

MHR SB GOVERNANCE COMMITTEE MEETING

April 12, 2016

4:00 p.m.

Agenda

Item	Information Enclosed	Action Required	Allocation Required	Page
1. Call to Order				
2. Recognition of Visitors				
3. Meeting Minutes: March 8, 2016	✓	✓		1-2
4. Governance Policies Revisions:				3
➤ Board Committees and Sub-Committees	✓	✓		4
➤ Board, Committee and Sub-Committee Meetings	✓	✓		5-6
5. MHR SB Committee Charters:	✓	✓		7
➤ Governance				8
➤ Planning & Finance				9
➤ Programs & Services				10
6. Strategic Plan Update	✓	✓		11
7. Diversity Workgroup Report (Separate Attachment)	✓	✓		12 (1-22)
8. Open Session				
9. Adjournment				

GOVERNANCE COMMITTEE MEETING MINUTES**March 8, 2016**

Governance Committee Members Present:

Audrey Weis-Maag	Pastor Perryman	Neema Bell
Linda Alvarado-Arce	Linda Howe	Tony Pfeiffer

Governance Committee Members Not Present:

Dr. Tim Valko	Lynn Olman	Andre Tiggs
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Staff: Scott Sylak, Tom Bartlett, Donna Robinson, Delores Williams.

Visitors: Richard Arnold; Paul Lewis, Recovery Council; Joshua Kenagy, BBBS; Deb Chany, SCAT; Tryna Sanders, SORC, LLC; Deb Angel, Recovery Council; Adam Nutt, Zepf Center; Geof Allan, UMADAOP.

Ms. Bell opened the meeting at 4:00 p.m., with introduction of visitors.

Minutes of Meeting – February 9, 2016

There was consensus to approve the minutes as presented.

MHR SB Committee Appointments

Mr. Sylak indicated that Chief George Kral was appointed on February 16, 2016 by the Lucas County Commissioners and stated that he will be sworn in as a County appointed MHR SB Board member at the March 15, 2016 Board meeting. Chief Kral was recommended for appointment to the Planning & Finance Committee effective April 5, 2016. In addition, Jim Stengle was appointed by the County Commissioners on February 16, 2016, and he will be sworn in at the August 2016 Board meeting. It was recommended that Mr. Stengle be appointed by the Chair to the Planning & Finance Committee as a non-trustee effective April 5, 2016, with a transition to trustee membership in August 2016 when he takes the Oath of Office.

Ms. Bell approved the appointments of Chief Kral and Jim Stengle to the Planning & Finance Committee, effective April 5, 2016.

MHR SB Policy Update – Governance and Public Affairs

Mr. Sylak stated that in accordance with the 3-year policy review cycle, nine of the Governance Policies and three Public Affairs policies were reviewed at the January 12, 2016 Governance Committee meeting, and the remaining four Governance policies were reviewed at the February 9, 2016 Governance Committee meeting with minor revisions requested by the Committee. The 20 Governance/Public Affairs policies were included on pages 9-45 of the meeting packet for the Committee's consideration. Mr. Sylak reviewed the four remaining Public Affairs Policies listed on page 7 of the meeting packet. Below is a summary of feedback provided by the Governance Committee:

The Committee requested that the Board staff create a log for individuals who request access to a public record in accordance with the Public Access to Board Records policy and include language of how documents are delivered to individuals requesting a public record.

GOVERNANCE COMMITTEE MEETING MINUTES

March 8, 2016

Ms. Bell asked if the Board widely publicizes community forums through social, television and print media. Mr. Sylak replied that the MHR SB doesn't advertise through television; therefore, the Committee recommended changing the language in the Community Forums Policy under Procedure B to state: "...widely publicized prior to the scheduled meeting date."

Ms. Weis-Maag referred to the Consumer Recommendations and Advice Policy on page 25 of the meeting packet in reference to Procedure 1 that removes the Recovery Council Chair from the P&S Committee, asking for clarification of how consumer input will be provided. Mr. Sylak stated that to fully comply with the Ohio Public Meetings Laws he has recommended a change in how certain committees are formed. Information from the Recovery Council is a single mechanism of many that we use to obtain consumer input. It's no secret that this group has struggled with attendance, maintaining leadership and meeting the requirements of its Charter. It is clear that change needs to occur, and Mr. Sylak plans to work with a core group of Recovery Council members to define what a new structure might look like. In any event, the proposed changes to the policies do not prohibit Recovery Council membership on the P&S Committee, nor does it eliminate its input.

Following extensive review of the Letters of Endorsement Policy, the Committee requested that the language "ballot initiative" be removed from the policy leaving it open for the Board to decide in the future what position, if any, the Board would take on future ballot initiatives.

Board staff recommended approval of the 20 Governance and Public Affairs policies, and presented the following motion for consideration:

The Mental Health & Recovery Services Board of Lucas County approves the Governance and Public Affairs Policies contained in the Board packet effective April 1, 2016.

There was consensus to move it forward to the Board of Trustees.

Open Session

- Mr. Arnold said that historically, the MHR SB has had consumer representation on the Programs & Services Committee; he expressed concern with the proposed Consumer Recommendations and Advice Policy/Procedure revisions that would change the procedure of having the Executive Director provide regular reporting of consumer feedback to the P&S Committee instead of through a mental health/addiction consumer committee representative.
- Ms. Angel referred to the Executive Director Responsibilities and Duties Policy on page 16 of the meeting packet, indicating that mental health or "alcohol or drug addiction" language listed in several places throughout the policy. The Committee recommended that the words: "alcohol or drug" be removed and replaced with "addiction services" throughout the policy in accordance with ORC language requirements.

Adjournment

The meeting was adjourned at 5:07 p.m.

Governance Policy Revisions

At the March 15, 2016 Board meeting, 20 policies related to Governance and Public Affairs were approved with revisions. Over the course of implementing these newly revised policies, Board staff has identified a potential problem with the manner in which a quorum is being defined at the Committee level that needs to be resolved. As currently stated, a quorum for the Board, Committees and Sub-committees is defined as over one-half of the present membership appointed and/or duly sworn into office.

The potential problem emerges related to voting and membership. Current policy restricts voting rights and membership for the Board to Trustees only. Additionally, sub-committee membership and voting rights are open to MHRSB Trustees and non-Trustees alike. In regard to committees, membership is open to Trustees and non-Trustees, and under current policy, over one-half of all members count toward establishing a quorum. However, current policy also restricts voting rights to Trustees only, thereby setting up a potential conflict where a committee could have a quorum of total members, but potentially only a limited number of Trustees that could actually vote to conduct business. While this is not an issue at this moment in time, Board staff is recommending a modest change in the way a quorum is defined to resolve any potential issues into the future. The recommended change impacts the following two policies (see attached revisions):

- Board Committees and Sub-Committees
- Board, Committee, and Sub-Committee Meetings

The following motion is presented for the Board's consideration:

The Mental Health & Recovery Services Board of Lucas County approves the Board Committees and Sub-Committees, and Board, Committee, and Sub-Committee Meetings Policies contained in the Board packet effective May 1, 2016.

**MENTAL HEALTH & RECOVERY
SERVICES BOARD OF LUCAS COUNTY**

Board Committees and Sub-Committees

COQ: VI-A.1
Effective: ~~4-1-16~~5.1.16
Supersedes: ~~10-16-124-1-16~~

POLICY

The Mental Health and Recovery Services Board (MHRSB) of Lucas County will establish a Governance Committee, Planning and Finance Committee and Programs and Services Committee. Additional committees may be established at the MHRSB's discretion.

Sub-committees may be established at the discretion of the convening committee as determined appropriate. Each committee or sub-committee will be established at a meeting of the MHRSB or convening committee, by a simple majority vote of its voting members in attendance; a quorum being duly constituted.

For each MHRSB committee or sub-committee established, the MHRSB or convening committee will develop and approve a charter that will define the following: Name, Leadership Structure, Purpose, Authority, Scope of Responsibilities, Decision Making Process, Membership Requirements, and Duration.

Each committee or sub-committee will adhere to its charter as established by its convening authority. Each active committee and sub-committee's charter will be reviewed and considered for renewal by the MHRSB or convening committee at least once every two years.

ACCOUNTABILITY

MHRSB Chair

Approved By:

Scott A. Sylak, Executive Director

Date

**MENTAL HEALTH & RECOVERY
SERVICES BOARD OF LUCAS COUNTY**

	COQ: VI-A.1
	Effective: 4-1-16
	5-1-16
Board, Committee and Sub-Committee Meetings	Supersedes: 10-16-124-1-
<u>16</u>	

POLICY

The Mental Health and Recovery Services Board of Lucas County will follow a clearly defined procedure for conducting its public meetings in accordance with ORC 121.22. All meetings of the MHR SB, MHR SB established committees and their sub-committees are public meetings.

Board, Committee and Sub-Committee Meetings:

A. Meetings and Quorum:

The Board shall meet at least six times a year, while Committees and Sub-Committees will meet as defined within their approved charter. A quorum for Board, Committee and Sub-Committee meetings is defined as over one-half of the voting present membership in attendance as appointed and/or duly sworn into office.

B. Order of Business and Record of Proceeding:

Meetings shall proceed according to an agenda prepared by the Chairs of the Board, Committee or Sub-Committee in cooperation with the Executive Director or the Executive Director's designee. Such agendas, together with the supporting data, shall be made available via electronic media to all Board, Committee and Sub-Committee members and anyone who requests notice prior to the meeting. At the discretion of the Executive Director, agendas and supporting data may be sent via regular mail to requesting parties. Board meeting minutes will be kept by the Secretary or their designee. Committee and Sub-Committee meeting minutes will be kept by a Board staff member designated by the Executive Director.

C. Meeting Protocol:

Member discussion on a Board motion will begin only after the Board motion has been seconded by another Board member. Before a Board member can speak on a motion, he/she must be recognized by the Chair. The floor does not pass from person-to-person, but must go through the Chair. Each speaker must be recognized by the Chair. All discussions of a motion must be directed to the Chair. The Chair may impose a time limit of three minutes for each member speaking to a motion. Once discussion has taken place on the proposed Board motion, a polling of all Board members will commence unless the Board member who placed the motion on the floor withdraws the motion and the seconding Board member agrees on the withdrawal. Members must be present to cast a

**MENTAL HEALTH & RECOVERY
SERVICES BOARD OF LUCAS COUNTY**

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<u>16</u>	

vote on a Board motion. Committee and Sub-Committee decision making will be made in the same manner, except that all recommendations made by a sub-committee vote must be forwarded to its convening committee, and if approved by that committee, the motion will be forwarded to the MHR SB for consideration. Committee recommendations are not considered binding without final approval of the MHR SB.

D. Visitor Participation:

Each meeting will provide an open session for the purpose of soliciting comments from visitors. The Chair will address the visitors and request that any person wishing to address the body shall:

1. Identify himself or herself;
2. Identify the group for which he/she is the spokesperson;
3. Identify each issue if there is more than one issue on which he/she wishes to speak.

Each person who has identified himself/herself will be allowed to speak during the open session of the agenda for a maximum of three minutes per issue. A new issue brought up by a visitor may not be considered by the Board, Committee or Sub-Committee. At the discretion of the MHR SB or Committee Chairs, issues brought up by visitors, may be forwarded to the Executive Director for follow up. Sub-committee Chairs may forward information to their convening committee for consideration. The Chair reserves the right to recognize visitors during other parts of the Board Committee, or Sub-Committee proceedings if he/she believes the visitor's comments would be pertinent to the motion or business being considered.

ACCOUNTABILITY

MHR SB, Committee and Sub-Committee Chairs

Approved:

Scott A. Sylak, Executive Director

Date

MHRSB Committee Charters

According to the Board Committees and Sub-Committees Policy recently approved, the MHRSB will approve a charter for each committee established under its authority. The approved Charter will include: name of the committee, leadership structure, purpose, scope of responsibility, authority, decision making process, membership requirements and duration. To comply with the Board Committees and Sub-Committees Policy, Board staff is presenting the attached draft Charters for the Governance, Planning & Finance, and Programs & Services Committees for review and approval.

The following motion is presented for the Board's consideration:

The Mental Health & Recovery Services Board of Lucas County approves the Governance, Planning and Finance, and Programs and Services Committee Charters contained in the Board packet effective May 1, 2016.

Governance Committee Charter

April 19, 2016

Leadership Structure: The Chair and Vice Chair of the Governance Committee will be the elected Chair and Vice Chair of the MHR SB. In the absence of the Committee Chair, the Vice Chair will assume leadership of the Committee. Chair and Vice Chair terms will be the same as their Board officer terms.

Authority: Ohio Revised Code Chapter 340 assigns the Mental Health and Recovery Services Board of Lucas County statutory responsibility for the planning, funding, implementation, monitoring and evaluation of prevention, treatment and recovery support services within the county. In performing its duties, the Board may establish such rules, operating procedures, standards and by-laws, and perform such other duties as may be necessary or proper to carry out the purposes of ORC Chapter 340. The Governance Committee was established under this authority by the Mental Health and Recovery Services Board of Lucas County.

Purpose and Scope: The Governance Committee will provide oversight for the implementation of the Strategic Plan, ensure the vision and mission of the organization is being fulfilled, evaluate the Executive Director and provide guidance on personnel related matters, policies and community relations.

Decision Making Process: The Governance Committee will make decisions by simple majority vote of its voting members, a quorum being duly constituted. A quorum will be defined as over one-half of voting members in attendance. Recommendations approved by the Governance Committee will be presented for final approval to the MHR SB at a regular or special meeting of the Board.

Membership: Membership of the Governance Committee is defined in MHR SB policy as the MHR SB Chair, Vice Chair, Treasurer, Secretary, Immediate Past Chair (if still a Trustee), Chair and Vice Chair of the Programs & Services and Planning & Finance Committees.

Duration: The Charter will be reviewed and considered for renewal by the MHR SB at least once every two years.

Schedule: The Governance Committee will meet: 1) At the discretion of the Chair, but at least once every three months, with proper public notice required; 2) At the request of any two Governance Committee members with voting privileges and proper public notice required.

Planning & Finance Committee Charter

April 19, 2016

Leadership Structure: The Chair and Vice Chair of the P&F Committee will be approved by a simple majority vote of the MHRSB Trustees at a regularly scheduled meeting of the MHRSB, a quorum being duly constituted. In the absence of the Committee Chair, the Vice Chair will assume leadership of the committee. Only MHRSB Trustees may serve as the Chair or Vice Chair of the P&F Committee. Chair and Vice Chair terms will be for two years beginning July 1, and Trustees may not occupy the same committee office for more than 48 consecutive months.

Authority: Ohio Revised Code Chapter 340 assigns the Mental Health and Recovery Services Board of Lucas County statutory responsibility for the planning, funding, implementation, monitoring and evaluation of prevention, treatment and recovery support services within the county. In performing its duties, the Board may establish such rules, operating procedures, standards and by-laws, and perform such other duties as may be necessary or proper to carry out the purposes of ORC Chapter 340. The P&F Committee was established under this authority by the Mental Health and Recovery Services Board of Lucas County.

Purpose and Scope: The P&F Committee will maintain oversight responsibilities for identifying and prioritizing community needs, maintaining an efficient organizational structure, and generating and allocating resources.

Decision Making Process: The P&F Committee will make decisions by simple majority vote of its voting members, a quorum being duly constituted. A quorum will be defined as over one-half of voting members in attendance as appointed. Non-Trustees appointed to the P&F Committee will serve in an advisory capacity and will not have voting privileges. Recommendations approved by the P&F Committee will be presented for final approval to the MHRSB at a regular or special meeting of the Board.

Membership: P&F Committee membership will include MHRSB Trustees, as well as any individual appointed by the MHRSB Chair.

Duration: The Charter will be reviewed and considered for renewal by the MHRSB at least once every two years.

Schedule: The P&F Committee will meet: 1) At the discretion of the Chair, but at least every other month, with proper public notice required; 2) At the request of any two P&F Committee members with voting privileges and proper public notice required.

Programs and Services Committee Charter

April 19, 2016

Leadership Structure: The Chair and Vice Chair of the P&S Committee will be approved by a simple majority vote of the MHRSB Trustees at a regularly scheduled meeting of the MHRSB, a quorum being duly constituted. In the absence of the Committee Chair, the Vice Chair will assume leadership of the committee. Only MHRSB Trustees may serve as the Chair or Vice Chair of the P&S Committee. Chair and Vice Chair terms will be for two years beginning July 1 and Trustees may not occupy the same committee office for more than 48 consecutive months.

Authority: Ohio Revised Code Chapter 340 assigns the Mental Health and Recovery Services Board of Lucas County statutory responsibility for the planning, funding, implementation, monitoring and evaluation of prevention, treatment and recovery support services within the county. In performing its duties, the Board may establish such rules, operating procedures, standards and by-laws, and perform such other duties as may be necessary or proper to carry out the purposes of ORC Chapter 340. The P&S Committee was established under this authority by the Mental Health and Recovery Services Board of Lucas County.

Purpose and Scope: The P&S Committee will maintain oversight responsibilities for improving and expanding collaborative opportunities, maintaining a quality, cost-effective and efficient system of care, increasing public awareness and maintaining stakeholder engagement.

Decision Making Process: The P&S Committee will make decisions by simple majority vote of its voting members, a quorum being duly constituted. A quorum will be defined as over one-half of voting members in attendance as appointed. Non-Trustees appointed to the P&S Committee will serve in an advisory capacity and will not have voting privileges. Recommendations approved by the P&S Committee will be presented for final approval to the MHRSB at a regular or special meeting of the Board.

Membership: P&S Committee membership will include MHRSB Trustees, as well as any individual appointed by the MHRSB Chair.

Duration: The Charter will be reviewed and considered for renewal by the MHRSB at least once every two years.

Schedule: The P&S Committee will meet: 1) At the discretion of the Chair, but at least every other month, with proper public notice required; 2) At the request of any two P&S Committee members with voting privileges and proper public notice required.

Strategic Plan Update

The MHRSB's two-year Strategic Plan expires in May of 2016. Previous discussions regarding updates to the plan inferred it would be revised before June 30, 2016. Board staff is recommending the continuation of the current plan through December 31, 2016 due to environmental conditions. The State is currently re-designing Medicaid benefits, the outcome of which will impact provider agencies as well as the Board's strategic direction. Additionally, the Board has several plans that have been developed that are contributing to the MHRSB's strategic vision. These include: Access to Treatment, Inclusion and Health Equity (under consideration), Justice Reform, Prevention and Mental Health Promotion (draft in progress), and Gambling Prevention and Treatment (needs updating.)

Together with our current Community Plan that will be updated in July, these documents will, and/or are providing substantive strategic vision for the MHRSB. Therefore, the need to update the Strategic Plan in May is diminished, and it is likely more cost-effective to delay our strategic planning process until October or November when more information regarding the impact of the state's Medicaid Redesign efforts are known. A copy of the MHRSB current Strategic Plan (2014) can be found at the MHRSB's website (www.lcmhrsb.oh.gov) under Board Resources.

The following motion is recommended to the Board of Trustees:

The Mental Health and Recovery Services Board of Lucas County approves the extension of the MHRSB two-year Strategic Plan through December 31, 2016.

Diversity Workgroup Report

In January 2015, MHRSB Chair, Audrey Weis-Maag, established the Diversity Workgroup and appointed Trustee, Rev. D.L. Perryman as its Chair. The Workgroup was formed to review and make recommendations for improving the diversity related policies and practices of the MHRSB and its funded system of care. Specifically, the Workgroup was developed to address issues relative to diversity and cultural sensitivity, policy formulation and implementation, data collection and reporting among other issues.

The Workgroup held its first meeting on February 12, 2015 and over the following thirteen months met eleven more times. Thirty-three individuals participated in the process including 20 community stakeholders, 4 MHRSB Trustees and 9 MHRSB Staff.

The Diversity Workgroup reviewed information relative to diversity and inclusion, discussed a framework for accountability, and created a "business case" for improving inclusion and health equity efforts. The Workgroup finalized its twenty-five recommendations on March 10, 2016 and is presenting them to the Governance Committee for consideration. Attached is a copy of the draft Diversity Workgroup Report.

The following motion is recommended to the Board of Trustees:

The Mental Health and Recovery Services Board of Lucas County accepts the Diversity Workgroup report as presented.

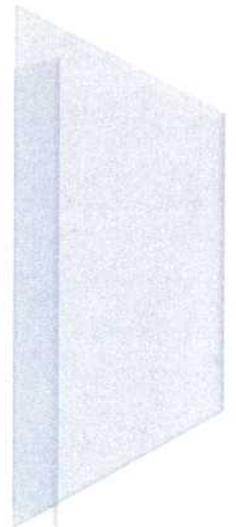
Mental Health and Recovery Services Board of Lucas County

Diversity Workgroup Report

**Rev. Donald L. Perryman, D. Min.,
Workgroup Chair**

March 6, 2016

The Workgroup was chartered in 2015 to address issues relative to diversity and cultural competency as a means of achieving greater health equity throughout the Mental Health and Recovery Services system. The report contains 25 recommendations for consideration by the Board.



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Letter from the Chair

This report summarizes the results of the Diversity Workgroup and draws upon the research, expertise, and experience of the members of the Workgroup established by the Mental Health and Recovery Services Board (MHRSB) of Lucas County. The output consists of twenty-five recommendations. Though they are not all encompassing, they are designed to drive the process of systemic change we believe is required to impact diversity, create a climate of inclusion and lead to greater cultural and linguistic competency that will ultimately result in greater health equity across populations.

The recommendations identify opportunities for the MHRSB system to increase outcomes in these areas. The proposal is submitted with the intent to enhance our existing efforts that will build upon current successes within the system.

The report begins with a description of the vision and mission developed by the Diversity Workgroup to help move through the process and includes a statement presenting a business rationale for the work of achieving greater diversity and inclusion within the MHRSB system of provider agencies. This rationale is followed by recommendations for a scorecard that identifies seven key areas of focus for the MHRSB: 1- Accountability, 2- Education/Training, 3- Sustainability, 4- Partnerships, 5- Recruiting, 6- Consumer/Staff Perceptions, and 7- Language.

We call upon the Lucas County Commissioners, Trustees of MHRSB of Lucas County and key stakeholders in the mental health and educational systems to partner with us and act on these recommendations in a manner that supports the resolution of the problem of health inequity in the Lucas County community.

Rev. Donald L. Perryman, D.Min.
Chair,
Diversity Workgroup
Mental Health and Recovery Service Board

Community Endorsements

Hold for Commissioner (requested)

Hold for Mayor (requested)

“Though we have had the pleasure of working collaboratively with many local minority leaders and organizations to provide education, support and advocacy to the African American and Hispanic/Latino populations; we are just barely scratching the surface. NAMI consumers and participants continually share their frustration concerning the inequities that exist in our system of care. NAMI is very encouraged that, as a system, we are finally working on a plan to address these important issues.”

***Robin Isenberg, Executive Director
National Alliance for the Mentally Ill for Greater Toledo***

“I am writing to express my full support and endorsement for the initiative the Mental Health and Recovery Services Board of Lucas County has undertaken to further inclusion and health equity among underserved populations. I also endorse the “Diversity Taskforce Report to the Board” which you will soon present...”

***State Senator Edna Brown,
Ohio Senate, District 11***

“The Lucas County Sheriff’s Office strongly supports and endorses the initiative to be undertaken by the Mental Health and Recovery Services Board of Lucas County (MHR SB) to further inclusion and health equity among underserved populations in our community...”

“We understand that MHR SB is undertaking a huge commitment to address and has begun to decrease existing disparities in mental health and recovery health care outcomes among underserved populations in our community and we endorse their initiative and we look forward to continuing to work with them.”

***Sheriff John Tharp,
Lucas County Sheriff’s Department***

“We appreciate the opportunity to be a part of this important conversation surrounding the access to services for the Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex and Asexual (LGBTQQIA) persons in our community. Toledo Streets Newspapers strongly supports any and all efforts made to ensure the equity, diversity and inclusion of all persons seeking services within the scope and mission of the MHRSB from the Board level, to the service providers and stakeholders.... The commitment to include, uplift, affirm and guarantee access to LGBTQQIA persons is precedence setting and vital to the general health and wellness of our community as a whole.”

Lilian Briggs, Director of Development
Toledo Streets Newspaper

“....As Chief of Police, I am acutely aware of the increasing numbers of individuals that come into contact with law enforcement which are suffering from some type of mental health or drug crisis. Many of these individuals are of color. In most instances, jail is not the appropriate place for these individuals.

Increasing services to this demographic will keep those individuals, who should not be in the criminal justice system, safe and in the community where they can receive the services which are more appropriate.

Again, I applaud the Mental Health and Recovery Services Board for undertaking such an important endeavor, and pledge the Toledo Police Department’s assistance wherever possible.”

George Kral, Chief
Toledo Police Department

“‘We all do better when we all do better’ said by the late author, Paul Wellstone. United Way of Greater Toledo fully endorses the Diversity Taskforce Report to the Board as an initiative that underscores clearly the steps necessary in our community to better meet the current mental health disparities of our community’s underserved populations.

At United Way of Greater Toledo our mission of uniting the caring power of people to improve lives is in full alignment with the Mental Health and Recovery Services Board in support of this initiative.”

Karen Mathison, CFRE, President and CEO,
United Way of Greater Toledo

“I wish to endorse the initiative undertaken by the Mental Health and Recovery Services Board of Lucas County to further inclusion and health equity among underserved populations in our community.”

W. Scott Fry, President and CEO
Hospital Council of Northwest Ohio

Executive Summary

Our nation is undergoing rapid change in its demographic makeup and in its awareness of the need for greater inclusion of representatives from its diverse communities into the workforce. In Lucas County, this shift in demographics has helped in the identification of imbalances between the makeup of health care professionals and the populations served in the MHR SB system. We believe this inequity may be a contributing factor to disparities in health outcomes experienced by racial and ethnic minorities as well as other underserved groups in who are consumers and/or their family members of the MHR SB system of care.

The MHR SB Diversity Workgroup, composed of 32 leaders from the fields of mental health, faith, business, law, and higher education, was tasked with the challenge of developing a strategy and recommendations that will lead to the elimination of the disparities currently present in Lucas County by increasing diversity and expanding inclusion throughout the system of care.

In February, 2015, the Workgroup began holding monthly meetings with the goal of developing a proposal, with key recommendations, that will lead to solutions for a more diverse and inclusive system of care. The recommendations contained in the plan provide a solid framework to increase workforce diversity, enhance and continue the process of achieving cultural and linguistic competence of staff and increase efforts to achieve health equity throughout the MHR SB system of care. As visionary leaders with the goal of an efficient and accountable network that delivers high quality care to the community impacted by mental illness and addiction, the Diversity Workgroup sees the process that is outlined as a necessary part of the effort to eliminate health inequities.

Introduction

The MHR SB of Lucas County is committed to the goal of diversity, inclusion and cultural and linguistic competency as a means of achieving greater health equity throughout its system of care. The Diversity Workgroup began its work by collecting existing data to establish baselines that would serve to guide the development of the plan. With the goal to provide a strategic framework that sets measurable actions in place, key recommendations are provided and separated into proposed timeframes for completion. With continuous reviews, outcome measurements and assessment; we believe the plan will lead to improvements in the level of cultural and linguistic competencies, climate of inclusion in the overall system and ultimately the elimination of mental health disparities.

Several resources were utilized in developing this plan, including The State of Ohio Mental Health and Addiction Services Cultural and Linguistic Competency Plan (OhioMHAS CLC Plan). This resource aligns efforts in Lucas County with those set for the State of Ohio, the Substance Abuse and Mental Health Administration (SAMHSA) Office of Behavioral Health Equity and the enhanced National Cultural and Linguistically Appropriate Services (CLAS) Standards published by the U.S. Department of Health, Office of Minority Health. The CLAS Standards provide a structured set of standards to health care institutions that serve the nation's diverse communities.

The Workgroup also reviewed primary data from the MHR SB, as well as secondary data from partner organizations, U.S. Census data, research and best practice models to provide information in the development of the recommendations.

The MHR SB Diversity Workgroup acknowledges that the vision of a well-integrated philosophy of diversity and inclusion requires strong commitment, relationships of trust and support to its local provider agencies, and the participation of other key stakeholders.

The six step process utilized by the Workgroup to develop the plan included:

- Selection of individuals willing to participate on the Workgroup;
- Identification of local, state and national strategies;
- Identification and collection of appropriate data sets;
- Review of current system data to assess baselines;
- Development of plan with ongoing review and feedback of the full Workgroup; and
- Presentation for review and action by the MHR SB Board of Trustees.

Diversity Plan Goals

- A plan that sets diversity, inclusion and health equity as a strategic priority with an unwavering commitment to its accomplishment.
- A plan that supports the development of an inclusive workplace culture, linguistically appropriate care and policies that guide service delivery in a manner that traditionally underserved communities have opportunities to achieve their highest quality of mental health and recovery outcomes.
- A plan that includes recommendations leading to the MHRSB establishing accountability standards and measuring progress for its own performance and for funded provider agencies and contracted services.
- A plan that leads to the MHRSB having increased presence in the community through its communications on diversity issues that impact health outcomes, demonstration of concern for quality care, collaborations and partnerships for greater diversity, inclusion and health equity.
- A plan that will position the MHRSB as a leader in Diversity, Inclusion and Health Equity that is built upon evidence-based research/best practices, benchmarking and visioning.

Key Concepts

Concepts and commitments adopted which helped guide the Workgroup:

- Where Diversity, Inclusion and Health Equity is a strategic priority with an unwavering commitment to its accomplishment.
- Where the MHRSB measures progress and along with all funded provider agencies is held accountable for quality outcomes.
- Where the MHRSB has an increased presence in the community and through its communications demonstrates concern for quality care, collaborations and partnerships for greater diversity, inclusion and health equity.

The Business Case

The rationale for improving diversity and establishing a culture of inclusion within the system of care can be tied to both the theme of social justice and standards of business. Social justice philosophy is primarily concerned, with ethical and practical considerations in the delivery of health services to underserved populations. From a business standards perspective, diversity and inclusion initiatives can improve an organization’s sustainability by mitigating organizational risks, reducing health care costs and minimizing health disparities, in part by matching the most appropriate service to a consumer’s need at the earliest stage of care possible. Both the business rationale and social justice case for achieving greater health equity throughout our system are critical.

The five output areas listed below summarize a strong rationale for diversity and inclusion work in any health care system and within their connected provider organizations. Each holds great potential for containing costs and furthering the state and local goals of eliminating health care disparities.

- Reduce the impact to communities of long-standing health disparities
- Respond to current and projected demographic changes
- Improve quality of services and health outcomes
- Meet federal and state legislative, and accreditation mandates
- Gain a competitive edge in the marketplace.

In Lucas County between 2000 and 2010 migration patterns listed in U. S. Census Bureau document increased percentages, some fairly significant, in all but one population group as reflected in Table 1 below:

Table 1

LUCAS COUNTY POPULATION BY RACE	ACTUAL COUNT	PERCENTAGES
American Indian and Alaska native	170	14.42%
Asian alone	1,237	22.38%
Black or African American alone	6,658	8.62%
Native Hawaiian/Other Pacific native	21	22.83%
Some other race alone	438	5.17%
Two or more races	4,047	41.12%
White Alone	-25,810	-7.32%
HISPANIC/LATINO ORIGIN OF ANY RACE		
Persons not of Hispanic or Latino Origin	-19,543	-4.50
Persons of Hispanic or Latino Origin	6,304	30.50%

Source: Lucas County Quick Facts from U.S. Census Bureau.

Race and ethnicity are not the only cultural areas of distinction where disparities in health outcomes have been documented. Many of the county's poor, homeless, individuals with disabilities, LGBTQIA, immigrant and refugee populations exhibit distinct cultural characteristics that often present unique demands upon our system of care. The enhanced CLAS standards have defined "culture" to be inclusive of the diverse needs of these groups. We believe that cultural and linguistic competency among professionals within our system of care is a part of the solution to greater health benefits for consumers and for the communities that house them. Additionally, among other positive outcomes, organizations that have cultural competence within the framework of their operation may have higher rates of employee retention from a more satisfied workforce as well as improvements in the wide health disparities that currently exist between people groups.

The following summary identifies government regulations, and credentialing agencies with standards for organizations within our system of care that require cultural and linguistic competence and care environments that are free from discriminatory practices:

Civil Rights Act of 1964, 42 U.S.C § 2000(e) Title VII states: No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance.

Federal Rehabilitation Act of 1973 U.S.C. § 794 (Section 504) prohibits a recipient of federal funds from discriminating against an individual with a disability solely by reason of that disability.

Americans with Disabilities Act of 1990, 42 USC § 12101 et seq. also prohibits state and local governments from discriminating against an individual with a disability solely by reason of that disability.

Improving Access to Services for Persons with Limited English Proficiency (LEP), Executive Order 13166, signed August 11, 2000. The Executive Order requires Federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP persons can have meaningful access to them. It is expected that agency plans will provide for such meaningful access consistent with, and without unduly burdening, the fundamental mission of the agency.

The Joint Commission (TJC), accredits hospitals and other health care institutions, and has published a document describing how their accreditation 2015 Standards for the Ambulatory Health Care Accreditation Program, both directly and indirectly supports the National CLAS standards.

Commission on Accreditation of Rehabilitation Facilities (CARF), a nonprofit organization that accredits health and human service organizations has issued standards that incorporate CLAS standards.

National Committee for Quality Assurance identifies standards for improvement in communication, cultural competency and patient-centered care as well as linguistic assistance services.

Each of the above regulations and credentialing agencies document the need for business models that incorporate ongoing growth and development of competencies which meet the needs of diverse communities.

Value Statements

- Inclusion, diversity and health equity are core principles of the MHRSB and serve as catalysts for ensuring culturally and linguistically appropriate mental health and addiction services are provided to Lucas County residents in a manner that respects the dignity of the individual and their families with the goal of achieving health equity.
- It will be assured that there will be fair, equal and inclusive contracting opportunities.
- It will be assured there is a supportive culture of diversity and inclusion that will attract, employ and retain a diverse and inclusive workforce that is reflective of the community being served.
- It will be assured that the diverse benefits, experience and expertise of the community's rich resources are included through our opportunities for collaboration and engagement with pertinent community groups and key stakeholders.

Definitions

Inclusion - the creation of an environment where people feel supported, listened to and able to do their personal best.

Diversity - the quality of being different or unique at the individual or group level. Diversity takes into account, but is not limited to race, religion, sexual orientation, gender identity, language, age, ethnicity, ability, physical and mental health status, sex, socioeconomic status, and national origin.

Health equity - attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Inclusive Organizations - organizations that embrace inclusion and the power of diversity to achieve health equity as measured by the National CLAS Standards Assessment Tool AND the achievement of quantifiable benchmarks that track progress on employment, leadership and consumer health related outcomes related to race, religion, sexual orientation, gender identity, language, age, ethnicity, ability, physical and mental health status, sex, socioeconomic status, and national origin.

Sources: Definitions formulated by the Federal Interagency Health Equity Team for the U.S. Department of Health and Human Services for the National Stakeholder Strategy.

Vision

Diversity, Inclusion and Health Equity and the provision of Culturally & Linguistically Appropriate Services will become:

The key strategic priority to reduce health care inequities throughout our MHR SB system.

Part of a sustainable organizational effort that is carried out in a strategic and intentional process with an appropriate infrastructure and measures.

A model in addressing health inequity through diversity and inclusion activities and in the provision of culturally and linguistically appropriate services.

A culture throughout the MHR SB of Lucas County.

Mission

Development and acceptance of a plan which outlines a strategic framework to guide the MHR SB in ensuring relevant, quality resources are being provided to meet the mental health and addiction needs of all individuals regardless of race, religion, culture, sexual orientation or level of ability.

Recommendations

Scorecard – establish a dashboard to reflect qualitative and quantitative performance measures for evaluation of community impact outcomes for the MHRSB and all funded provider agencies in each of the following areas.

Accountability

Year 0-3 Goals

- ▶ Develop policy that establishes Diversity, Inclusion and Health Equity as core values that affirm client's right to clinical treatment services within the system, regardless of any personal identifiers, which are driven by medical need, patient preferences and specific cultural values.
- ▶ Add diversity and inclusion performance related objectives to the MHRSB Executive Director's 2016 and future evaluations.
- ▶ Create an office within the MHRSB that will have accountability for leading diversity and inclusion efforts and that serves as an effective catalyst for achieving greater health equity for MHRSB consumers.
- ▶ Ensure that hiring and procurement opportunities are transparent.
- ▶ Provide funding and/or other appropriate incentives to support diversity/inclusion goal achievement.
- ▶ Publish periodic report to community on the progress towards greater diversity, inclusion, and health equity objectives and the impact on system goals.
- ▶ Establish a recognition program that acknowledges provider agencies within the system that demonstrate excellence in diversity and inclusion achievement.
- ▶ Ensure agency contracts include language requiring tracking and reporting of specific demographic data to assess progress towards achieving diversity goals.

Year 4-6 Goals

- ▶ Develop incentives and sanctions, if needed, to encourage and support funded provider agencies to develop strategies and mechanisms that guide achievement of their diversity, and cultural and linguistic competency efforts.

Education/Training

Year 0-3 Goals

- ▶ The MHRSB will provide regular system-wide continuing education on diversity/inclusion, language, and cultural competency.
- ▶ Advocate for university training programs for students in mental health programs that include specialized curriculum related to understanding the mental health needs of individuals with developmental disabilities.

Year 4-6 Goals

- ▶ Provide for leadership training and mentoring opportunities for individuals from underrepresented target groups that are employed in the MHR SB system.
- ▶ Maintain and strengthen partnerships with local law enforcement to ensure and facilitate additional training opportunities based on current community needs.

Sustainability

Year 0-3 Goals

- ▶ A permanent Diversity workgroup to serve in a structured advisory capacity on diversity and inclusion issues reporting to the MHR SB Executive Director and Board committee.

Year 4-6 Goals

- ▶ Periodic community needs assessment to support future goals as county demographics change.

Partnerships

Year 0-3 Goals

- ▶ Partner with public and private sector organizations that have strong proven diversity/inclusion programs for support and mentoring to the MHR SB and its agencies.
- ▶ Establish relationships with local law enforcement systems and 911 emergency personnel to collaborate on community engagement strategies as related to MHR SB consumers and their families.

Recruiting

Year 0-3 Goals

- ▶ Create and implement a public awareness campaign that encourages students from underrepresented groups to pursue a career in the behavioral health field.
- ▶ Encourage and incentivize provider agencies to increase the number of multilingual staff in the system's workforce as measured against client need.
- ▶ Encourage and incentivize provider agencies to establish diversity/inclusion requirements in their hiring and procurement activities.

Year 4-6 Goals

- ▶ Identify targeted institutions and culturally specific student organizations such as Toledo Public Schools, local Colleges and Universities, and Historically Black College and Universities (HBCUs) with established Schools of Social Work, National Association of Black Social Workers (NABSW), the various Chambers of Commerce,

LGBTQQIA community advocates etc., with the goal of establishing a workforce development pipeline for professionals that will serve the behavioral health industry.

Consumer and Staff Perceptions

Year 0-3 Goals

- ▶ Provide for periodic consumer and community surveys to measure levels of satisfaction and perceptions of “institutional climate” within the system as related to diversity and inclusion.

Language

Year 0-3 Goals

- ▶ Develop a centralized language translation approach for the MHR SB system and develop capacity for on-going skill building for system staff that will maximize full benefit of any language resources.
- ▶ Develop measurable vehicles for achieving cultural competency and linguistic skills for staff at the MHR SB and funded provider agencies.

Year 4-6 Goals

- ▶ Partner with local Board of Developmental Disability to develop non-traditional therapies for consumers with limited verbal skills.

Key Metrics

Maintaining a culture and system of diversity and inclusion begins with the establishment of a database of metrics. When accurately collected and analyzed, data will inform the development of enhanced approaches to meet community needs. The following list provides a partial set of system wide outcome metrics to be collected in addition to those included in the recommendations.

Reduced hospitalizations
Adjustment of service hours of operation based on demand
Translation or language services
Count of diverse consumers served
Comfort level of consumer while at provider
Number of consumers seeking different provider
Number of bi-lingual staff
Diverse make up of employees at all levels within the system
Procurement contracts

The above recommendations are based, in part, on reviews of MHR SB system data outlined in Tables 1 – 3.

Conclusion

The framework outlined in this document presents a guide which is intended to help the MHRSB of Lucas County begin the development of both short and long term strategies to enhance diversity and inclusion throughout the MHRSB system of care. The framework is intended to encourage the use of data, existing science, available knowledge in the field along with strong partnerships to drive needed enhancements in all areas that impact the mental health and the recovery status among underserved groups in our community.

We believe the work of improving the health of racial and ethnic minorities and other underserved populations as well as reducing and ultimately eliminating health disparities in Lucas County is complex and requires a multi-faceted, long term approach which is sustained over many years.

Should we fail to increase diversity, improve cultural competency and expand inclusion, we jeopardize positive mental health outcomes, client satisfaction and valuable economic benefits. Lastly, we risk having the benefits from the rapid social and demographic changes occurring in Lucas County and in the larger society pass us by. We must work hard and we must work together.

Appendix

Appendix A: Minority representation in MHR SB Trustee, Staff Leadership, and other positions					
	White Alone	Black/AA	Hispanic or Latino	Asian	All Others
Percentage of minority population in Lucas County as reflected in most recent U.S. Census data report.	70.2% (305,573)	19.5% (84,881)	6.5% (28,294)	1.7% (7,400)	2.1% (9,141)
Percentage of clients served in system by race or ethnicity	54.9% (14,391)	36.7% (9,609)	5.5% (1,438)	0	2.9% (760)
Percentage of 18 Board Trustee positions by race or ethnicity	66.6% (12)	27.7% (5)	5.5% (1)	0	0
Percentage of Board staff in the 7 Leadership positions by race or ethnicity	85.7% (6)	17% (1)	0	0	0
Percentage of other Board staff in 11 other positions by race or ethnicity	61% (8)	38% (5)	5.5% (1)	0	0
Percentage of all Board staff 18 other positions by race or ethnicity	66.7% (12)	22.2% (4)	5.5% (1)	0	5.5% (1)

Table 2. Source: Lucas Count Quick Facts from U.S. Census Bureau, MHR SB Personnel Records March 2015.

00 = Fluid numbers

Table

Appendix B: Minority representation in MHR SB Provider Agencies.					
	White Alone	Black. A.Am	Hispanic or Latino	Asian	All Others
Percentage of minority population in Lucas County as reflected in most recent U.S. Census data report.	70.2% (305,573)	19.5% (84,881)	6.50% (28,294)	1.7% (7,400)	2.1% (9,141)
Percentage of clients served in system by race or ethnicity	54.9% (14,391)	36.7% (9,484)	5.5% (1,438)	0	2.9% (760)
Percentage of 254 Provider Board Trustees by race or ethnicity	70% (177)	20% (50)	8%(21)	0	2%(6)
Percentage of 69 MHR SB Provider staff in Executive Leadership by race or ethnicity	68% (47)	20% (14)	10%(7)	1% (1)	0
Percentage of 182 MHR SB Provider staff in Manager categories by race or ethnicity	83% (151)	14% (25)	3%(5)	.5%(1)	0
Percentage of 476 MHR SB Provider staff in Licensed/Credentialed staff categories by race or ethnicity	78% (370)	18% (85)	3%(16)	0.6% (3)	0.4%(2)
Percentage of 641 MHR SB Provider staff in ParaProf/Support staff categories by race or ethnicity	62.1% (398)	30.6% (196)	5.8%(37)	0.6% (4)	0.9%(6)
Percentage of the 36 physicians serving system by race or ethnicity.	53% (19)	3%(1)	0	36% (13)	8%(3)
Percentage of the 103 MHR SB Provider staff RN's by race or ethnicity.	83% (85)	14%(15)	2%(2)	1%(1)	0%
Percentage of the 92 MHR SB Provider staff in "other" positions by race or ethnicity.	53% (49)	37%(34)	9%(8)	0	1%(1)

Table 3. Source: Lucas County Quick Facts from U.S. Census Bureau. MHR SB 2014 Data

00 = Fluid numbers

Resources

A business case for promoting equity in the behavioral health care system through cultural and linguistic competency (June 2015). Columbus, Ohio: Ohio Department of Mental Health and Addiction Services.

Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., . . . Feuerstein, C. J. (2004). **Strategies for improving minority healthcare quality** US Department of Health and Human Services, Public Health Service, Agency for Healthcare Research and Quality.

Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., Cooper, L. A. (2005). **Cultural competence: A systematic review of health care provider educational interventions**. *Medical Care*, 43(4), 356-373. doi:00005650-200504000-00007 [pii]

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research*, 7(1), 1.

Disparities and cultural competency care quality indicators (2014). Columbus, OH: Ohio Department of Mental Health and Addiction Services.

Goode, T. D., Dunne, M. C., Bronheim, S., & Fund, C. (2006). **The evidence base for cultural and linguistic competency in health care** Commonwealth Fund New York^ eNY NY.

Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock III, C. H. (2011). **Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research**. *Journal of General Internal Medicine*, 26(3), 317-325.

National Partnership for Action to End Health Disparities. **National Stakeholder Strategy for Achieving Health Equity**. Rockville, MD: U.S. Department of Health & Human Services, Office of Minority Health, [April 2011]. Federal Interagency Health Equity Team.

Saha, S., Beach, M. C., & Cooper, L. A. (2008). **Patient centeredness, cultural competence and healthcare quality**. *Journal of the National Medical Association*, 100(11), 1275-1285.

Sullivan, L. W. (2004). **Missing persons: Minorities in the health professions, a report of the Sullivan commission on diversity in the healthcare workforce**.

Wallace, B. C. (2007). **Toward equity in health: A new global approach to health disparities** Springer Publishing Company.

Young Jr, J. **Culturally competent providers and employee healthcare cost.**

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Rev. Donald L. Perryman, D. Min.
Chair,
Diversity Workgroup
Mental Health and Recovery Service Board

Diversity Workgroup Members

Rev. Donald L. Perryman, D. Min.
Senior Pastor, Center of Hope CBC,
President, United Pastors for Social
Empowerment
PhD Candidate, Antioch University
MHR SB of Lucas County
Board Member

Neema Bell, Attorney at Law
Shumaker, Loop & Kendrick, LLP
MHR SB of Lucas County
Board Member

Linda Alvarado-Arce, Executive
Director
City of Toledo, Board of Community
Relations
MHR SB of Lucas County
Board Member

Anthony Pfeiffer, MSW. LISW –S
Toledo Hospital
MHR SB of Lucas County
Board Member

Harold Mosley
Retired Law Enforcement Officer

Ray Wood, President
Toledo NAACP

James Meadows, Director
Human Resources Department
Lucas County Commissioners

Robert Lyons, Sr., GSM
Senior Pastor
St Mary's Baptist Church

Marijo Tamburrino, M.D.
University of Toledo
Department of Psychiatry

Larry Hamme, Ph.D.,
Chief Clinical Officer
Unison Behavioral Health Group

Michael Carter, Senior Pastor
Praise City/212 Worship Center

Joyce P. Litten, Ed.D., L.I.S.W.-S.
Associate Professor
Department of Social Work
Lourdes University

Calvin Brown, Director
Office of Affirmative Action/Contract
Compliance,
City of Toledo

Julie O'Hair, Director
Service and Support Administration
Lucas County Board of DD

Gwen Jones, Senior VP,
Quality Improvement & Compliance
Harbor Behavioral Health

David Browning, PhD.
University of Toledo
Retired

Larry Sykes
African American Chamber of
Commerce

Guisselle Mendoza
Executive Director
Adelante, Latino Resource Center

Jesus R. Salas
Senior Attorney
Advocates for Basic Legal Equality,
Inc.

Cheryl Grice, CEO
Pathway, Inc.

Thomas Osinowo, M.D.
Chief Clinical Director
Northwest Ohio Psychiatric Hospital

Eric Walker
Lucas County
Department of Planning and
Development

Sarah Twitchell, PhD.
Instructor
Owens Community College

Birdena Martin, Personnel Officer
Human Resources Department
Lucas County Commissioners

Board Staff

Karen Olnhausen, Director of
Programs and Services

Amy Priest, Manager of Treatment
Services

Robert Kasprzak, Manager of
Training and Development

Kristal Barham, Community
Engagement and Outreach Manager

Delores Williams, Manager of
Inclusion and Health Equity

Tom Bartlett, Associate Executive
Director

Donna Robinson, Office Manager

Siva Yechoor, M.D., Medical Director

Scott Sylak, Executive Director