

Access to Treatment Workgroup Report

William D. Sanford, Workgroup Chair

2/25/2016

Chartered in February 2015 by the Mental Health and Recovery Services Board (MHRSB) of Lucas County, the Access to Treatment Workgroup was established to review and make recommendations for improving access to community based mental health and addiction assessment and treatment services in Lucas County. This report contains 20 recommendations for consideration by the MHRSB Trustees.

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Forward

A Message from the Access to Treatment Workgroup Chair

Dear Access to Treatment Workgroup Members;

I want to thank everyone who has participated in the Access to Treatment Workgroup. Over the last 12 months, the process has led to the development of quality recommendations that will provide a roadmap for improved public policy and access to behavioral health care. The fact that several of your recommendations have already been implemented speaks to the importance and quality of your work.

Bad things, including death can happen when people who need behavioral health care cannot obtain assistance when requested. Our mutual goal moving forward must be to work together to ensure quality mental health and recovery services are accessible to every Lucas County resident who needs them. As a system we have to continue to look at ourselves and try new methods to ensure our services connect with those in need.

Thanks again for your participation in this workgroup and your daily commitment to serving one of Lucas County's most vulnerable populations.

Sincerely,

William D. Sanford
Chair, Access to Treatment Committee
MHRSB of Lucas County

Introduction

In an effort to improve the accessibility of quality mental health and addiction services to Lucas County residents with annual earnings below 250% of the federal poverty guidelines, the Mental Health and Recovery Services Board (MHRSB) of Lucas County implemented the following strategies:

- In fiscal year 2013, as a result of Lucas County residents approving a new 1 mill levy for mental health and addiction services, the MHRSB increased funding to its contracted treatment providers to expand treatment capacity.
- In fiscal year 2014, the MHRSB provided additional funding to its contracted treatment providers to again expand treatment capacity for traditional and Medication Assisted Therapy services. The MHRSB funded all dually certified providers to perform both mental health and addiction services. Additionally, the MHRSB expanded its number of contracted addiction treatment providers from 4 to 7 via the AOD Rapid Response Project. Furthermore, Medicaid Expansion began January 1, 2014 further improving access to treatment services for populations earning between 101% and 138% of the federal poverty guidelines.
- In fiscal year 2015, with Medicaid rapidly becoming the primary payer source for treatment services, the MHRSB re-designated a portion of its mental health treatment funding to support services while increasing its AOD treatment funding to ensure treatment capacity continues to expand in the midst of the heroin & opiate epidemic. In September 2014, the MHRSB began discussions regarding additional strategies to reduce delays in obtaining treatment services including the potential re-design of Central Access. In January 2015 the Access to Treatment Workgroup was formed with the first meeting held in February 2015.
- In fiscal year 2016, the Access to Treatment Workgroup concluded its efforts in February 2016. During that period, the MHRSB continued to “right size” the mental health funding to contracted agencies and maintained AOD treatment funding at previous levels. The MHRSB began to implement select recommendations from the Access to Treatment Workgroup. These included creation of a “no wrong door” system of care, increased access to urgent care and expansion of Assertive Community Treatment (ACT) services.

In all, 64 local treatment professionals and stakeholders met 11 times over the last 13 months to discuss and debate how to improve accessibility to mental health and addiction treatment services for the residents of Lucas County. In the end, the Access to Treatment Workgroup developed 20 recommendations that if implemented, could substantially reduce the time it takes an individual to receive care. Recommendations one through eight relate to issues of accessibility; recommendations nine through twelve relate to continuity of treatment services; recommendations thirteen through sixteen relate to inclusion and health equity; and recommendations seventeen through twenty relate to MHRSB policy and administration. A summary of the recommendations and their justification follows.

Recommendations

1. The MHR SB should establish a “No Wrong Door” access system into the public AOD/MH system where individuals seeking treatment services can be assessed and receive a meaningful treatment service within 48 hours of seeking services.
2. Detoxification, residential, IOP, and MAT should be available for youth and adults upon identification of need. In the event the assessed level of care is not available within 48 hours, agencies should support the consumer by providing “interim treatment services.”
3. Agencies unable to provide treatment services within 48 hours of initial contact with the consumer should “warm transfer” the consumer to a provider who can deliver the service within 48 hours. Transferring agency should provide support to the consumer during the transfer period.
4. Implementation of the Recovery Helpline must include: system’s level training, transparent reporting processes, promotion of both the 211 and the 1-800 numbers; clear articulation that it is not an emergency hotline, and a strategy for improving treatment capacity.
5. The MHR SB should develop a systemic process for tracking the impact of client choice on treatment service access.
6. Access to routine and urgent treatment services needs improvement, including access to afterhours and weekend treatment services at all treatment agencies.
7. The MHR SB should develop a strategy to work collaboratively with the treatment providers to improve access to prescriber services immediately upon identification of need.
8. Assertive Community Treatment (ACT) teams should be available to high-need consumers at all community mental health centers.
9. All agencies should commit to the sharing of client level data via the Ohio Health Information Exchange Program or similar.
10. Rescue Emergency Services Staff and Hospital Psychiatric Unit staff should have 24 hours per day, 7 days per week ability to schedule intake appointments at provider agencies.
11. Treatment providers should be notified when a current client is arrested and/or held in the Lucas County Corrections Center or Correction Center of Northwest Ohio. MHR SB billing rules should be modified to allow for the provision of community psychiatric supportive treatment (CPST) and case management services for discharge planning purposes within the last 30 days of their incarceration.
12. Case closures, discharges and re-admission processes need to be clearly defined by agency policy.
13. MHR SB should take the following actions to improve inclusion; provide access to training on the Culturally and Linguistically Appropriate Service (CLAS) Standards and serving

individuals who identify as LGBTQQIA; develop a strategy to provide consistent translations services 24 hours per day, 7 days per week at all contracted providers; and require relevant and pertinent treatment documents to be available in Spanish, Arabic and Chinese, at a minimum.

14. The MHR SB Quality Committee should review and recommend system wide data collection needs for youth and adults with a special emphasis on improving data collection efforts to support increased investments directed toward the LGBTQQIA communities.
15. A standardized orientation process should be developed and implemented across all MHR SB funded entities for consumers referred from the Lucas County Board of Developmental Disabilities, including establishing clearly defined roles and expectations between systems.
16. The MHR SB should develop a process to orient all health workers on adult and youth services provided throughout the MHR SB system of care.
17. The MHR SB should revise its treatment services benefit service limits to equal comparable behavioral health service limits for Medicaid recipients.
18. The MHR SB should repeal its Waiting List Policy until after the legislature provides clarity on the process or until September 15, 2016 whichever comes first.
19. The Access to Treatment Workgroup should be retained and meet on a regular basis to provide input into the implementation of the recommendations, including providing guidance regarding implementation of the Recovery Helpline and Urgent Care Center.
20. All MHR SB policies should be reviewed and revised to assure alignment and agreement with the recommendations listed above.

Discussion

Accessibility

1. The MHR SB should establish a “No Wrong Door” access system into the public AOD/MH system where individuals seeking treatment services can be assessed and receive a meaningful treatment service within 48 hours of seeking services.
2. Detoxification, residential, IOP, and MAT should be available for youth and adults upon identification of need. In the event the assessed level of care is not available within 48 hours, agencies should support the consumer by providing “interim treatment services.”
3. Agencies unable to provide treatment services within 48 hours of initial contact with the consumer should “warm transfer” the consumer to a provider who can deliver the service within 48 hours. Transferring agency should provide support to the consumer during the transfer period.

Justification 1-3: A review of the MHR SB Access Flowchart identified that an individual seeking routine mental health treatment services and routed through Central Access would receive their first billable treatment services at a treatment provider between 28 and 43 days after first requesting care. Individuals seeking routine AOD services and routed through Central Access would receive their first billable treatment services at a treatment provider between 12 and 20 days after first requesting care. There were obvious time variations between agencies and levels of routine. To address the delay in receiving care, it was agreed that while Central Access had some positive attributes, in a post Medicaid Expansion world, a centralized model was an unnecessary additional and costly step to receiving care. With the full impact of Medicaid Expansion being realized, it was recognized that most individuals seeking treatment services should have access to some level of insurance coverage via Medicaid or the Health Insurance Marketplace. Continuing to direct this group of individuals to Central Access failed to account for changes related to payer sources and unnecessarily limited client choice. Finally, there wasn’t a clear pathway in which someone could receive supportive services during the interim waiting period between a Central Access assessment and an agency’s intake. Removing Central Access from the assessment and referral process and implementing a No Wrong Door system of care will reduce the waiting period for mental health and/or addiction treatment services, ensure a full utilization of payer options and clearly establish a line of responsibility at the agencies for pre-treatment engagement activities.

4. Implementation of the Recovery Helpline must include: system’s level training, transparent reporting processes, promotion of both the 211 and the 1-800 numbers; clear articulation that it is not an emergency hotline, and a strategy for improving treatment capacity.

Justification 4: The Access to Treatment Workgroup reviewed the proposed Recovery Helpline model and identified that systemic training would be required to “retrain” the referral sources and provider network on how the referral process would work. There was a desire to have a public “dashboard” for how referrals were being distributed to document improved accessibility. Additionally, a concern was raised over how United Way’s 211 system processed cell phone calls with out of region area codes. Evidently, those calls would be diverted to their regional area code 211 system (if developed) even though the person may

have relocated to the Toledo region. It was recommended that a 1-800 number also be advertised. The workgroup was also concerned about the Recovery Helpline causing confusion with existing emergency/crisis lines established at Rescue and Behavioral Connections, recommending a clear delineation between the two lines. Finally it was recognized that the helpline may attract more people to seek treatment services and capacity would eventually become an issue. The workgroup members wanted the MHRSB to develop a strategy for how increased capacity issues may be resolved.

5. The MHRSB should develop a systemic process for tracking the impact of client choice on treatment service access.

Justification 5: The Access to Treatment Workgroup agreed that if the MHRSB is going to establish policy that support access to treatment services, the development of interim services or the warm transfer of individuals to other providers because of a lack of access within 48 hours, the MHRSB must recognize the role that client choice has on the agency's ability to meet the 48 hour requirements. Specifically, data received from Central Access that tracked the length of time between Central Access assessment and agency intake found that access was often delayed due to client choice. Referral data was tracked by the MHRSB from July 2015 through November 10, 2015 in cooperation with Rescue Central Access. During that period of time, 399 referrals for treatment services were made; 171 (43%) received an intake appointment at an agency within 48 hours, 228 (57%) did not. Of those 228, client choice was referenced in the delay of access 72 times representing 32%. Given the substantive impact that client choice can have on accessibility, the Workgroup believes it needs to be taken into account.

6. Access to routine and urgent treatment services needs improvement, including access to afterhours and weekend treatment services at all treatment agencies.

Justification 6: Over the course of the many discussions regarding access to care, Access to Treatment Workgroup members recognized that limiting accessibility to business hours had a profound effect on a consumer's need for an increased level of care. Additionally, the system lacked a mental health treatment intervention between routine care and hospitalization that very likely increased the need for crisis stabilization and hospitalization services. It was agreed that expanded hours of service, weekend access and urgent care services need to be available and easily accessible.

7. The MHRSB should develop a strategy to work collaboratively with the treatment providers to improve access to prescriber services immediately upon identification of need.

Justification 7: It is universally accepted that the length of time for an individual to obtain psychotropic medications at any of the community mental health centers is too long, often over 60 days. Zepf Center and Unison have "walk-in" clinics and at the time this recommendation was made, Harbor was considering the option. While exemplary, the "walk in" clinic model has capacity limitations that often result in decompensating consumers accessing higher levels of care. While the shortage of prescribers is well documented, the Access to Treatment Workgroup believes that a collaboratively implemented systemic solution should be considered. These may include: working with our UTMC, Wright State and OSU to attract graduating psychiatrists to the area; more effectively utilizing tele-

psychiatry services; and implementing proven effective methodologies for improving prescriber practices, such as “Just in Time” and “Same Day Access” prescribing methods and software.

8. Assertive Community Treatment (ACT) teams should be available to high-need consumers at all community mental health centers.

Justification 8: The Access to Treatment Workgroup members discussed factors related to discharge, case closure and re-admission. It was noted that there are several dozen consumers that float from agency to agency because of their aggressive and threatening behaviors. There is a similar group that cycles through emergency shelters and hospital emergency rooms on a weekly basis. The group recognized the difficulty in quantifying this population but understood that intensive programming for this population was limited. The workgroup also recognized that 8.5% of the individuals booked in the Lucas County Corrections Center make up 23% of all bookings. Of those 1,000 individuals, nearly 67% had involvement in the behavioral health system. As the criminal justice system reforms the manner in which individuals are recommended for pretrial release, more intensive mental health programming needs to be available to break the cycle of arrest and re-incarceration with this select group. The Access to Treatment Workgroup agreed that Unison’s PACT program was very successful in addressing this issue and recommended that ACT programming should be expanded and available at all community mental health centers.

Continuity

9. All agencies should commit to the sharing of client level data via the Ohio Health Information Exchange Program or similar.

Justification 9: The establishment of the No Wrong Door system of care and the potential development of the Recovery Helpline, increased opportunity for consumer mobility between agencies brought about by Medicaid Expansion, and the opportunity to re-invent the system’s relationship with the area hospitals to improve consumer care would suggest that the sharing of consumer level data between public and private providers is more important than ever before. Central to improving the consumer’s experience is maintaining continuity of care. Therefore, data sharing mechanisms must be established. Local efforts by the MHR SB to encourage agency level participation in the Ohio Health Information Exchange Programs has been met with mixed results as only two entities have agreed to participate (Rescue and Zepf). It is hopeful that a beneficial experience will be documented and used to encourage other providers to participate. In the meantime, all providers with an electronic health record should be encouraged to participate.

10. Rescue Emergency Services Staff and Hospital Psychiatric Unit staff should have 24 hours per day, 7 days per week ability to schedule intake appointments at provider agencies.

Justification 10: The Access to Treatment Workgroup discovered that consumers who have been stabilized after experiencing psychiatric distress would benefit if Rescue’s emergency services staff and Hospital Psychiatric Unit staff could schedule intake appointments at provider agencies 24 hours per day/ 7 days per week. It was identified that the private physicians staffing the private hospital psychiatric units often hold consumers ready for discharge over the weekend because of the inability to link consumers with follow up

appointments at the community mental health centers. It was felt that this process contributes to the lack of private and public hospital psychiatric beds available, specifically over the weekend, and often results in individuals experiencing psychiatric emergencies remaining in emergency departments and/or Rescue's Emergency Services area for a prolonged time. Furthermore, Rescue's Emergency services staff currently do not "warm transfer" consumers to a CMHC while in the field due to a lack of access to appointment times. It is likely the Recovery Helpline may resolve some or all of these issues depending on organizational participation.

11. Treatment providers should be notified when a current client is arrested and/or held in the Lucas County Corrections Center or Correction Center of Northwest Ohio. MHR SB billing rules should be modified to allow for the provision of community psychiatric supportive treatment (CPST) and case management services for discharge planning purposes within the last 30 days of their incarceration.

Justification 11: In addition to chronicity in which individuals with mentally illness or addictions are arrested and detained as previously discussed in the justification section for recommendation #8, a point in time study was conducted of individuals held in the Lucas County Corrections Center on an average day. Of the 502 names of those incarcerated were cross referenced with MHR SB treatment billing information to determine the percentage of those individuals in detention who have received a treatment service; 1) over their lifetime; 2) over the last 5 years; 3) within the last 6 months. It was determined that 67% had received a behavioral health service over their lifetime, 48% had received services within 5 years and 18% had received a service within the last 6 months. Understanding the density of the treatment population represented in the criminal justice system, the Access to Treatment Workgroup believes that a more robust process for engaging current consumers prior to release from detention should be considered. It was discovered that CMHC staff occasionally visit incarcerated consumers at the Lucas County Correction Center when they are aware of the consumer's incarceration. It was less likely, but not unheard of, that the agency would visit the Correction Center of Northwest Ohio. CMHCs were aware that they could bill their current Board contracts when doing so. However, this same benefit does not exist for AOD service providers. It was recommended that this benefit be extended to case management services and that a mechanism is established whereby providers can be notified when a current consumer has been arrested and detained at either facility.

12. Case closures, discharges and re-admission processes need to be clearly defined by agency policy.

Justification 12: The Access to Treatment Workgroup members agreed that there are differences between case closures and discharges and each should be clearly defined by the individual agency's policies. Closures were typically characterized by a failure to remain engaged in services with absences often exceeding 90 days and no identifiable effort on the individual's part to remain in care. On the other hand, discharges are typically characterized by a consumer's actions while in care. The workgroup did identify that specific policy language at each agency defining case closure and discharge was not available. They agreed that each agency should define in policy (to the extent possible) the circumstances that may lead to case closure and discharges as well as a re-admission process.

Inclusion

13. MHR SB should take the following actions to improve inclusion; provide access to training on the Culturally and Linguistically Appropriate Service (CLAS) Standards and serving individuals who identify as LGBTQQIA; develop a strategy to provide consistent translations services 24 hours per day, 7 days per week at all contracted providers; and require relevant and pertinent treatment documents to be available in Spanish, Arabic and Chinese, at a minimum.
14. The MHR SB Quality Committee should review and recommend system wide data collection needs for youth and adults with a special emphasis on improving data collection efforts to support increased investments directed toward the LGBTQQIA communities.

Justification 13-14: The Access to Treatment Workgroup discussions confirmed that agencies have processes in place to provide translation services as needed. However, each organization has its own way of providing these services. The logistics behind scheduling these services is often very difficult and not consumer focused. The workgroup also conceded that little training regarding how to implement the CLAS Standards has occurred at the agency level. Finally, few organizations confirmed that pertinent documents were available in languages other than English. The Access to Treatment Workgroup understood that the MHR SB established Diversity Workgroup would provide recommendations for improving systemic inclusion, diversity and health equity training opportunities and wanted to support those recommendations. It was also recognized that data collection related to special populations needs improvement so that additional investments can be justified.

15. A standardized orientation process should be developed and implemented across all MHR SB funded entities for consumers referred from the Lucas County Board of Developmental Disabilities, including establishing clearly defined roles and expectations between systems.

Justification 15: The Lucas County Board of Developmental Disabilities estimates that approximately 30% of its population of 5,000 Lucas County residents receives behavioral health services from an MHR SB contracted provider. It was recognized that the service model that the Lucas County Board of DD currently utilizes is changing and private contractors are consuming a larger proportion of the work load. As such, closer and consistent collaboration between behavioral health providers and the Board of DD is desired. The Workgroup believed that improved consumer focused communications would be beneficial.

16. The MHR SB should develop a process to orient all health workers on adult and youth services provided throughout the MHR SB system of care.

Justification 16: The Access to Treatment Workgroup universally agreed that a person's physical and behavioral health outcomes are interconnected. Generally, it is believed that the average health care worker has little knowledge of the MHR SB system of care or how to link patients to behavioral health care. This lack of knowledge can inhibit accessibility to behavioral health services which often negatively impacts physical health outcomes for the individuals. The Access to Treatment Workgroup believes that increased outreach to the health care professionals regarding the MHR SB system of care and accessibility options are warranted.

Policy and Administration

17. The MHR SB should revise its treatment services benefit service limits to equal comparable behavioral health service limits for Medicaid recipients.

Justification 17: Since July 2014 the MHR SB has strived for integration and equity between mental health and addiction treatment benefit limitations, regardless of payer source. While the current treatment service limits in the MHR SB benefit package for mental health services is more robust than the service limits in the Medicaid benefit package, the opposite is true for AOD benefits. However, expansion of Medicaid has largely resolved the issue of unequal AOD service limits with few exceptions. These exceptions include intensive outpatient services, individual counseling, case management and urinalysis. It was recognized by the Workgroup that the limitations were established prior to the Heroin and Opiate epidemic as well as Medicaid Expansion and the passage of the new 1 mill levy in 2012. Given the intensity of treatment needs and evolution of treatment approaches that now include MAT services for individuals with Heroin and Opiate addictions, and the availability of additional funds, the MHR SB AOD benefit service limits appear outdated. Conversely, this recommendation also places limitations on current MHR SB funded mental health treatment benefits that previously were not imposed. The Access to Treatment Workgroup believes that the impact to mental health consumers is negligible and recommends the MHR SB behavioral health services limits should be consistent with Medicaid benefit service limits.

18. The MHR SB should repeal its Waiting List Policy until after the legislature provides clarity on the process or until September 15, 2016 whichever comes first.

Justification 18: The Access to Treatment Workgroup supported repealing the MHR SB's Waiting List Policy. This policy was drafted to meet state requirements as established in the 2015/2016 state budget bill for reporting waiting lists related to individuals seeking Heroin/Opiate related services. The MHR SB policy was intended to be implemented in June of 2014, but local implementation wavered as questions regarding state support materialized. Recent discussion driven by OMHAS, OACBHA and a number of provider agency associations suggests that changes will be made to the legislation prior to its required implementation date of September 15, 2016. It is practical to wait and implement the final legislation.

19. The Access to Treatment Workgroup should be retained and meet on a regular basis to provide input into the implementation of the recommendations, including providing guidance regarding implementation of the Recovery Helpline and Urgent Care Center.

Justification 19: The Access to Treatment Workgroup believes that provider and community stakeholder input is key to successful implementation of the MHR SB approved recommendations and major MHR SB funded initiatives such as the Recovery Helpline and Urgent Care Center. As such, it is recommending the continuation of the workgroup to provide guidance and feedback on the implementation of the initiatives and recommendations.

20. All MHRSB policies should be reviewed and revised to assure alignment and agreement with the recommendations listed above.

Justification 20: To institutionalize the recommendations as approved by the MHRSB Trustees, the Access to Treatment Workgroup is recommending a revision of all related policies and procedures related to the approved recommendations.

Participant List

ACCESS TO TREATMENT WORKGROUP ATTENDANCE

NAME	FEB 2015	MAR	APR	MAY	JUN	AUG	SEPT	OCT	NOV	DEC	FEB 2016
Bill Sanford, MHR SB Member/Chair of Workgroup	1	1	1	1	1		1		1	1	1
Scott Sylak, MHR SB Executive Director	1	1	1	1	1	1	1	1	1	1	1
Dr. Siva Yechoor, MHR SB Medical Director						1	1	1	1		
Tom Bartlett, MHR SB Staff	1	1	1	1	1	1	1	1	1	1	1
Tim Goyer, MHR SB Staff	1		1		1	1	1	1	1	1	1
Karen Olnhausen, MHR SB Staff	1	1				1	1	1	1	1	
Amy Priest, MHR SB Staff	1		1	1	1			1	1	1	1
Cami Roth Szirotnyak, MHR SB Staff	1	1	1	1			1	1			
Dr. Mary Gombash, MHR SB Member	1	1		1	1	1	1	1	1	1	1
Linda Howe MHR SB Member		1									
Kyle Schalow, MHR SB Member	1	1		1	1						
Sgt. Chris Curley, LCSO	1	1					1				
Jane Moore, United Way	1	1	1	1	1	1	1		1		1
John DeBruyne, Rescue			1	1							
Jason Vigh, Rescue			1		1	1					
Carole Hood, Rescue			1								1
Jessi Broz, Rescue	1	1	1	1	1	1	1	1	1		
Merisa Parker, Rescue						1	1	1	1		1
Ashley Kopaniasz, Unison	1	1		1		1	1				
Marsha Elliott, Unison	1	1	1	1	1	1		1	1		1
William Talbot, LCSO	1	1									
Robin Isenberg, NAMI	1	1		1					1		
Barb Gunning, TLCHD			1								
Rebecca Anderson, TLCHD	1	1	1	1	1	1		1			
Lindsey Rodenhauser, TLCHD – Intern					1						
Jim Schultz, Harbor			1								
Theresa Butler, Harbor	1	1		1	1			1			1
Jim Aulenbacher, Harbor	1					1	1	1	1		
Janice Edwards, New Concepts				1					1	1	1
LaShanna Alfred, New Concepts	1		1	1	1		1		1		
Johnetta McCollough, TASC	1		1	1	1	1	1	1	1		1
Mike Zenk, TMC	1					1					
Eddie Norrils, TMC	1										

No meetings held in July 2015 and January 2016.

ACCESS TO TREATMENT WORKGROUP ATTENDANCE

NAME	FEB 2015	MAR	APR	MAY	JUN	AUG	SEPT	OCT	NOV	DEC	FEB 2016
Christina Rodriguez, A Renewed Mind	1		1	1	1	1	1		1	1	
Wendy Shaheen, A Renewed Mind				1							
Jennifer Riha, A Renewed Mind				1							
Deb Angel, Recovery Council	1	1	1	1	1	1	1		1	1	1
Ed Speedling, Harbor	1			1							
Shelly Ulrich, YWCA	1	1		1	1	1		1	1		
Kathy Didion, Zepf Center		1	1	1	1	1					
Angela Hendren, Zepf Center				1	1		1				
Lisa Faber, Zepf Center						1		1	1		1
Michelle Hurless, Zepf Center							1				
Julia Bryant Bey, Zepf Center									1		
Jason Langlous, LCSO		1									
Jan Ruma, HCNO/CareNet		1	1		1	1					
Renee Palacios, Family House		1									
Audrey Davis, Family House					1						
Shawn Dowling, VA		1									
Kim Krieger, LCBDD				1	1	1			1		
Jennifer Wolfe, LCBDD								1			
Tamika Butler, New Concepts									1		
Kimberly Pullom, New Concepts										1	
Dennis Whaley, DART				1							
Chris Henthorn, Salvation Army					1						
John Edwards, Jr., UMADAOP					1						
Pam Myers, Unison										1	
Nichole Monahan, UTMIC						1					
Meg Naparstek, UTMIC						1	1				
Lilian Briggs, TSN/PHP								1	1	1	
Courtney Billian, TSN/PHP								1		1	
Tiffany Runion, TSN/PHP								1			
Walter Wehenkel, Unison											1
Total Participants - 63	27	24	21	28	26	24	20	21	25	14	16

No meetings held in July 2015 and January 2016.