BUILDING BRIDGES:
PROVIDER SURVEY RESULTS

THE OHIO STATE UNIVERSITY
NISONGER CENTER

Building Bridges

For Adults with ID/DD
(Intellectual Disability and
Developmental Disabilities)
and MHD
(Mental Health Disability)

Provider Survey Results

Contents

Survey Development

The project's funder, the Administration for Community Living (see Funding Acknowledgment on page 21), provided initial guidance on the survey's scope through meetings with the Project Officer. Development of the survey's structure, questions, and distribution was also guided by members of the project's State Team during quarterly meetings. A multi-step process was conducted by project staff to inform and refine the final list of survey questions, which included stakeholder interviews and focus group sessions.

Project staff conducted ten stakeholder interviews with mental health providers and disability professionals that focused on learning about training needs and gaps related to serving adults with intellectual and developmental disabilities (IDD) and mental health disabilities. Field notes from the interviews were reviewed and summarized to develop questions that were used to guide focus group discussions with stakeholders related to effective therapeutic and intervention techniques for providing mental health treatment and services to adults with IDD.

Focus group questions asked about the referral process, the coordination of services, support, discrimination, and professional development needs. Three focus group sessions were held with stakeholders ranging from three to six participants who served adults with IDD as mental health or disability providers. Sessions were recorded and transcripts were analyzed and coded into themes. The resulting code book was used by the project staff to inform the survey scope and question development.

Project staff drafted a list of survey questions based on the results of stakeholder interviews and focus groups, which were reviewed internally for clarity and plain language and by members of the State Team for recommendations and refinement. The final list of questions was built into an online survey platform for distribution and data collection.

Survey Distribution

The provider survey was distributed through our collaborators and close networks such as Department of Developmental Disabilities, Ohio Department of Mental Health and Addiction Services, Ohio Provider Resources Association, Ohio Association of County Boards of DD, Ohio State Nisonger Center, and Nationwide Children's Hospital-Center for Autism Spectrum Disorders. We also asked our state team to share it within their networks. With the help of our state team and different sources, we were able to reach representative groups of providers from across the state (see figure 1).

Sample

There were a total of 273 total respondents; of those, 266 consented, 232 met eligibility criteria, and 216 submitted responses.

A majority of eligible respondents indicated that they were a mental health (MH) provider (n=145) and about a third indicated that they were an Intellectual Disability/Developmental Disability (ID/DD) provider (n=78).

Note*: **Seven ID/DD provider participants were missing a majority of responses for the survey, so they were removed from the final dataset.

The final dataset included N=216 providers, of which n=145 selected being a MH provider and n=71 selected being an ID/DD provider.

- **67% Mental Health (MH) Providers (n=145)**
- **33% Intellectual Disability/Developmental Disability (ID/DD) Providers (n=71)**

Of those who agreed to participate, 232 indicated that they provide services in Ohio, which was an eligibility requirement.

Ohio Service Area

Over a third of the eligible participants indicated that they provide services in counties that include Ohio's three largest cities:

- 16.0% Franklin County (Central – Columbus)
- 12.2% Cuyahoga County (Northeast – Cleveland)
- 9.4% Hamilton County (Southwest – Cincinnati)

Other Central Ohio counties included: Delaware (2.4%); Clark (1.9%); Licking (1.9%); Champaign (1%); Pickaway & Union (<1%).

Other Northeast Ohio counties included: Mahoning (2.8%); Stark (2.8%); Summit (2.4%); Medina (1.9%); Portage (1.4%); Richland (1.4%); Wayne (1.4%); Lorain (1%); Ashtabula, Lake, Jefferson, and Trumbull (<1%).

Other Southwest Ohio counties included: Montgomery (5.7%); Greene (3.8%); Butler (2.4%); Clark (1.9%); Warren (1.4%); Miami (1.4%); Ross (1%); Preble (<1%).

Northwest Ohio counties included: Auglaize (2.8%); Allen (1.9%); Wood (1.4%); Lucas (1.4%); Hancock (1%); Defiance, Erie, Mercer, Ottawa, Paulding, Seneca, and Van Wert (<1%).

Southeast Ohio counties included: Athens (2.4%); Muskingum (1.9%); Jackson, Lawrence, and Gallia (<1%).

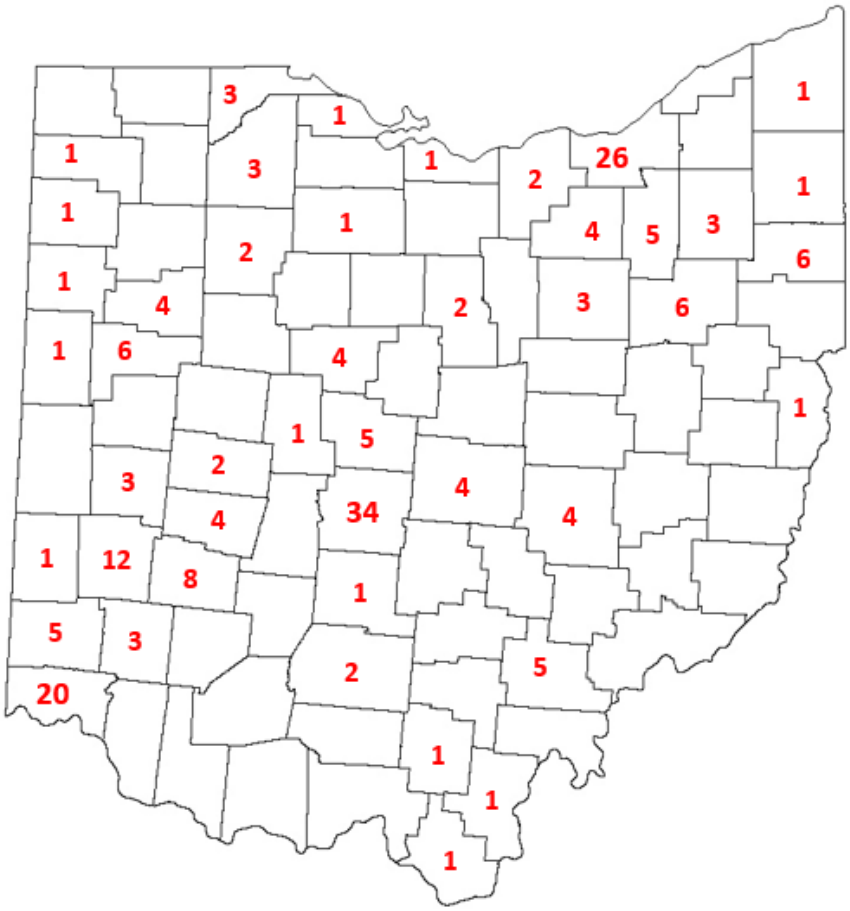

Figure 1. Map of Ohio County Representation

Professional License

A majority (87%) of all provider respondents (i.e., MH and ID/DD) indicated that they had a professional license or certification. The top two professional licenses were psychology license and Licensed Independent Social Worker with Supervision Designation.

- 28% Psychology License (n=52)
- 23% Licensed Independent Social Worker with Supervision Designation (n=44)

Additional license/certification types included:

- n=12 Licensed Professional Clinical Counselor (LPCC)
- n=11 Medical Doctor (MD)
- n=9 Social Security Administration (SSA)
- n=8 Licensed Professional Clinical Counselor with Supervision Designation (LPCC-SD)
- n=6 Licensed Independent Social Worker (LISW)
- n=5 Licensed Social Worker (LSW)

**Note*: Other types included: Certified Employment Support Professional (n=2); Adult Services Certification; Certified Rehabilitation Counselor; Investigative Agent; Registered Nurse; and Superintendent.

Years of Professional Experience

Nearly three quarters (n=160) of all provider respondents indicated that they have been working in their professional field for 10 or more years, and about 20% (n=42) selected 5 – 10 years of professional experience (n=42). About 7% (n=15) selected less than 5 years' experience.

Provider Type: Mental Health (MH) Providers

Job Titles

Social workers and psychologists were the top two types of MH providers:

- 38% Social Workers (n=54)
- 28% Psychologists (n=40)
- 18% Licensed Professional Counselors (n=25)
- 5% Psychiatrists (n=7)

Other job titles included: Marriage and Family Therapist (n=3); Physician (n=3); Administrator, Behavior Specialist, Behavior Intervention Coach, Clinic Owner, Social Work Intern, and Vocational Counselor (n=1), respectively.

Work Setting

About a third of the MH providers worked at a private practice. Outpatient clinics and community mental health centers/federally qualified health centers were also common work settings amongst the sample.

- 31% Private Practice (n=44)
- 22% Outpatient Clinic (n=31)
- 18% Community Mental Health Center/Federally Qualified Health Center (n=26)

Other types of settings included: emergency rooms, hospitals, medical centers and outpatient clinics, and pediatric and integrated primary care offices (n=12); local education agencies and institutes of higher education (n=6); psychiatric inpatient facilities (n=5); County Board of Developmental Disabilities (n=3); ADAMHS Board (n=2). Additional settings included: community telehealth; county therapeutic school; grief counseling agency; criminal justice and forensic setting; foster care; government; on-site consultation services; peer support facility; residential reentry facility; Veteran's Affairs.

Education Status

Nearly all (98.6%) MH providers indicated that they had earned a graduate or professional degree. Two participants were college graduates.

Age Groups Served

A majority (58%) of the MH providers indicated that they provide services to adults (i.e., 18+), and over 40% indicated that they provide services to children (i.e., 0 – 18). Participants were allowed to select multiple age ranges.

Years of Experience Providing MH Services to Adults with ID/DD and MHD

A majority (59%) of the MH providers selected that they have 10 or more years of experience providing services to adults with ID/DD and MHD, and about a third have 5 – 10 years' experience. About 8% selected less than 5-years of experience.

Provider Type: Intellectual and Developmental Disability (ID/DD) Providers

Job Titles

Over a third of the ID/DD providers were Service Coordinators/SSAs.

- 37% Service Coordinators/SSAs (n=28)
- 9% Direct Support Supervisors/Managers (n=7)
- 5% Direct Support Professionals (n=4)
- 5% Behavior Specialists (n=4)

About 40% (n=31) of the ID/DD provider participants selected *Other*, and job titles included:

- Psychologists (n=11);
- Administration/Management/Directors (n=6);
- Physicians (n=2).

Additional titles included: Behavior Specialist and License Social Worker; Independent Provider; Family Member; Investigative Agent; Medical Geneticist; Mental Health Therapist; Pediatrician; Physical Therapist; Registered Nurse; System Coordinator; and Trainer.

**Note*: Due to the overlap between ID/DD and MH provider job titles, some data was combined to summarize outcomes reported by both provider groups.

Work Setting

A majority (60%) of the ID/DD providers work in a community setting (n=45).

Eight percent indicated that they work in a hospital (n=6), and about five percent in clinics, residential programs, and day programs, respectively (n=4).

Other settings included: County Board of Developmental Disabilities (n=3); Intermediate Care Facility (n=3); Job Training; Outpatient Office; and In and Out of Home Waiver Services.

Education Status

A majority (89%) of the ID/DD providers indicated that they had earned advanced college degrees or higher.

- 46% (n=35) earned a graduate or professional degree, and 45% (n=34) were college graduates.

- Others earned a 2-year degree or had some college (n=5) or had a high school diploma (n=3).

Years of Experience Providing DD Services to Adults with ID/DD and MHD

A majority (66%) of the ID/DD providers selected that they had 10 or more years of experience providing services to adults with ID/DD and MHD (n=43) and nearly a quarter had 5 – 10 years' experience (n=15). About 11% selected between 1 and 4 years of experience.

NOTE: Supervise or Provide Services to Adults with ID/DD and Co-Occurring MHD

A majority (70%; n=150) of all provider respondents indicated that they provide services to adults with ID/DD and MHD. The responses of those who provide services are detailed first, followed by those who indicated they do not provide services to adults with ID/DD and MHD.

Referring and Initiating Services for Adults with ID/DD and MHD

Getting Connected to Adults with ID/DD and MHD

According to the provider participants, professional referral and family initiated contact were the top two ways that adults with ID/DD and MHD get connected to services.

- About 45% (n=94) of all provider respondents indicated that they get connected to adults with ID/DD and MHD through **professional referral**;
- About 30% (n=64) indicated that the family initiates contact;
- 9% (n=19) indicated that they make contact through a hospital discharge plan.

Other connections were made through a local County Board of DD (n=13); court or justice system (n=4); Local Education Agencies or school districts (n=3); and self-referral (n=3).

Barriers for Adults with ID/DD and MHD to Get Connected to Services

Of the 515 responses (select all that apply): (i) a shortage of adequately trained providers [23%]; and (ii) a lack of resources to support adults with ID/DD and MHD [22%] were selected as the top two barriers for adults with ID/DD and MHD to get connected to MH services;

- About 15% of the responses identified (i) difficulties with accessing systems and services [e.g., transportation; distance]; and (ii) difficulties in care coordination as key barriers to service, respectively;
- 12% of the responses identified that providers do not have the time it takes to make connections with the population;
- 9% indicated that insurance reimbursement was a barrier.

Collaboration Among Services and Treatment Teams

Collaboration teams are comprised of individuals who provide care and services to adults with ID/DD.

Survey Question: Who do you collaborate with when working with adults with ID/DD and mental health disability? (Select all that apply)

Of the 771 responses), about 14% identified individuals and caregivers, respectively, as members of a collaboration team.

- About 11% of the responses identified direct support professionals and service coordinators or SSAs, respectively, as members of a collaboration team;

- Fewer responses identified psychiatrists (9%), behavior specialists (8%), direct support supervisors or managers (8%), primary care physicians (6%), social workers (6%), and licensed professional counselors (5%) as collaboration team members.

- Only about 4% identified psychologists and nurse practitioners as members of a collaboration team, respectively;

- Responses also indicated that family members (n=3) and school staff (n=2) were members of a collaboration team.

Barriers to Collaboration

Of the 349 responses (select all that apply): (i) lack of funding for time spent collaborating [22%]; (ii) lack of support from mental health systems involved [21%]; and (iii) lack of knowledge of who needs to be involved in care coordination [20%] were selected as the top three barriers to collaboration.

- Additional barriers selected included lack of time to commit to collaboration (18%) and lack of support from disability systems involved (13%).

- Other responses included: lack of coordination/collaboration (n=5); lack of funds (n=3); and lack of training (n=3)

Training to Support Adults with ID/DD and MHD

Previously Received Training to Support Adults with ID/DD and MHD

Of n=135 responses, 79% indicated that they had previously received training to support adults with ID/DD and MHD.

Barriers to Training

Provider participants selected a lack of training resources as the top training barrier (40%) [n=204]

- About a quarter selected a lack of time to commit to training as a major barrier;
- Fewer respondents indicated that they did not know where to find training resources (10%) and a lack of support by their agency or employer (7%);
- Another identified barrier to training was a lack of funding (n=5) to provide or receive training;
- Other barriers to training included: lack of provider collaboration (n=2); lack of qualified staff; lack of provider buy-in; lack of training provided to direct support staff; "lack of emphasis on the importance of this issue in medical school and residency training;" and "willingness to recognize MH influence on a person's behavior [and] vice versa" as training barriers.

Training Priority Areas

The training areas included as options were generated as a part of key stakeholder interviews and focus group. Of the 674 responses (select all that apply), about **17% identified training around how different MH diagnoses present in adults with ID/DD as the top training priority area.**

- About 13%, respectively, indicated: (i) training on supporting the communication and learning needs of adults with ID/DD; (ii) training on systems of care for adults with ID/DD and MHD; and (iii) trauma informed care training when working with adults with ID/DD and MHD as training priority areas.

- About 11%, respectively, indicated: (i) introductory training on ID/DD; (ii) introductory training on autism; and (iii) cultural humility training when working with adults with ID/DD and MHD as training priority areas.

- About 10% of the responses represented person-centered care as a priority area.

Additional priority areas included:

- Practical strategies on how to support the mental health of adults with ID/DD and MHD;

- Evidence-based interventions and practices in mental health treatment for adults with ID/DD and MHD;

- Practical strategies on how to apply research in practice.

Other responses included:

- Ethics in diagnosing autism spectrum disorders;

- "Training specific to differential diagnostics with comorbid disorders and disabilities (*top training priority*);"

- "Behavioral and direct communication techniques, [such as] de-escalation and redirection skills;"

- "Training on what can be billed to insurance and what rules are regarding client engagement" [in mental health treatment];

- "Training on the treatment of problem behaviors;"

- "Rules to make sure people providing treatment have knowledge in providing treatment, as they do if it is a non-ID person;"

- "Training for how to understand coping with clients who might trigger staff's MH issues, and how to cope through this during a shift - the staffing shortage is burning many staff out despite the trainings;"

- "Affording an administrative component to the rate structure that specifically accounts for 1 on 1 training with new DSPs to work directly with the individuals they will be serving;"

- "Working memory training, sensory integration, learning styles, understanding how [to] work with each person [and] individualized to the patient's strengths and needs (*communication/cultural humility*), understanding how comorbid diagnoses impact treatment (*top training priority*), specific interventions, approaches to interventions, outcomes, the need for reimbursement for CBMT codes from both Medicaid/Medicare and commercial insurances, [and training] for multiple providers/caregivers/guardians to learn systematic ways to intervene consistently (*systems of care*)."

Preferred Training Format

Of the 354 responses (select all that apply), about a **quarter represented online learning collaborative with interactive case discussion (e.g., ECHO) as a preferred training method.**

- Webinars (23%), interactive online learning modules (20%), and videos to watch at my own pace (20%) were also selected as preferred training methods.

- Fewer respondents selected receipt of information from someone else in my agency who has expertise in this area (n=28) as a preferred training method.

Of the n=25 *Other* responses, 17 indicated in-person training (e.g., traditional classroom-style; hands-on demonstrations). Additional responses included university or graduate level coursework, conferences, seminars, and text or audio books.

Training Incentive

Of the 288 responses (select all that apply), 40% identified training that leads to continuing education credit as the top incentive.

- About 31% represented training that leads to a pay raise, and 24% represented training that leads to a certificate as training incentives.

- Other training incentive ideas included: payment for time spent; mandatory training; free availability; local relevance; positive outcomes; and agency support to allow time for training completion.

Services Provided:
Those Not Providing Services to Population of Interest

If No, Reasons for Not Providing Services to Adults with ID/DD and MHD

MH Providers

40% of MH providers who do not serve adults with ID/DD and MHD (n=34) indicated that the population is beyond their scope of work, including age range, and 30% indicated that the population is not referred to them. About 15% also indicated that they feel like they need more training to serve the population. Very few (n=3) indicated issues with financial reimbursement related to insurance.

ID/DD Providers

Four ID/DD providers indicated that their agency does not serve adults with an intellectual disability/developmental disability/autism and co-occurring mental health diagnosis, and one indicated that they refer mental health issues to psychiatry or psychology. *Note*: many ID/DD providers indicated a MH provider job title.

If No, Training Needed to Help Support or Serve Adults with ID/DD and MHD

MH Providers

- 18% of the MH providers who do not serve the population (n=26) indicated that training on **evidence-based practices** in mental health treatment for adults with ID/DD would be helpful.
- 16% (n=24) selected training on **supporting the communication and learning needs** of individuals with ID/DD
- 14% (n=21) selected training on **systems of care**
- 10% (n=15) selected training on **trauma informed care**
- About 10% (n=14) also selected a training on the **presentation of mental health symptoms** in adults with ID/DD
- Other training topics selected included: Background information on intellectual and developmental disabilities (ID/DD) and autism; practical strategies of how to apply

research in practice; manualized treatments; and accessibility and accommodations.

- Additional training topics included: person-centered care and safety.

ID/DD Providers

Two ID/DD providers that indicated that they do not serve the population selected: (i) Background information on co-occurring mental health diagnosis; and (ii) Presentation of mental health symptoms in adults with ID/DD as top training needs. Other training topics included: accessibility and accommodations; communication strategies; systems of care; and manualized treatments.

Additional Important Information

All respondents were invited to share any additional information related to the survey that they thought was important. Responses were coded and confirmed by four team members using a code book that was developed to analyze focus group data from this project gathered from prior listening sessions with mental health providers who had experience serving adults with intellectual and developmental disabilities (ID/DD). The top two themes identified by frequency across the survey responses included: (1) Bureaucratic Issues; and (2) Lack of Provider Coordination.

Addressing administrative and coordination concerns between developmental disability and mental health systems is needed to advance mental health care for adults with ID/DD in Ohio.

One respondent noted that:

> Both department directors need to emphasize an expectation of the two systems to work together and incentivize collaboration. Patients would be better served in a system that supported collaborative dialogue, mutual respect, and problem-solving approaches.

However, one developmental disability provider wrote that "Mental Health in my area seems to be unwilling or lack time to work with me or to attend team meetings where their expertise is invaluable to the team as a whole to support the person with dual diagnosis."

Another respondent wrote that:

> The Dual Diagnosed population should be respected as it own category need[ing] professionally trained services. Mental Health Agencies do not understand or know how to serve Dual Diagnosed and County Developmental Disability Agencies do not know how to support Mental Health.

One respondent submitted that the "systems seem to be either focused on disability services OR [*sic*] mental health," but if an individual is not "'severe enough', they cannot get the same support as [an individual] with more 'severe' developmental disabilities."

Another respondent lamented that there are "so many gaps in services, so many different holes in the system. So much money being spent on people who are 'easier to serve' [*sic*] in the DD system."

Another respondent mentioned:

> When encountering a person in the public mental health system who is suspected of having ID/DD in addition to mental health diagnosis, getting them connected to the DD system is extremely challenging. Often it is the lack of educational records that might support such involvement, but it is also due to the DD system personnel not understanding and/or not wanting to work with person with MH diagnoses.

As an example of coordinated care, a respondent suggested that "direct care staff need to have access to behavioral health consultation for specific clients to develop individualized treatment interventions."

"Good psychological treatment is needed," another respondent wrote, "but the department has done little to attract appropriate professional[s]," such as licensed counselors and psychologists. "By allowing 'behavior specialist[s]' to treat without even testing for knowledge has kept professionals out of the field. It saves money but would never be allowed for the general public."

One respondent noted that the "mental health care [system] and developmental disability system can't treat the same client due to insurance," which "causes lots of problems." And, another respondent noted general misunderstandings from DD system staff, who may think that Medicaid can be billed for all services. However, clients must be engaged in applicable services and show up to appointments. Recreational activities and team meetings are generally not billable services.

Another bureaucratic issue and potential solution noted by a respondent was that "there is a struggle to find time to complete [relevant] trainings. In the county board setting, billable time is preferred, and thus, many SSAs cannot complete trainings […] unless CEU's are offered" to professionals.

Moreover, one respondent suggested that "training on ways to get the Mental Health system and DD system to work together would be useful […] MH says their issues are DD, and DD says their issue are MH, and they are stuck in the middle with limited help."

One respondent concluded, "the two systems need to talk trainings on how to make this happen."

Other themes identified with high frequency, often in relation to the issues described above, included: (i) Barriers to Effective Treatment; (ii) Barriers to Establishing Care; (iii) Provider Training Content; and (iv) Provider Training Targets.

A major barrier to effective treatment was related to the need for relevant cross-disciplinary training for both developmental disability and mental health providers.

One comment emphasized the need for developmental disability providers to receive training on mental health conditions and symptoms: “Often staff felt mental health symptoms were behavioral issues that needed to be corrected instead of understanding clients were depressed or anxious or experiencing symptoms of trauma.”

Moreover, one respondent noted that individuals with dual diagnosis “are accepted into County Board of DD Agencies, yet they do not know how to care for this population.” They added, “Dual Diagnosed persons [are] desperately needing supports from trained professionals, [but] we place [them] in a community [where they] are kept and provided for by untrained staff who do not know/understand how to serve this population.”

“As a DD Professional,” one respondent noted, “mental health is not my area of expertise. Yet, I'm expected to know what supports to put into place for people who have serious mental health concerns.”

Cross-disciplinary training was also suggested by another respondent as an important strategy for improving care for adults with dual diagnosis: “Typically, it's hard to find someone who is comfortable with BOTH mental health and IDD. Usually, it's one or the other. Despite the fact that very little changes in terms of treatment for these individuals.”

Furthermore, a mental health provider explained:

> When I have provided some services to adults with both MH and DD challenges, I did not have the training to know the best approach to providing therapy to a DD individual. I felt like I was winging it and was worried I was not providing adequate care. I have almost never come across trainings to work with this population in my time in the field. Offering free or reduced cost trainings to clinicians would greatly increase the knowledge in the field to work with these populations.

Another mental health provider indicated that they “live in a very rural county where there are few mental health resources.” This barrier was accentuated by a lack of trained professionals.

> My son is an adult with developmental delay, and when we have looked for mental health services, the agencies say they aren’t trained to work with this population. It is very frustrating, as a clinician myself, that there are so few people who are trained or even interested in working with [this population].

One respondent mentioned that education and counseling “for clients and caretakers/professionals would go a long way,” but another mentioned that the “training has to be relevant.” While “theory provides insight and a direction to go, theory alone can be useless in the real-world, real-time application.” They suggested that “staff need to know what to do when and the supports need to be relevant to the individual,” such as knowledge of their trauma timeline.

Additionally, one respondent suggested that “having more training on this topic would be beneficial in many ways, as almost all of the individuals on my caseload have experienced trauma(s), and it impacts the way they interact with the world. Sometimes, it leads to MH challenges as well.”

One respondent specifically emphasized the need to train staff who work directly with the population on a daily basis: “It isn't about training the SSA or anyone other than the DSP [Direct Support Professional], who is with that person day in and day out. The DSP's need the training.”

One respondent recognized the need to provide training resources to law enforcement because “this population is often called to the attention of law enforcement without specific resources in the community.”

Finally, one respondent indicated that engagement in group therapy may be a barrier to effective treatment for autistic individuals or individuals with intellectual disability. An implication is that one-on-one therapy sessions may be beneficial for these populations. In fact, one mental health provider stated, “I am finding more young adults with ASD are seeking individual therapy and I want to make sure I am providing the best care possible.”

Themes identified with lesser frequency, which were also related or embedded within issues and responses described above, included: (i) Resources Needed; (ii) Discrimination; (iii) Direct Support Professional [DSP] Crisis; and (iv) Resources Identified.

In one example, a respondent commented that "my practice is primarily corporate, however, I get referrals for people with mental health issues [e.g., adults with depression, anxiety, and personality issues]. I am frustrated with the system and lack of resources."

Other respondents mentioned that "information specific to additional local resources and workflows for accessing these would be helpful," as well as "how to access supports within the system of DD."

One respondent commented that "mental health professionals/counselors continue to say they cannot support people with IDD."

Lastly, one respondent identified the Ohio Association of County Boards (OACB) as an existing community resource and potential collaboration partner for this project's work: http://www.oacbdd.org/.

Acknowledgements

Funding Provided to the Building Bridges Project, by ACL Award #90DDTI0045-01-00.

Report authors are as follows: Christine Brown, Andrew Buck, Manisha Khatiwada, Andrea Witwer

We would like to acknowledge and thank the following state team members for their contributions to this project:

Susan Havercamp, Paula Rabidoux, Marc Tasse, Andrea Witwer, Manisha Khatiwada, Kelly Barnett, Kellie Brown, Mark Butler, Dana Charlton, Julie Gentile, Abby Hammond, Erin Harris, Jason Harris, Tanya Hitchens, Willie Jones, Sara Lawson, Scott Marks, Latisha Martin, Vicki Montesano, Cindy Nava, Minerva Perez-Vargas, Barbara Sapharas, Emily Schmidlin. Lauren Shepler, Gary Tonks, Nathan Henninger, Jennifer Riha, Melissa Bacon, Kara Ayers, Meredith Mendoza