

## Intensive Treatment Services Summit Minutes

### March 29, 2018

#### ***Opening Remarks- Sandy Hunt***

Chris Santaniello was unable to attend to give opening remarks so Sandy Hunt Bureau Chief for BDS under the Division of Long Term Supports and Services filled in. There have been three Summit meetings. This month marks a year from when the first Summit was held. There was a follow up Summit in September 2017 to review the seven ITS workgroups that were established. These seven workgroups provided an overview of the work they completed. It was at the September Summit that attendees provided feedback to gather again today. The purpose of the Summit is to help build capacity in New Hampshire for those individuals who have high risk/high needs.

Intro to Attendees: who is new at the table? See below for all that attended today's Summit.

#### **Consultants**

Isadora Legendre-Rodriguez- DD Council

Laurie Guidry- The Center for Integrative Psychological Services

Bob Bowen- Fellowship Solutions

#### **Mental Health Center**

Celia Felsenberg- CLM

Steve Arnault- CLM

#### **Public Guardians**

Stephen Jewell- OPG

#### **DRC**

Stephanie Parker

#### **START**

Barb Drotos-R4

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Val Tetreault- R4

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#### **MCOs**

Mary Jo Benosky- Well Sense

Lisa O'Connor- New Hampshire Healthy Families

#### **DHHS**

Sue Nickerson- Bureau of Licensing

Karl Boisvert-Bureau of Behavioral Health

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**BDS**

Jennifer McLaren  
Jan Skoby  
Sandy Hunt  
John Capuco  
Ken Lindberg

Darlene Ferguson  
Todd Ringelstein  
Cheryl Bergeron  
Kaarla Weston

**Provider Agencies**

Steve Tuck- Becket  
Lisa D’Innocenzo- Becket  
Sue Silsby- Easter Seals  
Jill Fitzgerald- Easter Seals  
Amanda Nelson- Neuro-International  
Teena Ouellette- Neuro-International

Deb Descenza- Farmsteads  
Maureen Butler- Neurorestorative  
Lorrie Winslow- Neurorestorative  
Noah Riner- Neuro-International

**Area Agencies**

Shanon Mason- R1  
Missy Hill- R1  
Joe Smith- R2  
Lexie Raptis-Santry- R3  
Shannon Kelly- R3  
Rebecca Bryant- R3  
Kyle Dopfel- R4  
Nick Hunt- R4  
Ann Potoczak-R4  
Ellen Denoncour- R5  
Mari Schacht- R5  
Cathy Bergeron- R6  
Christine Bergeron-R6  
Sandy Pelletier- R6  
Kathye King- R7  
Greg Steelman- R7  
Karen Mclaughlin- R8  
Chris Muns-R8  
Josh Gehling- R8  
Lenore Sciuto- R8  
Sofia Hyatt- R9  
Gayle Tondreau- R9  
Kori Boeckler- R10  
Jennifer Chisholm- R10

Lisa Houde- R10  
Cynthia Mahar- R10

## Mental Health and IDD Targeted/Dual Case Management Waivers

*Karl Boisvert from the Division of Behavioral Health along with Sandy Hunt from Bureau of Developmental Services*

Since one of the discussions at the September 2017 Summit was regarding IDD and mental health working together. Specifically, if an individual is receiving case management at the area agency; can they also receive case management through the mental health center? Sandy passes out a “cheat sheet” which cites He-M 503.08 and He-M 426.15. [See attached](#)

The word “primary” is used twice in both these regulations. It states that the word primary means “the agency that provides the greater dollar value of services to the individual;” so in most cases this means the DD service delivery system. The process that has been used to date is that the non-primary agency (mental health) applies for a waiver.

Karl Boisvert also handed out a “cheat sheet” that condensed the waiver language. [see attached](#) Karl shared his mental health background that prior to working for the state, he worked in community mental health and at that time, there were not a lot of barriers for individuals to obtain case management from dual agencies. Since the ruling has changed, there have been barriers. One of Karl’s roles working for the state is that he looks at the waiver requests. Not all, but most of the rules under mental health have a waiver provision. Rule 426.15 has a provision. Karl presented some rough numbers regarding rule 426.15 (dual case management services). Three mental health centers have submitted waivers. One center that requested waivers; 36% of them were related to rule 426.15. The second center was 20% and the third center was at 7%. Again, this is a rough number, but the other 7 mental health centers are not submitting waiver requests under this ruling of dual case management. Karl shares that these percentages have been at 100% approved for the waiver of dual case management services. **If there is a client at the mental health center who also receives DD services, ask the case manager and/or supervisor to request a waiver for these dual services. Karl clarifies within the handout, that individuals that are receiving DD case management services, can also apply for the waiver at the very least on the low utilization end.**

Dr. McLaren from DHHS asked about clients who have a service coordinator at an area agency and have a therapist or psychiatrist, but no case manager at the mental health center. She shared that the client also has an eligible mental health diagnosis. The mental health center is sharing that since the individual has a service coordinator at the area agency, case management services cannot be provided. Karl shared that the mental health centers are not just serving state funded services; they serve private pay, meds only, adult outpatient therapy services etc. If an individual (or agency) is requesting an eligibility determination, the mental health center is required by rule to provide that. **However, if the eligibility determination states that the impairments that are listed in rule are not from a mental health condition then the individual/agency/advocate/guardian can ask for an appeal of the eligibility determination decision.** Karl also indicated that if a client feels there is limited access to services; they are referred to the QI or complaint investigator. If this has been done, and there seems to be little movement, please feel free to reach out to Karl. (Contact info above in attendees)

There is a real interest in the two Bureaus (BDS and BMH) to close the gap to make sure that individuals are receiving all case management needs. Dr. McLaren from DHHS shared that there is a miscommunication around this when she is working with individuals who definitely meet the eligibility determination criteria; they have not been able to receive the dual case management services. Karl shared that there is the common goal among the Bureau of Developmental Services and the Bureau of Mental Health Services to close the gap. One of the differences between these two service delivery systems are that mental health centers have a per member per month rate where the DD system has a different funding mechanism.

Todd Ringelstein from BDS asked if an individual needs mental health case management and meets the eligibility determination, the step to take would be to go through the mental health center's intake. Karl indicated that this is correct.

John Capuco asked about Karl getting an appeal and/or denial taken care of through the mental health center (with the option of getting Karl involved if needed). Karl shared that you start with the QI department and/or the complaint investigator. Karl shared that Jamie Kelly is logging and processing the appeals and there is no time restriction on a determination.

Sandy Pelletier from R6 asked if Karl has had these conversations with the mental health executive directors and he has. At the most recent QI meeting, Karl shared that there was definitely an uneven amount of waiver requests from the mental health centers and **Karl is unsure why the mental health centers are not submitting waivers when there is a 100% acceptance rate of the waiver.**

Barb Drotos from R4/START stated that the "symptoms" presented from the individual are related to their ID and not their mental health diagnosis. Barb shared that the individual does present with both. She shared that it's really challenging to "determine" which condition (mental health and/or developmental disability) the symptoms at the time are related to. Barb shared that if we are to contact Karl and problems solve this; this would be a theme that would be shared from the mental health system. Karl and Barb agree that this is a systems issue. Karl shared for example, that NHH is not an ID treatment facility; it's a mental health treatment center. There is a buildup of needs (in the ER or other locations) for the ID population who also have mental health diagnoses. It is this population that does not gain entry to NHH because it is not an ID treatment facility, despite the fact that these individuals are/could be in need of mental health services.

Laurie Guidry shared that there is an underlying culture issue that the ID population with co-morbid psychiatric conditions is behavioral. There is a misconception that the ID population does get pushed aside versus an individual who has just has a mental health condition. **Can we shift the way that the mental health centers look at serving the population that have both ID and mental health. Karl shared that it starts with education. There are some mental health centers that are "better" at this than others. The collaboration with the mental health center and the area agency is key!**

Lisa O'Connor from MCO New Hampshire Healthy Families asked Karl about ID clients accessing the ACT team through the waiver. Karl shared that they need to first get on the state funded services plan through the mental health center and then there is an internal process. Criteria that might be reviewed are substance abuse, how many hospitalizations have occurred etc. The bottom line is that everyone will be assessed and they will get the services that they need. Lisa shared that the ACT team is really beneficial, but the problem she feels is that the ID individuals who may or may not be SPMI eligible will not be able to access these services because the "symptoms" are more behavioral and fall under ID services and not mental health. **Karl shared that the rules are the guidelines and the multiple State Agencies are working internally on these difficult cases for those that fall outside of these criteria. Karl shared to feel free to reach out to Sandy Hunt or himself if you have one of these cases.**

Greg Steelman from R7 shared that he loves Karl's approach that there is no finger pointing and it's more of a problem solving approach. An individual with ID can attend an eligibility determination meeting and 40 minutes later have a mental health diagnosis. **How do we problem solve with language barriers and data systems to work together with this special population.** Karl shares that there is a short supply of these resources working with this dual population of ID and mental health. **What can the area agencies do to communicate in our language to the needs of the mental health center?**

#### **Mental Health Centers and Area Agencies: Suggestions on Collaborative Strategies**

*Jennifer Chisholm from Community Crossroads along with Steve Arnault and Celia Felsenberg from Center for Life Management*

Jennifer Chisholm from Region 10 introduced herself and the folks from Center for Life Management (CLM). Jen shared that another key player from CLM Julie Lago is also part of this process, but is unable to be here today. Region 10 and CLM have a great relationship, but the larger question they asked was **how can they make it great for the individuals that they dually serve.** They developed a continuum of collaborative care between CLM and Region 10. They learned that essentially the services were the same, the language between DD and MH was different. DD has service agreements and MH has treatment plans. Individual goals were the same at each agency, so they worked together to develop an **integrative model.** Meetings are held jointly, skills that are being worked on in therapy and with the service coordinator are being carried over to the home care providers, parents or guardians and anyone in their circle. **It is the expectation and not the exception that both R10 and CLM work together.** This is a partnership and the two agencies don't work separately. There are interagency meetings held every other month for educational trainings and presenting cases with problem solving. The best part of these interagency meetings is that relationships and connections are being made with both parties. These are run by Jen Chisholm (R10) and Julie Lago (CLM). These collaborative meeting opportunities are also offered to providers and other agencies that are also connected with Region 10 or CLM.

**There are 76 individuals that have this integrative approach with CLM and Region 10. This model was developed in May 2014. Since this approach, there have been zero psychiatric hospitalizations for these 76 individuals.**

Celia Felsenberg from CLM shares that the interagency meetings are not just “meetings,” because there is always an opportunity to learn. When these meetings are happening there is such energy and being proactive in problem solving.

Steve Arnault from CLM shares that he is frustrated and embarrassed about the continued struggles between the mental health and DD systems. Steve worked on the ID side 30 years ago; unfortunately, the same conversations happened back then. Steve referenced Dr. Guidry’s question of what is the problem. Steve indicated that it’s lack of education, fear, ignorance and finance. Finances are a big part of this, however, people are priority. **When CLM and R10 started this process of the continuum of collaborative care, there was a lot of non-billable time but at this point in the investment, the return is huge.**

Hospitalization is down; the ability to serve individuals is up. What Region 10 and CLM have is a service delivery system that works. They serve the people; one client at a time; if they have ID or MH or both. **The continuum of collaborative care does not have to be a language barrier; the services are the same thing. Steve questions why his mental health center is the only one in the room. He questions how area agencies are doing this alone?**

Steve repeats again that it is fear and financial concerns that prevents other mental health centers from getting on board. Steve shares that there is a real dollar value in this process; they have increased their patient base and consequently, their Per Member, Per Month (PMPM) revenue. Additionally, vendor agencies are now asking for consultation, further increasing patient/member opportunity. The investment is also in your staff, your time, and your partnership. Steve shared that at the every other month interagency meetings there are curriculum options and the topics within the curriculum are done based on need; client by client and situation by situation both formal and informal. The trainings are also open to vendor agencies.

Jen shared that they are preventative instead of reactive. Region 10 works with START, the Emergency Services team at CLM through Parkland Medical to do emergency assessments. It cuts down the lead time because the relationships are already there. The service coordinator knows who to contact at CLM and CLM knows who to contact at Region 10. **Region 10 has a prescreen tool upon intake to assess the need for integrative collaboration. Please contact Jennifer Chisholm to get more info about this model of treatment and she can share her resources and insights in more detail.** Steve shares that the two agencies have a data tracker where they follow and assess incident reports so they know when to intervene with individuals.

Jen indicated that this model is the expectation and not the exception.

John Capuco asked if this integrative model is for only ID or is it for ABD as well. Steve shared that it the same and would not rule anyone out.

### **The START Center and how Area Agencies are getting more involved with START**

*Barb Drotos and Val Tetreault (Team leader who works with regions 1-5)*

The START Center is a national program in 17 states. The Center for START Services is out of New Hampshire. There can be confusion with the names of the two programs. [see attached](#)

The Center for START Services- nationwide (but the home base is in NH). NH START- includes the clinical program and the START resource center (located in Boscawen).

START coordinators work for Community Bridges but their home base is out of each of the 10 area agencies. Each region that has individuals with both ID and mental health should have a START coordinator. START coordinators are Master's level clinicians who have a clinical degree and background with either ID or mental health. They received 60 plus hours of online training, lots of job shadowing and a final presentation similar to a dissertation. This intense training is about 12 months long and at the same time that the START coordinators are receiving this training, they are carrying a partial or full caseload. The core of The Center for START Services knows how one affects the other (ID and mental health).

The Center for START Services supports ages 6 and up (95% are age 21 and over). When folks are involved in START there are less hospitalizations. 87% of the time when a START coordinator is called in an emergency, there is no hospitalization. The START coordinator's job is to keep the individual in their setting and help provide support and resources to the providers that are serving the individual.

NH START also provides Comprehensive Systems & Services Evaluation (see handout); Cross Systems Crisis Intervention Planning and the most frequently requested service at NH START is the training component. NH START has a variety of set training topics, but they will reach out to get trainings on any topic nationwide. There is a rotating monthly training calendar. [See attached \(page 2\)](#)

#### **The START Resource Center**

25% of the individuals that receive NH START clinical services are referred to the START Resource Center. The START Resource Center is a physical location in Boscawen that is a 6 bed homelike facility. The following services are: a consulting psychiatrist, part time nurse, well trained staff, highly skilled program with daily groups. It is not a locked facility nor is it a psychiatric treatment facility. There are 3 planned beds and 3 emergency stay beds. If an individual needs to use the emergency stay bed, the START coordinator still needs to do a face to face mental health status assessment.

The START Resource Center is for 21 and over.

People with high risk/high needs can get NH START services, they just may not be able to attend the START Resource Center. Any individual who presents with ID and a mental health diagnosis is eligible to receive a START coordinator.

#### ITS Summit Workgroup Updates:

**Training Workgroup:** *Steve Tuck* and **Trauma Informed Care:** *Greg Steelman* [see attached](#)

Both groups (training and TIC) have worked separately and jointly for the last 6 months. Both felt that presenting together made sense. Steve expressed his thanks for the workgroup members for contributing to this report out and he also thanked Val from Community Bridges, NH START for all of their help with Becket.

There are two components to the trauma informed care topic. There is the training curriculum and what the content is and then the second component is adapting it to each organization's needs. Administrators need a different level of training than direct care staff. Jill Fitzgerald from Easter Seals put together a PowerPoint that standardizes the curriculum for TIC as baseline training for everyone and then they can tailor to the specific population and audience.

Lisa D'Innocenzo from Becket shared that she has staff attend TIC trainings internally and integrate it within their program from day one.

John Capuco indicated that attending the training once is not adequate. There needs to be continued supervisor, monitoring and really immerse the folks that are trained to practice this model. **Steve mentioned the recommendations from the workgroup regarding the consistent network of supervision were monthly skype supervision, train the trainer, and restarting the Moore Center training program that was developed a few years back.** There are a lot of resources within the state who discuss this topic; START does an online webinar, David Prescott, Laurie Guidry, Jill Fitzgerald and Greg Steelman.

**The Moore Center is hoping to activate this clinical training group again that focuses on the high risk/high needs population and invite other staff from other area agencies and build the skill set of these staff. The training would also incorporate those individuals who have already gone through it and give them a more advanced view with the option of those individuals being the "champions."**

Jen Chisholm shared that R10 is doing follow up from when Greg (R7) came and did TIC for their region.

Karla Weston from BDS asked how many have folks went through the Moore Center clinical training. Rough numbers estimate that it was 20 folks over the course of 2 years.

Kat King from R7 shared that when a new staff member comes on board at the Moore Center, TIC training in their orientation from day 1. The Moore Center also uses consultation from a TIC clinician at their staffed residences for their programs.

Dr. Guidry shared that **you have to support the staff and sustain this method of treatment over time. The staff needs consistent supervision to learn how to talk about the case; this is the investment that can change the culture in the system and reduce the cost in the long run.**

Bob Bowen from Fellowship Solutions indicated that it's really hard for staff to practice this technique if they themselves have trauma. The first step is to **support the staff**. He worked with The Moore Center by developing a survey to get data on this and he hopes to **work with other NH agencies to get some really good statewide data**. If our staff does not have the hope and desire for themselves, how can we expect them to give it to the individuals that we work with?

John Capuco agreed that this is a huge endeavor in which these are only the beginning steps we speak of today. There has been no firm decision about the direction of TIC statewide and we really need input from each region.

Steve Tuck concluded with **an ask from the regions to collect all training info to develop a master list**.

❖ **Operational Standards:** *Marissa Berg* [see attached](#)

Marissa is a new participant to the Operational Standards workgroup. Initially it was one group, but as the work progressed, it split into two subgroups; Administrative Standards and Clinical Standards. The group is asking on a larger scale, **what are the best practices in working with the high risk/high needs population?** There are a few states that have best practice manuals (Vermont and Pennsylvania) so NH is working on developing our best practices and eventually sharing this manual with the AA's, vendors, mental health centers, etc. to make sure that all agencies are on the same page. Jen Cordaro from Easter Seals wrote nearly all the administrative standards so credit is due to her for her efforts.

**Marissa asked folks that are here today; please assist the Operational Standards workgroup with your knowledge and what should be in this best practice manual. Please outreach to Marissa Berg (contact info within attendees).**

Cynthia Mahar from R10 asked if all the clinical standards are done and have they been shared out? Marissa explained that the best practice manual is in its beginning stages. Once the workgroup feels confident that the manual can be shared, it would go to the service coordinators group, the Community of Practice (CoP), and the QI group. It has been decided that during the monthly CoP committee meeting that a few standards would be reviewed there. From there, it would go to BDS and the CSNI full board which includes all 10 area agencies executive directors.

Todd Ringelstein reiterated that collaboration with all the stakeholders (especially the ones that presented today; mental health, vendors, START etc) is important. **The goal with the development of this best practice manual is to be a go to guide with all those parties that might come into contact with those that we serve.**

**Other topics discussed:** *Sandy Hunt*

Sandy Hunt provided an update on the *Emergency Department Protocol* that was shared out with the 10 area agencies as a recommendation at the last summit. This has been utilized and has been effective. Dr. McLaren agrees. Another project that has been underway are the *ITS Metrics*. This is a pilot that Easter Seals, Columbia House, Neuro-International and Becket are participating in. These vendors are tracking data on the top 3 high utilizers within each of these programs. The first set of data is due in April. The *ITS Steering Committee* which includes Jonathan Routhier, Allison Howe, Marissa Berg, Sandy

Hunt and John Capuco meet regularly to continue to discuss and make sure the workgroups that were established continue to be on task and complete any follow up. *Community of Practice* continues to meet on a monthly basis to review ITS beds that are filled and the movement of these individuals when appropriate.

#### **Increasing Capacity: How to serve individuals within the existing service delivery system**

##### *Open discussion with Sandy Hunt*

Cottage House will be a 4 bed licensed home located on the state grounds in which Easter Seals will oversee. One of the challenges is that each individual that will reside in the home has their own budget and comes from a different region. This makes it difficult when the waitlist funding dollars are used differently in each region for various reasons. The regions and vendors are collaborating in making sure the rates are set. This has been a huge challenge for capacity development, but its finally working.

Carriage House which will be overseen by Becket is a 3 person male bed home with fire setting behaviors. Currently the budget for the environmental modifications is being addressed between the three area agencies that will be involved.

R9 is transitioning what was a respite home into an ID/TBI/dual diagnosis transition (18-36 months) residential treatment program that will have a 3 bed capacity called Bunker Lane. It could be a 4 bed home in the future, but moving to a 4 bed home is required to be licensed which requires education on the vendors part.

R8 is opening a 4 bed home with the hopes to expand to 6 beds called Prescott Road managed by Easter Seals. This home will either serve folks that have inappropriate sexual behavior and/or Autism. The challenge is that if HUD home funding is used, registered sex offenders are not permitted.

R7 is operating a 3 bed emergency short term placement called the Emergency Transition Program (Hall Street). Currently; it is only accepting Moore Center individuals. Kat King from The Moore Center shared that they are building staff capacity in order to open it up to other regions.

Neuro-International is coming to NH, however the requirement for their model is to work with the mental health center/NHH to their programs success.

**If you are a region or a vendor that would like to be part of increasing capacity within NH, please be in touch with the bureau and/or Marissa Berg from CSNI.**

Stephen Jewell from OPG questioned the mandates from the lawsuit against the mental health system regarding the development of the ACT teams Sandy Hunt responds that she has not had that specific discussion yet, but with the joint meetings that BDS and BMH are having this could be added.

#### **Program Model needs within the high-risk service delivery system in New Hampshire**

##### *Open discussion with Marissa Berg*

One of the conversations that was had recently at the ITS Steering Committee meetings was the continuum of care and what it looks like. Instead of using the word continuum, how does the word

ecosystem sound? A continuum concludes that it is directional; either way from one end to the other. **However, the services that are provided at the ITS level are cyclical; sometimes services need to be increased and at other times decreased.** Marissa is having open discussions with a group of folks regarding the ITS continuum/step down program models. **Marissa asked the questions: What actually exists in our ecosystem? Do we have partial hospitalization programs? Do we have a crisis center for individuals who have forensic involvement? Maybe this is looks like an individual living in their own apartment with a staff available right away for check ins? Will these individuals eventually be able to live independently?**

Kat King from R7 agreed that it's more cyclical versus directional (from one end to the other) with our population that has mental health and ID where supports may be needed greatly at one time of year than others. Unfortunately, with the 3 bed model and specialty services billing, it drives the cost up. **It could be beneficial to use share expenses among consultants. Marissa shared that we can look at the models that the mental health centers operate.**

Barb Drotos recommended that we **be mindful of when we are talking about services increasing and decreasing with the possibility of a move**, can we look at developing a model that takes this into consideration.

Bob Bowen from Fellowship Solutions shared that **OH has a model that separates the home from the service providers. The home stays the same and the service provider's change when the services need to change.** There were upfront costs to the non-profits, but the individual was in a consistent place. The resource is John Martin in OH.

Greg Steelman shared that kids who start in institutions also head into institutions as adults. **How do we help the bigger picture to minimize this option?**

Sandy Hunt shared that the area agencies have articulated that there are very little resources for transition planning for kids aging out of school (unless they have special education and the area agency has been working in conjunction with the school). In many cases, area agencies don't know about these individuals until they turn 21. Sandy Hunt has had a discussion with the Department of Education regarding a MOU with Vocational Rehab.

**Where do we go from here and final remarks: *Sandy Hunt***

Please make sure that evaluations in your folder are completed. If you did not complete a survey, please feel to complete the online version here:

<https://www.surveymonkey.com/r/NWVP55W>

There was discussion about holding an ITS Conference versus a Summit with the ITS Steering Committee, but a quick survey around the room suggested that a **yearly summit in March** would be good.

Unfortunately, we were not able to finish the updates to the Provider List located on the BDS website, but please check this link for the most current provider's that serve our individuals sometime in July 2018.

<https://www.dhhs.nh.gov/dcbcs/bds/documents/provideragencies.pdf>

Marissa is attending each area agencies Local Risk Management Committee meetings to give updates. Please be in touch with Marissa if you have any questions about ITS. Her contact info is

**Marissa Berg Office: 603-229-1982**

**E-mail: [mberg@csni.org](mailto:mberg@csni.org)**

Dr. Guidry is putting together a professional organization regarding treating individuals with problematic sexual behavior. The meetings take place at 4:30PM on the last Wednesday of the month at her office; 15 Pleasant Street Suite 3A Concord. Please e-mail Dr. Guidry at [lguidry@cipsinc.net](mailto:lguidry@cipsinc.net) to RSVP and to get on her e-mail distribution list regarding this new development.

You may find all the workgroups reports on the BDS website under Intensive Treatment Services as well as the minutes from all three Summits.

<https://www.dhhs.nh.gov/dcbcs/bds/its.htm>

Thank you all for coming to today's Summit; for working collaboratively, for your commitment to the people that we support and your creativity and flexibility. We have come a long way and we really appreciate your feedback.

Signed,

*Allison Howe, MS*

Allison Howe, MS

CSNI ITS Summit Coordinator

5.29.18