities and disciplinary and fee dispute programs
  - Coordination and integration of health care services
- Nondiscriminatory physician payment system
  - Fee schedules available to patients
- Funding for primary care physician education to improve access by encouraging primary care physician practices in delaware and to ease educational costs
  - Loan abatements
  - Financial incentives
  - Tax relief
- Employer incentives for healthy workplaces

Proposed Medical Society of Delaware Health Reform Plan

revised 9/10/93

LEGISLATION

U.S. Congress
- Amend ERISA
- Employer/Individual/State Mandate
- Antitrust Reform
- Medical Liability Reform
- Funds MIS Start Up
- Funds Electronic Intermediary
- Funds Primary Care Physician Education

Delaware State Legislature
- Medical Liability Reform
- Insurance Reform
- Funds Primary Care Physician Education
- Employer/Individual/State Mandate, if necessary
- Funds MIS Start Up, if necessary
- Funds Electronic Intermediary, if necessary

POLICY

Federal Public/Private Health Board
- Sets Basic Benefit Plan
- Sets Community Premium/Global Budget
- Sets Federal Criteria for MIS
- Outcomes Research Using MIS

Delaware Health Care Commission
- Establish a Regional MIS
- Establishes Clinical Pathways Based on Outcomes Research Data from MIS
- Obtain ERISA/Antitrust/MA/MC Waivers, if necessary
- Monitor Quality/Access/Patient and Provider Satisfaction

FINANCING

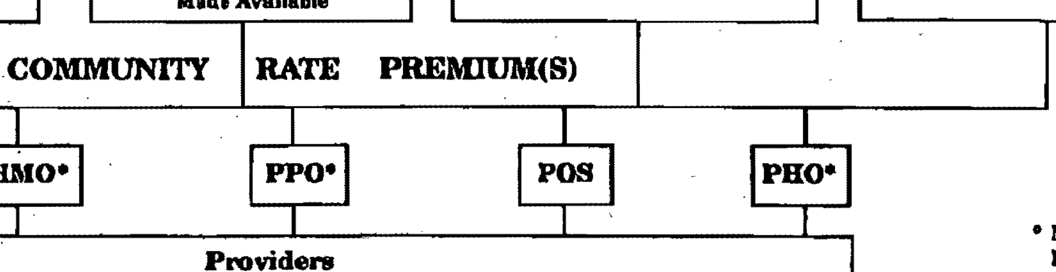
Federal Government
- 50% Medicaid
- Medicare
- FEHBP
- VA, CHAMPUS
- Congress

Delaware State Government
- 50% Medicaid
- Premiums for Uninsureds < 200% of Poverty
- Employee Contribution For Those < 200% Of Poverty

Employers
- Some Percent of Community Premium/ FTE
- Dependent Coverage Made Available

Employees > 200% Poverty
- Balance Of Community Premium
- Copays And Coinsurance

Individuals > 200% Poverty
- Community Premium
- Copays and Coinsurance



* Must Have Off-Panel Benefit

Proposed MSD Health Reform Plan
Basic Benefit Plan

Service	Cost
PHYSICIAN SERVICES	
• Office Visits (Sick/Follow up Visits) • Allergy Treatments • Urgent Care at Physician's Office • Emergency Care at Physician's Office	$5 copayment if < 200% of poverty level $10 copayment if > 200% of poverty level
• Periodic H & P's • Family Planning • Routine Gynecological Exam & PAP Test • Well Child Care • Immunizations • Newborn Care • Prenatal & Postnatal Maternity Care • Cancer Screening (as defined by DHCC)	$0 copayment
• Allergy Testing	50% copayment
• Specialist Services	$5 copayment if < 200% of poverty level $15 copayment if > 200% of poverty level
INPATIENT HOSPITAL CARE	
• Unlimited Hospital Days (semi-private) • Private Room When Medically Necessary • Medications & Drugs • Nursing Care • Professional Services • X-rays & Laboratory • Intensive/Coronary Care • Radiation Therapy • Administration of Blood	$400 coinsurance per admission
OUTPATIENT FACILITY SERVICES	
• X-rays & Laboratory • Ambulatory Surgery	10% coinsurance
SHORT-TERM THERAPIES BY PHYSICIAN REFERRAL	
• Physical • Speech • Occupational • Respiratory • Cardiac Rehabilitation • Nutrition Counseling	20% coinsurance

Benefit	Member Cost
REPRODUCTIVE BENEFITS	
• Elective Sterilization, Male or Female	$0 copayment
• Termination of Pregnancy	$0 copayment
SKILLED NURSING FACILITY	
• Facility, Supplies and Equipment Authorized in Lieu of Acute Care Hospitalization Within the Service Area	$0 copayment
HOME HEALTH CARE	
• Authorized in Lieu of Acute Care Hospitalization Within the Service Area	$0 copayment
HOSPICE	
• Authorized in Lieu of Acute Care Hospitalization Within the Service Area	$0 copayment
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	
• Authorized Certain Prosthetic Devices and Durable Medical Equipment	20% coinsurance
URGENT AND EMERGENCY CARE SERVICES	
• At Medical Aid Units	$25 copayment
• At a Hospital Emergency Room (waived if admitted)	$50 copayment
• Ambulance	$25 copayment
PRESCRIPTION DRUGS	
• Including Insulin and Supplies	10% coinsurance
MENTAL HEALTH	
• Inpatient (30 days per year maximum)	$400 coinsurance per admission
• Outpatient (20 visits per year maximum)	$5 copayment if < 200% of poverty level $15 copayment if > 200% of poverty level

SUBSTANCE ABUSE

Benefit	Cost sharing
• Inpatient (28 days per year maximum) **NOTE: Maximum of two courses of therapy per lifetime**	$400 coinsurance per admission
• Outpatient (10-week intensive sessions per year plus 12 monthly follow-up sessions per year) **NOTE: Maximum of two courses of therapy per lifetime**	$5 copayment if < 200% of poverty level $15 copayment if > 200% of poverty level

VISION

Benefit	Cost sharing
• Exam (every two years, or as referred)	$5 copayment if < 200% of poverty level $15 copayment if > 200% of poverty level
• Eyeglasses - Annual Benefit (to Age 18) - Biennial Benefit (Adults < 200% of poverty level)	$120 maximum benefit $50 maximum benefit

EXCLUSIONS/LIMITATIONS

- Organ transplants only covered in accordance with list to be developed by DHCC
- Durable Medical Equipment only covered in accordance with list to be developed by DHCC
- Cosmetic surgery — not covered
- Obesity services — covered only if in conjunction with treament of a medical condition
- Cosmetic contact lenses — not covered except for diopter > -8

MAXIMUM OUT-OF-POCKET COINSURANCE

- $600 annual maximum per individual
- $900 annual maximum per individual plus child
- $1200 annual maximum per family

Much about Delaware's approach closely parallels the President's.

The Ad Hoc Reform Committee adopted the following guiding principles for reform this past September:

Universal Access to health insurance coverage through:

Employer mandate for their employees

State coverage for unemployed and self-employed

Individual mandate for people above poverty

Insurance reforms to make health care more secure:

Guaranteed availability of insurance

Community rating for all of Delaware

Elimination of pre-existing condition exclusions

ERISA reforms

integration of workers comp and auto insurance

Choice of doctor and health plan

Administrative simplification

Cost control based on limit on insurance premium

Anti-Trust relief

These are all the same core foundations of the President's plan: we are heartened that Delaware has independently sought out the best answers to the health vcare crisis they are facing, and has come to the same conclusions as we have for the best approach to build on what's best about the current system while fixing the elements so in need of repair.

We will continue to work together to preserve these shared goals as the President's plan moves through the Congress.

STATE OF DELAWARE
DELAWARE HEALTH CARE COMMISSION
TATNALL BUILDING - GROUND FLOOR
WILLIAM PENN STREET
DOVER, DELAWARE 19901

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EXECUTIVE DIRECTOR

ROBERT G. KETTRICK, M.D.
CHRISTINE M. LONG
CARMEN R. NAZARIO
DONNA LEE WILLIAMS
GREGORY J. WILLIAMS

MEMORANDUM

TO: SUE CAMPBELL
FROM: MARLYN BROWNING
DATE: NOVEMBER 29, 1993
SUBJECT: ATTENDANCE LIST FOR NOVEMBER 30 MEETING - 4:30 P.M.

The following members of the Delaware Health Care Commission will attend tomorrow's meeting at 4:30 p.m. in the Governor's Wilmington office:

Marcella Copes, Ph.D.
Sarah Gore
Sarah Jackson
Bruce Karrh
Robert Kettrick, M.D.
Carmen Nazario
Gregory Williams

The following staff members will attend the meeting:

Scott Harrison
Kay Holmes
Paula Roy
Muriel Rusten

Thomas Eichler is unable to attend due to a prior commitment that he is unable to break.
Scott Harrison will represent Donna Lee Williams, who is in Hawaii.
Christine Long may or may not attend, and is not able to make a commitment, due to her health.

Governor Carper and the following staff members:
Liz Ryan, Ed Freel, Jeff Bullock, Lisa Blunt-Bradley

MBNA America/Benedictine Homes of Delaware
Tour and Schedule of Events
November 30, 1993

Luncheon:	**1:00 - 2:00 p.m., White Wing, Room 304**
Guests:	
Senator Joseph Biden	United States Senator (Delaware)
Maureen Byrnes	MBNA America, Manager of People Services
Charles Cawley	MBNA America Bank, Chairman and Chief Executive Officer
Julie Cawley	Special Education Advocate
Micki Edelsohn	Parent Advocate
Sr. Jeannette Murray, OSB	The Benedictine School, Director
Karen Nygaard	MBNA, America Benedictine Program Coordinator
Peter Raffa	Benedictine Homes of Delaware Program Coordinator
Carol Rasco	The White House, Domestic Policy Advisor
Kathy Way	The White House, Asst. to the Domestic Policy Advisor
Lance Weaver	MBNA America Bank, Vice Chairman and Chief Administrative Officer

Work - Place Tours:	**2:00 - 3:00 p.m.**
1) Scott Dillon	Financial Institutions
2) Brenda Phipps	Corporate Affairs
3) Carl Williams	Fitness Center
4) Julianne Johnson	Copy Center
5) Julie Baker	Environmental Srvcs. (Capital)
6) Robert Dunphy	Mail Center
7) Kevin Daly	Fleet (time permitting)
8) Ramon Granados	

Benedictine Homes Tour: **3:00 - 3:30 p.m.**

1) 100 Diminish Drive
2) 103 Diminish Drive

Return to White Wing

MEMORANDUM

TO: CAROL RASCO
FR: JOHN HART
DT: NOVEMBER 29, 1993
RE: DELAWARE'S HEALTH CARE REFORM

In preparation for your trip tomorrow, I put together a brief overview of health care reform in the state of Delaware; the history of reform; the key players; and state demographics.

I. Overview of Health Care Reform Proposals

The Delaware Health Care Commission (DHCC) under Governor Tom Carper's direction hopes to have the outline of a comprehensive plan prepared by January 1994 and a more detailed version by March 1994. They hope the legislature will adopt the proposal by June 1994 and that Delaware will be on track to comply with national reform. Governor Carper has charged the commission with developing a health care reform plan by March 1994.

The Delaware Health Care Commission was established by the General Assembly in 1990 to oversee implementation of then-Governor Michael Castle's Indigent Health Care Task Force report issued May 31, 1990. The Commission was also charged with exploring and recommending an initiative to "provide basic, affordable, quality, accessible health care to all Delawareans." In addition, Delaware passed a number of small scale legislative initiatives focusing on Medicaid expansion and small business reform. General state funds and a cigarette tax will finance any reform. Uniform physician billing has been enacted to contain costs and simplify administrative procedures. Governor Castle's proposal was passed by the Delaware General Assembly in 1992.

In 1993, Delaware expanded Medicaid eligibility to include all children (through age 18) up to 100 % of Federal poverty level. This expansion of Medicaid was one impetus for the development of the Delaware Medicaid Managed Care Demonstration.

In July, 1993, Delaware was granted a waiver request that allows the state to pay local clinics a fixed monthly rate for the care of children who have no insurance or who are covered by Medicaid.

II. The History of Reform

Former Governor Michael Castle's four-pronged plan for health care reform was adopted by the general assembly during the 1992 session. Implementation will be overseen by the Delaware Health Care Commission. The reforms focus on health care for

children, improved access and delivery of health care, insurance reform, and cost containment.

A. **Children's Health Care** - The reforms focus on increased access to primary health care. Under a joint partnership between the state and the A.I. du Pont Nemours Foundation, childrens health clinics will be established throughout the state. The programs will:

- extend Medicaid-like, state funded coverage for all children up to age 18 living in poverty;
- increase Medicaid eligibility for pregnant women and infants up to 185 % of federal poverty level;
- extend coverage to children up to age 18 living below 175% of poverty according to a sliding fee scale; and
- develop satellite health centers throughout the state, with a focus on undeserved areas.

B. **Health Care Delivery** - The reforms focus on an improved health care delivery system, including:

- development of a managed care pilot project to test new ways of providing health care to the working uninsured;
- increased efforts to recruit primary and family practice physicians to the state;
- increased Medicaid reimbursement fees for physicians; and
- establishment of a Voluntary Initiative Program with the Medical Society of Delaware to encourage more primary care physicians to treat Medicaid and indigent patients.

C. **Insurance Reform** - A small group reform bill was enacted to stabilize the small group market and encourage small employers to provide health insurance benefits for their employees. Highlights of the bill include:

- guaranteed issue, requiring all companies doing business in the small group market to write coverage for any group wishing to purchase is;
- establishment of rating bands to limit premium increases from one year to the next;
- development of a basic and standard benefits package; and
- protection for individuals changing jobs or health insurance companies with respect to having to meet new pre-existing requirements.

C. **Cost Containment** - A Cost Containment Committee was created within the Delaware Health Care Commission. By December 31, 1993, the committee will recommend ways to contain the growth of hospital costs.

II. The Players

Governor Tom Carper (D) has been very supportive of the Administration's Health Security Plan and has made positive comments to the press. As you recall, he was one of the 11 governors who came to the White House for a briefing prior to the President's Health Care Address to the Joint Session of Congress with the President, Ira Magaziner, Judy Feder, and yourself on September 14, 1993.

DHCC Chair Sally Gore - the Commission has been holding public hearings and is charged with presenting a plan to the governor by March 1994.

DHCC Vice Chair Dr. Robert Kettrick

DHCC Executive Director Kay Holmes

Former Governor Michael Castle

Carmen Nazario - Secretary Department of Health & Social Services (single state agency)

Philip Soule, Sr. - Medicaid Director

Stephen Golding - DHCC 1992 Chairman

Ernst Dannemann - A Dover businessman who formed DelaCare Inc., a nonprofit group that has been researching a comprehensive plan for years. His proposal would divide Delawareans into groups of insurance-buying cooperatives. The cooperatives would rely on the existing system of private insurers and health-care providers. Employers would be required to purchase comprehensive insurance, with the employer and employees sharing the costs.

Michael Cruse - HCFA Region III Contact

III. State Demographics

1991 Total Population: 680,000
1990 Population below poverty: 6.9%
1990 Rural population: 27.0%

Health Insurance Coverage:
Population covered by Medicaid: 5.6%
Population covered by Medicare: 12.7%
Population covered by Private Payers: 78.1%
Population uninsured: 13.2%

Non-Elderly with Selected Sources of Health Insurance
1992 Population with employer coverage: 71.1%
1992 Population with other private insurance: N/A
1992 Total population with private insurance: 77.7%

Public Health System
PHS public health expenditures (FY 1992): $22,100,100
State public health expenditures (FY 1989): $59,470,000
Local public health expenditures (FY 1989): N/A
Community & Migrant Health Centers: 2
Population undeserved: 12.7%

Health Indicators
Infant mortality rate per 1000 live births (1991): 11.8
Two year olds appropriately immunized (1989): 53.2%
Prenatal care stated in first trimester (1991): 77.8%

Medicaid
Total Medicaid Recipients in 1993: 61,000
Total Medicaid Payments in 1992: $219,000,000
Medicaid Payment per Recipient: $3,610
Medicaid Expenditures as Percentage of State Expenditures: 7.3%

Managed Care
HMOs in 1992: 4
Percent of Population in HMOs in 1992: 17%
Operational PPOs in 1990: 0

E X E C U T I V E   O F F I C E   O F   T H E   P R E S I D E N T

23-Nov-1993 08:57pm

TO: Rosalyn A. Miller

FROM: Carol H. Rasco
Economic and Domestic Policy

SUBJECT: Delaware trip

I am putting in my outbox the information Kathi has prepared to date for the Delaware trip. I need for you to do the following:

✓ Pull anything I have received to date from the Benedictine School.

✓ Pull my Ark. Hospital ASsociation file as it has, I hope, the notes from my speech to them.

I need all this stuff to review upon my return Sunday night....could you put it in my car which I will leave here at White House complex. I have just checked to make sure the keys are in the usual spot in drawer of my desk. If I fail to lock car will you do so.

By the way, if you pull that folder and the hospital speech is in any kind of readable order, could you type it up...as I remember it is now in cut and paste form and then I could proof, edit, etc. and we could get it typed up in final form, maybe even large print before i go? I'll need to make SURE I have the packet recently sent to me on health care plan as well as the book to go with me to Delaware. Please help to see that all this happens. (The packet is on my desk...not sure where I've put book and pamplet with it at moment.) attached

Also, remind me to make sure I have my info on kids with disabilities in that packet. It is in latest LR folder I think, we can check on Monday. See file

If speech is too difficult to type now we'll go over it Monday but I definitely want to take a clear typed version. attached

Thanks.