

DEPAKOTE TOXICITY

District Central IOC Motion regarding Ammonia Toxicity; June 28, 2022

District Central IOC has made a motion to raise the level of awareness with the doctors prescribing Depakote; specifically that the medical profession needs to be aware of the side effect of Ammonia Toxicity, especially given that the symptoms of the Ammonia Toxicity are gradual, and difficult to detect in the population served by the Division of Developmental Disabilities, and sometimes detected only upon hospitalization. Once a member is stabilized, the hospital will discharge, usually to a rehabilitation facility, because of the loss of physical abilities. The gradual decline of the individual, the trauma of a possible hospital stay, as well as the unfamiliar surroundings of a hospital and possible rehabilitation facility, not to mention the cost, could be avoided by a simple and routine blood test. Additionally, the labs need to be aware of the procedure for drawing blood for ammonia toxicity, specifically that the vial needs to be refrigerated immediately upon the blood draw.

Background: 4 out of 13 Members on the District Central IOC have had their child diagnosed with Ammonia Toxicity due to Depakote. In 3 of the 4 cases, the parents had to go from specialist to specialist in trying to determine the cause of the symptoms, specifically confusion, inability to ambulate, or even stand up straight, lethargy. One had to insist, while during a hospital stay, that blood work be done for ammonia toxicity. That individual, while now off of Depakote, is now ammonia sensitive, and blood work has to continue to be drawn in order to maintain stability. A second Individual is currently in the hospital, waiting to be discharged to a rehab facility. The prescribing doctor of the 4th Individual was aware of the side effect, and routinely prescribed blood work to detect ammonia toxicity. Those are the Individuals we have been made aware of. Depakote is widely prescribed for seizure activity as well as mood disorder through the Primary Care Physician, Neurologist, or Behavioral Health provider. We are certain that there are many other Individuals that have not been diagnosed, misdiagnosed or not properly treated for Ammonia Toxicity.

This issue was brought up in a previous District Central IOC meeting, and Karen Kramer, who represents United Health Care at our meetings, elevated this issue to the UHC Director, who passed it along to the Pharmacy Director. She reported to us in our most recent meeting of June 28, 2022, that the AHCCCS drug list specifies what medications require a prior authorization prior to dispensing, and right now Depakote does not require a prior authorization per the AHCCCS drug list. The recommended monitoring parameters include serum ammonia with symptoms of unexplained lethargy, vomiting, hypothermia, or mental status change. Currently with no prior authorization requirement from AHCCCS, the responsibility for monitoring lies with the prescriber. United Health Care would need AHCCCS to require and dictate the prior authorization requirements in order to implement any change.

District Central IOC Recommendation: DDD and AHCCCS review and determine that because of the seeming lack of awareness of this very serious side effect from Depakote, that Depakote be elevated in the AHCCCS drug list to be included in the Prior Authorization category, or at minimum, recommend that quarterly serum levels be drawn on Members who take this medication, in order to monitor for ammonia toxicity before it becomes a very serious issue, involving the aforementioned side effects. Additionally, this is a very costly expense for our Individuals, Medicare, Medicaid, AHCCCS, and the Supportive Health Insurance companies as individuals may often require hospitalization and/or rehabilitation.

As a result of this motion, Dr. Anthony Dekker, DES Medical Director, attended a following IOC meeting where he discussed with us his findings. Because the medication has been on the market for many years, and because many individuals are receiving Depakote, Dr. Dekker informed us that DDD is going to raise awareness of this issue. His findings indicated that of the 1700 individual records he reviewed, less than 1% were receiving regular blood tests for ammonia levels.

RESIDENTIAL BILLING ERRORS AND MOTION

MOTION REGARDING RESIDENTIAL BILLING PROCESS

For a number of years, DDD District Central Independent Oversight Committee has been aware of a consistent issue related to residential billing errors. A bill may represent an amount due, and then the following month the amount would be completely different. At other times, the amount is a credit, and nothing is due. We have heard stories from families who have not paid anything, per the instructions on the bill, and then presented with a balance due of several thousand dollars, when the previous month indicated a credit, which may create a real hardship for the family or the member who is served by the Division.

We are asking what the plans are, and when they will be implanted, for review of the DDD residential billing process, as well as correction of the systemic error in billing calculations, as well as more transparency reflected in the Member's residential bill in order to achieve a correct monthly statement for the Members and confidence in the residential billing system.

DDD RESPONSE TO OUR MOTION

"The Division is currently updating DDD Operations Policy 4002, Client Billing. We expect to submit to public comment in February 2023. This policy indicates the financial responsibility for the cost of care portion based on DDD eligibility. (ALTCS and non-ALTCS members). The Division utilizes the Federal Poverty Guidelines to calculate the monthly statements for members. This amount can change based on the member's income, or benefits the Member receives, including Social Security, Veteran's, and Railroad Retirement benefits. Additionally, every year new rates for benefits are updated which typically takes 2-3 months to reflect in the monthly

statements. For instance, Social Security benefits and Supplemental Security Income (SSI) payments increased by 8.7% in January 2023, therefore by March all monthly statements will reflect this change. In addition, it is essential members/responsible persons provide recent tax information annually. The Responsible Person or Representative Payee may request a financial review of the Member's Cost of Care Portion payment amount, by requesting in writing anytime. The Responsible Person or Representative Payee shall submit the request via email to dddrevenue@azdes.gov and include recent tax forms."

Upon review of DDD's response, we felt that our questions were not answered. We know what the policies are. We are concerned with the systemic data system that consistently sends incorrect monthly statements regarding the residential billing. We followed the process for follow-up to our motion by requesting an in-person meeting with DDD Asst. Dir. Mr. Garcia-Ramadan. Larry Allen, our ADOA liaison, requested the meeting for us, stating that our concerns are not with regards to policy or to an individual, but rather "Specifically the detail they are concerned with is that the monthly billing cycle is systemically not working due to showing wrong amounts due for the DDD member."

IOC Member Carol McNulty, IOC Vic-Chair Debbie Stapley, and Chair Linda Mecham met with Mr. Garcia-Ramadan, as well as Larry Allen. After we explained the issues and gave him specific examples, Mr. Garcia-Ramadan understood that in order to get the information we were requesting, and also to determine if and when the changes can be made to the data system in order to have correct monthly residential statements, he needed to go to DES.

We did have a follow-conversation with Mr. Garcia-Ramadan. He stated that upon meeting with DES, it was determined that in order to fix the residential billing problems, **"it would take years to fix this issue"**.

As IOC Committee Members, as parents of individuals served by the Division, and representing so many families/representative payees who rely on accurate billing in order to have a well-functioning budget, this response from DES/DDD is incomprehensible and irresponsible. We believe that a complete auditing of the billing process and system is needed, as well as expectations that an accurate monthly residential bill will be sent each month. We have included three examples of statements that a member of committee submitted. It was also submitted to Mr. Garcia-Ramadan in our motion.

An additional consequence of this incorrect billing is that the DDD Member's AHCCCS/ALTHCS eligibility may also be at risk, through no fault of their own, because the balance is over the allowable \$2000.00 limit, per AHCCCS/ALTHCS/CMS rules.

PAIN

District Central IOC has been very interested in the Supreme Court ruling regarding the 90 mg statement for pain medications. Because some Individuals who served by DDD may not be able to express when they are in pain, that expression may manifest itself in the form of a behavior. With this new ruling, those individuals may be able to have better control over their pain levels, thus decreasing interfering behaviors and increasing quality of life. We were informed that Dr. Anthony Dekker would inform medical professionals throughout the state who are willing to treat DDD Individuals and their pain management.

ARTICLE 9

Article 9 has been a topic of conversation for the IOC's for several years. This fiscal year was the year that the changes to the Article were presented to GRRC. We were disappointed with the way we found out that Article 9 had been submitted to GRRC. We were under the assumption that we would be able to review it one final time before the submission. When we asked in a Statewide IOC meeting what the status was for Article 9, we were surprised to learn from Mr. Garcia-Ramadan that it had already been submitted to GRRC. He did tell us that he would let us know when it would come up on the GRRC Calendar for final review. Our committee, as well as a few other individuals, both providers and IOC members from other Districts, found the submitted Article 9 on the Secretary of State's website. We found many issues with which we disagreed, and so determined to find out for ourselves when it would come before GRRC. Believing very strongly that it did not represent the original intent of Article 9, nor was in the best interests of the Individuals served by DDD, not to mention the many inconsistencies contained therein, we prepared and delivered our specific concerns to GRRC. The following week were pleased to learn DDD had pulled Article 9 from the GRRC calendar. We know that DDD would like to change Article 9, and we also look forward to a more open dialogue, open participation, and with one single committee, not internal and external stakeholders making suggestions. We look forward to seeing the final document BEFORE it is submitted to GRRC. The IOC's are statutorily tasked with defending the Individuals served by DDD, and insure that their rights, per Article 9, are not violated, and that they are treated with respect and dignity in all aspect of their lives.

"ABUSE AND NEGLECT" CURRICULUM FOR DDD INDIVIDUALS

This curriculum was mandated by Governor Doug Ducey, when the "Hacienda Incident" occurred. (A young lady was raped and a pregnancy resulted.) District Central IOC has no issues with the curriculum for the Provider community. Our issue was with the curriculum that was developed for DDD Individuals. We felt it was extremely explicit, and generally above the ability for DDD Individuals to understand. Additionally, we were concerned about the possible PTSD effects the training could have on individuals who had experienced some type of abuse and/or neglect, and the need to have a professional presenting the curriculum who is licensed/trained in trauma informed care,

who has the ability to recognize and deal with possible side effects of this training. We were also concerned with the training being done in a group setting, when it should be extremely individualized, especially if it triggers behaviors that may be upsetting to others in a group setting which could set up a snow ball effect of behaviors.

Last year's Annual Report outlined our concerns. DDD representative stated that the plan is to have a Request for Information sent out to the public, with proposals out by June, 2023. We asked what is happening in the meantime with the curriculum. We were told it was optional, and that DDD is not seeing a lot of individuals using it. Again, we strongly suggest that there needs to be follow-up with training for when the curriculum triggers unwanted behaviors or responses, and interpreted by someone who is highly trained with the different I/DD learning styles. DDD stated that the IOC's would be included in the workshop and development of the new curriculum. We do not know what the status of this is at this time.

ASH and BEHAVIORAL HEALTH GROUP HOMES FOR DDD INDIVIDUALS

One member from District South, and two DDD Members who reside within District Central Zip Codes, are currently housed at ASH, and have been there from 5-10 years. We are not sure, and have not been able to get a consistent time frame for them. We have been told that they are probably not eligible for release to a facility outside of ASH. We have several concerns: Why are they not receiving Active Treatment, per Statute, and the Seclusion and Restraint reports that we are receiving leave us with more questions than answers. We also question why the new Behavioral Health Group Homes would not be an appropriate setting for these individuals currently at ASH, especially if the facilities and staff are appropriate. We have been told by DDD that the individuals at ASH have been housed at several Behavioral Health facilities, and ultimately go back to ASH because of severe danger to themselves, danger to others, and other interfering behaviors. The ASH Chief Medical Officer informed DDD that they have maximized all they can do for our members living there. Per DDD, this statement has caused concern for DDD and the lack of progress being made by these individuals, which causes concern for a rapid discharge from that level of care back into the community. The statement was made by an IOC member that there are placements in other states that are lockdown, secure facilities where individuals can obtain Active Treatment. Also, because of liability, ASH will probably not allow DDD personnel in to provide Active Treatment. The Department of Health Services and AHCCCS would probably be the entities on that level of discussion who can make changes.

We have only become aware of additional items in this new fiscal year, especially with the policies and statutes which outline specific guidelines for Seclusion and Restraints. We will discuss this in the Annual Report for fiscal year 2023/2024. However, we realized that we were not receiving the Incident Reports from ASH for these individuals. When we asked DDD Quality Management to look into this, it was discovered that ASH was sending the reports to DDD Behavioral Health, but that the Behavioral Health Unit was not forwarding them on to the Quality Management Unit to be included with the Incident Reports read by the IOC's. They are now being forwarded onto QM, and we are once again able to read them.

Regarding the Behavioral Health Group Homes, we were informed by DDD that the Division is working to implement a new service around housing for members who have complex needs and are dually diagnosed. The initial goal is to open at least ten group homes around the state in order to accommodate those members in a community based setting and provide opportunities for successful living.

MORTALITY/DEATHS OF DDD INDIVIDUALS

Because one of the many categories of Incident Reports that we review is “Death”, the District Central IOC is interested in learning more about mortality in DDD members. This past year we learned that in the general population, about 10% of natural deaths can be classified as unexpected. [This estimate is based on the Sudden Unexpected Death in North Carolina (SUDDEN) project (<https://openheart.bmj.com/content/3/1/e000321>).] Unexpected vs. Expected Deaths in DDD Members

For DDD members, approximately 90% of deaths are classified as Unexpected Deaths. The definition of Unexpected Deaths is broader in the DDD population than in the *SUDDEN* project. The *SUDDEN* project includes only unexpected deaths from natural causes. The DDD definition includes unexpected deaths from all causes: “Unexpected Death means a sudden death and may include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma, sudden deaths from undiagnosed conditions, or generic medical conditions that progress to rapid deterioration”. Expected Deaths, about 10% of DDD member deaths are defined as “natural death, and may include deaths from long-standing, progressive medical conditions or age-related conditions. Most expected deaths occur in hospice care.

DDD members are at higher risk of unexpected death than the general population: they have a higher rate of multiple chronic health conditions and are often on multiple medications for medical and behavioral health issues. The term “polypharmacy” is often used to describe medical care involving multiple medications. There are a variety of definitions of polypharmacy, but the most common is taking 5 or more medications each day (<https://www.webmd.com/drug-medication/what-is-polypharmacy>). Polypharmacy, even when necessary and unavoidable, has risks. As the number of medications increases, there is a higher likelihood of side effects, drug interactions and medication errors. Because DDD members may not report side effects reliably, problems from polypharmacy may be missed.

The “Fatal Five” (described in DES/DDD Medical Manual 6002M) is a group of preventable conditions that are often fatal for people with intellectual and developmental disabilities. They are:

- Aspiration
- Bowel obstruction
- Gastroesophageal reflux
- Dehydration
- Seizures

As a result of the review of the “Death” Incident Reports, and our findings thus far, we will be reviewing and reporting on the policies and protocols relating to deaths of DDD Members as outlined in DES/DDD Medical Manual 6002-F Investigative Process, 6002-M Mortality Review Process, 960 Quality of Care Concerns, and 961 Incident, Accident, and Death Reporting. Specific topics are as Follows:

1. Clarification of the Quality of Care Concerns process and the Mortality Review Process described in 6002-M and 960, respectively.
2. Current data on the top 10 causes of death in DDD members.
3. Discussion of the “Fatal Five” preventable conditions. How can these conditions be better addressed in the Person-Centered Service Plans (PCSPs)?
4. How are unexpected deaths handled differently from expected deaths?
5. Clarification on the review of records required after a death: the committee was told that all deaths require a review of records 90 days prior to death. However, the 90-day requirement doesn’t seem to be included in 6002-M or any of the other policies listed above.
6. When are death certificate information and/or autopsy results used in the QOC Concerns and Mortality Review processes?

PERSON CENTERED SERVICE PLAN

One of the responsibilities of the IOC’s is to participate in the Program Review Committee. This committee reviews Behavior Treatment Plans (BTP), which are a part of the Person Centered Service Plan (PCSP). The PCSP was adopted this year following adoption from the requirements of AHCCCS, and should contain the information that was in the previous service document, the Individual Service Plan. While reviewing the BTP, looking for possible violations of Article 9, we also review the PCSP. Upon this review, we have noted consistently that the following was missing, even though it should be included:

Contact Information for the responsible person;
Historical Background;
Individual Goals, Outcomes, and Methodologies;
Rights Restrictions;
Consistency of medications throughout the document;
Spending Plan;
Signatures with Dates, to indicate Informed Consent AND Team Agreement (No contract is complete without signatures.)

We have met with Support Coordination leadership, to express our concerns with this new PCSP, information that is missing from the old document (ISP) and not included in the new PCSP, and the importance of consistency within the document. DDD has told us that they will begin to implement training on how this new PCSP document needs to be completed and its importance in the ongoing record keeping for individuals served by the Division.

ELECTRO-CONVULSIVE THERAPY and DDD INDIVIDUALS

The Division of Developmental Disabilities met with District Central IOC in April to discuss the use of Electro-Convulsive Therapy (ECT). Leah Gibbs presented the following information to us (per the transcribed minutes) :

“Historically, it was known as electric shock therapy. Governmental regulatory involvement in the use of ECT has historically been prohibited for various reasons, including patient advocacy, and prior abuse by the medical community of people with developmental disabilities. This is contributed to heavy regulation, by state administrative codes and regulations.

“We're here today to propose consideration of amending Arizona Revised Statute 36-561. Through legal consultation, it was reported that the original language of the statute passed in 1978 and that this legislation was passed in a much larger piece of legislation, regarding individuals with developmental disabilities. The division believes the statute as it reads, is not reflecting current practice. And was created to protect vulnerable populations from overuse, misuse, and abuse of non-evidence-based medical practices. The division also believes the current statute does not take into consideration. The current clinical indications, based on research and best evidence-based practices, and is considering proposing to amend the statute to present it to the state legislature for approval. Today, the use of electroconvulsive therapy is permitted in certain circumstances and is a covered service under AHCCCS as well as our subcontracted health plans, United Healthcare Community Plan and Mercy Care Plan.

“The Arizona Revised Statute 36-561 is titled “Prohibiting, Certain Treatment and Drugs, Use of Aversive Stimuli” . The language in the statute reads. *‘No psychosurgery, insulin shock or electric shock treatment, or experimental drugs shall be administered by the department to any client. Nor shall the department license, approve, or support any program, or service, which uses such treatment and or drugs. The Department shall adopt rules and regulations specifying. The immersive stimuli used for any developmental disabilities program or service provided directed by licensed or supervised by or supported by the department. Copies of such rules and regulations shall be made available to all parents, guardians, applicants and clients participating in placement evaluations. The Department shall provide at least 60 days' notice to all responsible persons or to implementing any modifications to such rules or regulations. No aversive stimuli shall be used, or permitted by the Department in any such program or service except in accordance with the adopted rules and regulations and the client's individual program plan’.*

“Electroconvulsive therapy today is a medical treatment completed under anesthesia by a team of trained. Medical professionals. When least restrictive options such as therapies and medications have been intolerable or ineffective. It is also used for people who require a rapid response because of the severity of a condition. Electroconvulsive therapy today is much different than it has been in the distant past and is highly regulated and is effective for many psychiatric disorders. For example, People who may be diagnosed with severe depression, especially when accompanied by a detachment from reality, psychosis. Or a desire to commit suicide or the refusal to eat. Another condition would be catatonia. A condition in which a person can become increasingly agitated or unresponsive. Another being treatment resistant. Bipolar

depression and mania And another being schizophrenia. In fact, the first use of electroconvulsive therapy in psychiatry was in the treatment of schizophrenia. Based on clinical observation of persons with epilepsy and schizophrenia also often had an improvement in symptom severity, following a spontaneous seizure treatment guidelines have been developed by the American Psychiatric Association related to its use and these guidelines are supported by the Joint Commission on Accreditation for Health Care Organizations. Also known as JACO. A United states-based nonprofit, tax-exempt organization that accredits US healthcare organizations and programs. The international branch accredits medical services around the world.

“So today the Division has a proposed position. In that position, despite the potential revision, the Division still maintains its position, which is consistent with Article 9 that electroconvulsive therapy cannot be used as abuse, as an aversive intervention, or as an intent to cause physical, or psychological pain, or harm to a member, or as a form of punishment, because of the consequence of the behavior. DDD would like to consider the possibility of using electroconvulsive therapy when clinically indicated and least restrictive treatment options have been exhausted. I have a brief little summary. I'd like to share: “Today electroconvulsive therapy is currently a Medicaid covered service that is evidence-based and is no longer performed in the manner it was used in the past. Currently DDD members who have exhausted all other options are unable to access this option as a form of treatment. Other people in the state of Arizona with these types of psychiatric disorders have access to this treatment. However, this law restricts this option for people with developmental disabilities.” (End of transcribed minutes, from March 2023 as presented by Leah Gibbs)

DDD has since held a meeting with the IOC Chairs, as well as other IOC members who were interested. In this meeting, it was discussed whether the IOC's scope of authority includes ECT Review/Approval, as well as whether or not the IOC should be able to approve this medical procedure for the Individual. If a doctor is requesting/authorizing this procedure, the IOC's are not in a position to determine medically if this is correct. Our only concern is whether the rights of this Individual are being violated, whether through Informed Consent and the following of all procedures which would safeguard the Individual and possible overuse or inappropriate use of this procedure. Therefore, the questions/concerns from District Central IOC remain the same:

DDD has not provided us with any data regarding ECT; such as success rates, long and short term side effects.

We still believe that IF this AZ Statute is changed, it MUST contain wording to the effect that a Doctor's prescription must be presented, how many times the procedure has been used on the individual (to avoid possible overuse), results of previous procedures, and IOC review and approval that all policies (which DDD has not formulated, but which must protect the Individual) have been followed.

If, Per the IOC statute, it is beyond our scope of authority to review this medical procedure, we would request that in addition to the change in legislation for the use of ECT for DDD members, an addition be added to the IOC Statue which includes our ability to review this possible use/misuse of ECT.

988 EMERGENCY/CRISIS PROGRAM

Because many DDD Individuals are referred to Crisis Intervention, we invited Paloma Kwiedacz from the Arizona Crisis System and 988 to explain to us what the 988 Program is and how it involves the DDD Community. We learned that Arizona's Crisis Care Continuum is developed to help draw in all the resources to one place and best serve our citizens. This single hub style network works to minimize the decrease in jail and emergency rooms. The 988 system routes callers based on the area code of their phone number, and currently working on protocols to help transfer callers to a local center in their area. 988 will never replace 911, but is another tool available in case of an emergency. Public marketing began in early 2023, with an evaluation period to begin June 2023.

While much continues to be learned and developed as this new system is introduced and evaluated in Arizona, District Central IOC's issue currently is regarding the fact that 988 system routes call to a center based upon the area code of the phone being used to call in the emergency. In today's society, many people do not have area codes that correspond to an area code in Arizona, and therefore the calls are routed to another state, again, based upon that area code. That does not seem to help the emergency situation in question at the time the call was placed.

MONITORING OF DDD GROUP HOMES

An issue that comes up consistently for District Central IOC is the monitoring of Group Homes. We were notified that a parent of an DDD Member living in a Group Home received a call from the Group Home requesting updated information such as medical records and signatures on the required paperwork because "Monitoring is coming." Additionally, the group home was stocking up on pantry items that are generally not in the home, and cleaning the home in order to pass monitoring inspection. This is not an uncommon occurrence. We have been hearing of incidents like this for many years. We invited DDD to comment on this issue, especially with regards prior notification of monitoring being announced, and why not surprise visits, so DDD can see the Group Home on any given day as it is in a normal daily situation. DDD informed us that prior notification is not given for monitoring, however, because monitoring is an annual occurrence, agencies can generally determine when the monitoring will occur and prepare for that. If there are concerns, an Incident Report can be submitted and DDD can then investigate.

While we notified the parents of this response, District Central knows this is an ongoing concern and should be elevated in order to insure that safety, security, health, and appropriate record keeping is current and in the interest of all individuals living in the home.

MEMBERSHIP OF DISTRICT CENTRAL I.O.C.

This year has been a difficult year for the membership of District Central IOC. Sherry Howard-Wilhelmi was a member of the then Human Rights Committee, which was formed shortly after the “lawsuit” which brought about the de-institutionalization of Arizona. Sherry was working at the Phoenix Institution until it was closed, and then began her numerous years of advocacy for the DDD Individuals. In spite of her many health issues, Sherry participated on many committees, including the Governor’s Council, education groups, championed medical issues and needs, testified at the Legislature, and was tireless in her efforts to defend Article 9 and those served by DDD. She was active in her participation in IOC until her passing in April. She is missed.

Even though a long-time member of our committee, Eduarda Yates passed away in August, 2023, after the ending of this fiscal year, I mention her as well. She too was a member of the Committee from its inception, and was tireless in her efforts to advocate for the educational opportunities for the Individuals served by DDD. Eduarda is missed.

Carol McNulty, after a lifetime devoted to the DDD Community, also retired from our committee. Her recall of the historical rationale which was behind so many of the rules, statutes, Article 9, and implicit understanding of DDD, was so vital to the IOC, especially in the recent years as changes are taking place in the DDD world. I still call on Carol for advice, counsel, and recall, but her attendance in our meetings is missed.

We have also lost Individuals due to conflict of interests they felt were beyond their ability to allow them to serve on IOC, as well as 2 parents whose children’s needs increased and needed to spend more time with them. These individuals are always welcome back, and they, too, are missed.

We are always looking to improve our committee membership, and have called upon the DDD volunteer unit to help us. As we sit in different meetings, or visit with parents who contact us, we invite them to join. We are hopeful, but remain positive, and as always, we remain dedicated to defending and protecting the rights of those Individuals served by the Division of Developmental Disabilities, and whose voice is sometimes not loud enough to be heard.

Respectfully submitted,

Linda S. Mecham
Division of Developmental Disabilities, Independent Oversight Committee Chair