Integrating the Accountable Health Communities Model to Assess and Address SDOH in Home Care

Laura Benzel, MS, BS, CSSGB
Health Equity Lead

November 16, 2023
Agenda

• The Importance of Patient Data Collection to Address Health Disparities
• Overview of the CMS Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool
• AHC Case Studies for Culturally Responsive Approaches to Screening
• What To Do Once the HRSN Data is Collected
• Challenges to Screening
• Z-Codes
• Discussion
The IPRO QIN-QIO

- A federally-funded Medicare Quality Innovation Network–Quality Improvement Organization (QIN-QIO)
- 12 regional CMS QIN-QIOs nationally

**IPRO:**
New York, New Jersey, and Ohio

**Healthcentric Advisors:**
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

**Qlarant:**
Maryland, Delaware, and the District of Columbia

Working to ensure high-quality, safe healthcare for 20% of the nation’s Medicare FFS beneficiaries
Aligning Quality Goals

- Improving Care Transitions to Reduce Unnecessary Hospitalization
- Reducing Opioid-Related Adverse Events
- Promoting Chronic Disease Management
- Supporting Immunizations
- Enhancing Patient Safety
- Advancing Infection Control Strategies & Emergency Preparedness

**Partnership for Community Health**

Health Equity – Patient & Family Engagement – Health Information Technology
Patient Data is Foundational to Identifying Disparities & Unmet Social Needs

1. Commit to collecting high-quality patient sociodemographic data to identify and address disparities and unmet social needs.

2. Identify opportunities for improvement in your organization’s ability to collect, validate, stratify, and analyze patient sociodemographic data to identify and address disparities.

3. Take action by developing and implementing a plan to address the opportunities to improve the collection and utilization of patient sociodemographic data to identify and address disparities.
Sociodemographic Data

- Race
- Ethnicity
- Sex (assigned at birth)
- Sexual Orientation / Gender Identity (SOGI)
- Preferred Language
- Disability Status

- Social Risk Factors:
  - food insecurity
  - transportation barriers
  - housing instability
  - interpersonal safety
  - utilities difficulties
  - social isolation
  - poverty
## Sources of Patient Data

<table>
<thead>
<tr>
<th>Publicly Available</th>
<th>Internal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mapping Medicare Disparities Tool</td>
<td>• EHR/EMR</td>
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<tr>
<td>• Area Deprivation Index (ADI)</td>
<td>• Social Needs Assessments</td>
</tr>
<tr>
<td>• Social Vulnerability Index (SVI)</td>
<td>• Medicare Claims Data</td>
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<tr>
<td>• America’s Health Rankings</td>
<td>• Proprietary Analytic Platforms</td>
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<tr>
<td>• SDOH Dashboard Action Tool</td>
<td>• Patient / Provider Surveys</td>
</tr>
<tr>
<td>• County Health Rankings &amp; Roadmaps</td>
<td>• ICD-10-CM Codes</td>
</tr>
</tbody>
</table>
OASIS Section A

- A1010: Race
- A1005: Ethnicity
- A1110: Language
- M0069: Gender
- A1250: Transportation
- M0150/M0065/M0065: Dual Eligibility
- M0060: Zip Code

Health-Related Social Needs Screening Tools

The Accountable Health Communities
Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Service’s (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model. Thereby linking to work of systematically assessing and addressing social needs within healthcare settings. This tool helps identify social needs that have an effect as their total health care costs and helps their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that when we deal with social determinants like homelessness, hunger, and exposure to violence, we can only fully treat health. Only when with clinical assessment tools, providers can see the results from the HRSN Screening Tool to inform patient treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSN is a standard clinical practice yet. By using the AHC HRSN Screening Tool, you can ask your doctor about the tool in your community to make an AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper, we shared the 15-item HRSN Screening Tool. The Tool can help providers find out a patient's needs in these 5 core domains that community services can address:

- Food insecurity
- Transportation
- Housing
- Smoke
- Utility bills

Center for Medicare and Medicaid Innovation

Network of Quality Improvement and Innovation Contractors
Centers for Medicare & Medicaid Services
Quality Improvement & Innovation Group

QNNIC
HQIC
IPRO
Methods of Collection

The Accountable Health Communities Health-Related Social Needs Screening Tool

What’s the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

You at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model. We’re testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patient treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn’t standard clinical practice yet. We’re making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We’re sharing the AHC HRSN Screening Tool for awareness.

What’s in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper, we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients’ needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

Ways to collect social needs data

- Paper Survey
- Tablet
- Patient Portal
- In-Person
Discussion Question

What methods are your organization using to collect HRSNs data?

• Paper form
• Tablet
• Patient portal

• In-person
• Other method
AHC Screening Tool Core Domains

• Living Situation
• Food
• Transportation
• Utilities
• Safety
• Financial Strain
• Employment

• Family and Community Support
• Education
• Physical Activity
• Substance Use
• Mental Health
• Disabilities
AHC Case Studies

Using Culturally Responsive Approaches to Screening for HRSN
# Using Culturally Responsive Approaches to Screening

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Solution</th>
<th>Case Study</th>
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<tbody>
<tr>
<td>Patients over age 65 tended to be less receptive to HRSN screening and navigation services.</td>
<td>An engagement strategy to highlight the value of HRSN screening in a way that resonates with this population and improves engagement.</td>
<td>Accountable Health Communities Model awardees communicate the value of addressing health-related social needs</td>
</tr>
<tr>
<td>Empowering and inspiring clinical site staff to address HRSNs and educating them on how and why to do so.</td>
<td>Staff participated in simulation activities to increase awareness of the impacts of poverty on individuals’ lives and day-to-day decisions. Following the training, offers to screen increased by 160 percent.</td>
<td>A Spotlight on Aligning Clinical Partners to a Collective Vision to Address Health-Related Social Needs</td>
</tr>
<tr>
<td>How to continue HRSN screening during the COVID-19 public health emergency.</td>
<td>Launched an email campaign to conduct HRSN screening remotely. Used patient’s preferred language and the screening tool was beneficiary-specific to increase trust, included PCP name, and was accessible by mobile devices. Result: four-fold increase in % of patients who identified a HRSN.</td>
<td>You’ve Got Mail! A Spotlight on Using Email to Screen for Health-Related Social Needs</td>
</tr>
<tr>
<td>Identifying promising practices to better engage patients for screening.</td>
<td>Met in-person for patients who prefer this method of contact, used motivational interviewing that focuses on patients’ strengths and self-efficacy, and used multiple methods of contact for those patients with housing insecurity.</td>
<td>Promising Strategies For Community Service Navigation: Lessons From Health Quality Innovators</td>
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## Using Culturally Responsive Approaches to Screening

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<th>Identified Need</th>
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<tr>
<td>How to use technology to advance health equity.</td>
<td>• Provides access to culturally competent screening tools and referral resources in languages appropriate to the community.</td>
<td>Advancing Screening, Referral, and Navigation Beyond the AHC Model</td>
</tr>
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<td></td>
<td>• Collects, stores, and analyzes race, ethnicity, and language data to understand patient population and existing disparities.</td>
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<td></td>
<td>• Offers internships to surrounding schools and recruits bilingual interns. Bilingual staff are helpful in reaching non-English-speaking beneficiaries and connecting them to community resources.</td>
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<tr>
<td>How to foster trust and build confidence in patients to increase HRSN screenings.</td>
<td>• Uses customized scripts to engage patients in screening.</td>
<td>A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Updated August 2022 Promising Practices and Key Insights</td>
</tr>
<tr>
<td></td>
<td>• Co-creates scripted language with screening staff to help staff set the right tone with patients in a way that reflects their personal style and increases the chance that a patient will agree to participate in screening.</td>
<td></td>
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<tr>
<td></td>
<td>• Developed introductory screening scripts to describe the screening programs to better enlist patients in screening.</td>
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# CMS AHC Promising Practices and Key Insights

<table>
<thead>
<tr>
<th>Population</th>
<th>Screening-Related Challenges</th>
<th>Strategies</th>
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</thead>
</table>
| Patients with behavioral health needs | Patients may lack trust in the staff, providers, or health care system, and it may take longer to screen them. | • Train staff on communication strategies (for example, active listening and trauma-informed care) and draw on partnerships with peer supports, behavioral health providers, and community services to build trust and rapport with patients.  
• Ensure staff are prepared to spend extra time assisting patients with behavioral health needs. |
| Elderly patients                 | Patients may refuse screening because of stigma, fear of losing independence, or privacy concerns. | • Train screeners on using empathic inquiry and active listening techniques to engage elderly patients.  
• Enlist student or elderly volunteers who may be able to spend more time with patients. |
## CMS AHC Promising Practices and Key Insights

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<th>Population</th>
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<tbody>
<tr>
<td>Patients from racial or ethnic groups that differ from staff</td>
<td>Staff may have unconscious biases or make assumptions based on patients’ physical appearance or race/ethnicity.</td>
<td>• Enlist the expertise of diversity and inclusion committees to help staff recognize cultural differences, biases, and assumptions, and to promote cultural sensitivity.</td>
</tr>
<tr>
<td>Non-English speakers</td>
<td>The AHC screening tool is publicly available in <a href="#">English</a>, <a href="#">Spanish</a>, <a href="#">Portuguese</a>, <a href="#">Arabic</a>, <a href="#">Chinese</a>, <a href="#">Japanese</a>, <a href="#">Korean</a>, <a href="#">Vietnamese</a>, <a href="#">Tagalog</a>, <a href="#">German</a>, and <a href="#">Ilocano</a>. Note: the non-English translations were made using the multiuse version of the screening tool.</td>
<td>• Translate the AHC HRSN Screening Tool and any related materials to languages commonly spoken in the community. When developing translations, engage a native speaker in the process to ensure quality and be sure to consider the dialect. • Hire bilingual screeners who represent common languages in the population served, and use telephonic interpreting services.</td>
</tr>
<tr>
<td>Sexual and gender minorities (SGM)</td>
<td>Patients may not feel accepted at the screening site.</td>
<td>• Promote an inclusive and welcoming culture, train staff on SGM needs and hold staff accountable for creating a safe space. • Use signs, stickers, or flags to signal that the site is SGM friendly. • Note that the proxy and multiuse versions of the AHC HRSN Screening Tool include gender-neutral and inclusive language.</td>
</tr>
</tbody>
</table>
What Should You Do Once You Have the HRSN Data?
Have a Plan in Place

• Prior to initiating HRSN screenings:
  - Train staff.
  - Establish a referral workflow or process.
  - Create and sustain partnerships with community-based organizations.
  - Identify social service providers (e.g., social workers, care managers, patient navigators).
  - Identify appropriate resources and services.
    • All screening and referral staff should be aware of and have access.
When a Patient Screens Positive

• Ask the patient if they would like support
  – Through shared-decision making, offer to help them prioritize their needs.
  – Consider using trauma-informed techniques, empathic inquiry, and culturally appropriate language when discussing HRSNs.
  – Ensure sufficient time to discuss the HRSN(s) with patients.
  – Consider developing tailored scripts to address different HRSNs, different languages, and cultural differences.

• Anticipate challenges
  – Shame, fear, stigma, trauma associated with HRSNs.
  – Perceived power imbalance between staff and patient.
  – Social and cultural norms.
Once the Patient is Referred

• Document HRSNs using ICD-10 Z-codes.

• Follow closed loop procedures to ensure the patient is connected to appropriate resources or services and are not lost in the process.

• Use bidirectional data sharing between your agency and community partners to better understand outcomes such as whether:
  - Patients used the service(s) offered;
  - Patients’ experience with the service/resource.

• Rescreen patients at regular intervals to determine whether the HRSN has resolved or if they need additional support.
Leveraging HRSN Data

• Review aggregate HRSN data across patients regularly to:
  – Understand overall trends in HRSNs including reductions in HRSNs over time among those patients screened.
  – Identify at-risk populations allowing for a targeted approach to improve screening and support of identified at-risk populations.
  – Reassess and recalibrate your approach to address HRSNs to meet evolving patient needs.
  – Prioritize development of new community partnerships, social services, and other resources.
Understand the Data

Example HRSN Services

<table>
<thead>
<tr>
<th>Food/Nutritional Insecurity</th>
<th>Utilities/Housing Instability</th>
<th>Transportation Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supplemental Nutrition Assistance Program (SNAP)</td>
<td>• Subsidies for utilities</td>
<td>• Parking / bus passes</td>
</tr>
<tr>
<td>• Medically tailored meals</td>
<td>• Subsidies for rent or assisted living communities</td>
<td>• Non-emergency / non-medical transportation</td>
</tr>
<tr>
<td>• General meal services</td>
<td>• Structural home modifications</td>
<td>• Local discount transportation services</td>
</tr>
<tr>
<td>• Food vouchers / food cards</td>
<td>• Family &amp; martial counseling</td>
<td>• Reimburse for transportation</td>
</tr>
<tr>
<td>• Home-delivered meals</td>
<td>• Access to companion care</td>
<td>• Transportation vouchers: taxi, Uber, Lyft</td>
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<tr>
<td>• Congregate meal settings</td>
<td>• Events to address isolation</td>
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</tbody>
</table>
Screening Challenges - Staff

• Staff may be reluctant to screen patients due to:
  – Discomfort or lack of confidence discussing social needs with patients.
  – Time required to appropriately and responsibly screen for and discuss HRSNs with patients.
  – Lack of a standardized process to screen patients and track referrals among those who screen positive.
  – Inability to adequately address patients’ social needs.
  – Limited knowledge of available resources and/or lack of available resources.
  – Insufficient training on how to properly screen for and discuss HRSNs with patients.
## Addressing Staff Reluctance

<table>
<thead>
<tr>
<th>Screening Challenge</th>
<th>Best Practices</th>
</tr>
</thead>
</table>
| Staff discomfort                     | • Train staff on motivational interviewing and cultural sensitivity.  
• Educate on the importance of collecting HRSN data.  
• Share patient success stories. |
| Time required                        | • Integrate screening into workflows.  
• Encourage use of multiple modalities: phone, in-person, or via portal. |
| Lack of standardized process         | • Select evidence-based screening tools such as PRAPARE and AHC HRSN.  
• Conduct Z-Code training and designate staff for data entry. |
| Inadequate IT infrastructure         | • Select a platform with a central database that tracks referrals to community-based organizations. |
| Inability to address the need        | • Engage social workers, case managers, and community health workers as appropriate. |
| Lack of knowledge about resources    | • Collaborate with community-based organizations to identify available resources and educate staff on the resources. |
Patient Screening Challenges

• Patients may be reluctant to answer screening questions or discuss their social needs due to:
  – Shame or embarrassment.
  – Concerns about how the information will be used and potential consequences of screening positive for a social need.
  – Stigma and bias from others and/or the community.
  – Perception of unequal power dynamic between the patient and person/agency collecting the data.
  – Systemic racism and discrimination in the healthcare system.
  – Discomfort sharing struggles or needs due to social and cultural beliefs.
Addressing Patient Reluctance

• Provide training and hire appropriate staff
  – Use empathic and motivational interview approaches, racial inequity, cultural competence, trauma-informed care.
  – Consider using community health workers from patients’ communities.

• Build collaborative relationships with communities
  – Understand social and cultural differences, potential stigma, and bias around screening.

• Create a safe space
  – Discuss patient privacy and confidentiality of their data.
  – Offer to screen or discuss positive screening results in different settings (phone, telehealth, in-person).
  – Listen and learn from the patient to understand their concerns.
SDOH Z Codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter codes used to document SDOH data.

<table>
<thead>
<tr>
<th>Z55 Problems related to education and literacy</th>
<th>Z60 Problems related to social environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z56 Problems related to employment and unemployment</td>
<td>Z62 Problems related to upbringing</td>
</tr>
<tr>
<td>Z57 Occupational exposure to risk factors</td>
<td>Z63 Other problems related to primary support group</td>
</tr>
<tr>
<td>Z58 Problems related to physical environment</td>
<td>Z64 Problems related to certain psychosocial circumstances</td>
</tr>
<tr>
<td>Z59 Problems related to housing &amp; economic circumstances</td>
<td>Z65 Problems related to other psychosocial circumstances</td>
</tr>
</tbody>
</table>
New CMS OMH Resource

IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes

What Are Z Codes?
- Z codes refer to factors influencing health status or resources for contact with health services that are not classifiable elsewhere as diseases, injuries, or external causes.

What Are SDOH & Why Collect Them?
- SDOH are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and costs.

Using Z Codes for SDOH
- SDOH information can be collected before, during, or after a health care encounter through structured health risk assessments and screening tools.
- These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor that influences the patient's health.
- Coding professions may include documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record.

ICD-10-CM Z Codes Update
- New SDOH Z codes may become effective each April 1 and October 1. New codes are announced prior to their effective date on the CDC website.
- Use the CDC National Center for Health Statistics ICD-10-CM Browser Tool to search for all the current Z codes.
- Join the public process for SDOH code development and approval through the ICD-10-CM Coordination and Maintenance Committee.

For Questions Contact: The CMS Health Equity Technical Assistance Program | ICD-10-CM Office Guidelines for Coding and Reporting FY 2020

go.cms.gov/OMH

Health Equity 2000 - SDOH healthcare organization
New CMS OMH Resource

Exhibit 1. Recent SDOH Z Code Categories and New Codes

- 255.5 – Less than a high school diploma (Added, Oct. 1, 2021)
- 255.6 – Problems related to health literacy
- 256 – Problems related to employment and unemployment
- 257 – Occupational exposure to risk factors
- 258 – Problems related to physical environment (Added, Oct. 1, 2021)
- 258.81 – Basic services unavailable in physical environment
- 258.82 – Other problems related to physical environment
- 259 – Problems related to housing and economic circumstances
  - 259.0 – Homelessness (Updated)
  - 259.01 – Homelessness unspecified (Added, Oct. 1, 2021)
  - 259.02 – Unsheltered homelessness (Added, Oct. 1, 2021)
  - 259.03 – Inadequate housing (Updated)
  - 259.04 – Inadequate housing, unspecified (Added, Oct. 1, 2021)
  - 259.12 – Inadequate housing utilities
  - 259.13 – Other inadequate housing
  - 259.4 – Lack of adequate food (Updated)
  - 259.41 – Food insecurity (Added, Oct. 1, 2021)
  - 259.45 – Other specified lack of adequate food (Added, Oct. 1, 2021)
- 259.8 – Other problems related to housing and economic circumstances (Updated)
- 259.81 – Housing instability, housed, with risk of homelessness (Added, Oct. 1, 2021)

- 259.924 – Housing instability, housed, unassigned (Added, Oct. 1, 2021)
- 259.913 – Housing instability, housed, unspecified (Added, Oct. 1, 2021)
- 259.912 – Housing instability, housed, homelessness in past 12 months (Added, Oct. 1, 2021)
- 259.911 – Housing instability, housed, unspecified (Added, Oct. 1, 2021)
- 259.82 – Transportation insecurity (Added, Oct. 1, 2021)
- 259.91 – Financial insecurity (Added, Oct. 1, 2021)
- 259.97 – Material hardship due to limited financial resources, not elsewhere classified (Added, Oct. 1, 2022; Revised, April 1, 2022)
- 259.81 – Other problems related to housing and economic circumstances (Added, Oct. 1, 2021)

- 260 – Problems related to social environment
  - 260.22 – Upbringing away from parents
- 261.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)
- 260.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)
- 260.9 – Other specified problems related to upbringing (Updated)
- 260.91 – Personal history of abuse in childhood
- 260.814 – Personal history of child financial abuse
- 260.615 – Personal history of intimate partner abuse in childhood
- 260.82 – Parent-child conflict
- 260.63 – Non-parental relative or guardian-child conflict (Added, Oct. 1, 2023)
- 260.93 – Non-parental relative-child conflict (Added, Oct. 1, 2023)
- 260.923 – Non-parental relative-guardian conflict (Added, Oct. 1, 2023)
- 260.93 – Group home staff-child conflict (Added, Oct. 1, 2023)
- 260.98 – Other specified problems related to upbringing
- 260.692 – Runaway from current living environment (Added, Oct. 1, 2023)

- 263 – Other problems related to primary support group, including family circumstances
- 264 – Problems related to certain psychosocial circumstances
- 265 – Problems related to other psychosocial circumstances
Q&A
Discussion Question

What obstacles has your organization encountered when screening for health-related social needs?
Discussion Question

Has your organization experienced any successes in terms of your processes or approaches to screening?
Discussion Question

Please share your responses in the chat

How is your organization leveraging its HRSN screening data to improve health equity?
Resources On Data Collection and Scripting

Center for Medicare & Medicaid Services (CMS)
- Accountable Health Communities Health-Related Social Needs Screening Tool
- Accountable Health Communities Model Website
  https://www.cms.gov/priorities/innovation/innovation-models/ahcm
- Disparities Impact Statement

National Association of Community Health Centers®
- PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
  https://prapare.org/the-prapare-screening-tool/

Fenway Institute
- SOGI Data Collection Resources

The Physicians’ Foundation
- Take 5 Conversation Starter
  https://physiciansfoundation.org/take-five/

IPRO QIN-QIO
- Social Determinants of Health: A Guide for Getting Started
  https://qi-library.ipro.org/2023/01/31/social-determinants-of-health-sdoh-a-guide-for-getting-started-for-getting-started/
Have Questions? Contact us!

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<tr>
<td>Fred Ratto</td>
<td>Diane Judson</td>
<td>Sara Butterfield</td>
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References


