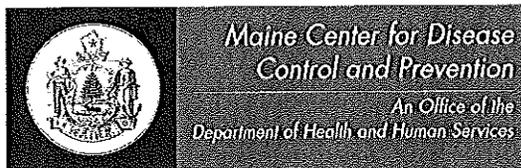


Report
from the
Maine Injury Prevention Program
and
Maine Primary Care Association
sponsored
Symposium on
Integration of Suicide Prevention in
Maine's Community Health Centers

June 29, 2010



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Executive Summary

Every year, the Maine Injury Prevention Program's (MIPP) convenes a symposium on a leading cause of serious injury and death in Maine. The purpose is to provide education and data on the topic and to engage key stakeholders in active discussion to address the injury cause. In 2010, the symposium focused on suicide prevention, specifically on the integration of effective suicide prevention strategies within Maine's network of Community Health Centers.

Suicide and suicide attempts are tremendously costly, emotionally and financially. Suicide deaths have immediate and long-term financial, emotional, and social consequences. Suicide is a leading cause of death in Maine and in 2007, the most current year that national data are available, Maine ranked 14th highest in the nation for suicide among persons of all ages. The number of people who die by suicide in Maine has been fairly consistent over the decade; however, there has been an increase in the number of deaths from suicide in recent years, beginning in 2007 and continuing through 2010. Although it is too soon to know whether this increase will become an increasingly upward trend in the suicide rate, it is cause for concern and provides a strong impetus to focus on suicide prevention in Maine's Community Health Centers.

The Maine Primary Care Association (MPCA) was instrumental in the planning and delivery of this symposium and served as co-sponsor for the event with the MIPP. Participants included approximately 60 individuals representing eleven community health centers, federal and state agencies, School-based Health Centers, a variety of relevant non-governmental organizations and suicide survivors. The symposium was designed to increase participants' understanding of suicide in Maine, effective suicide prevention strategies currently being used in primary care settings in Maine and across the nation, and the resources available in a new toolkit for primary care settings. At the same time, opportunities were created to build relationships, initiate collaboration, and identify realistic next steps for improving the integration of suicide prevention into the services of Maine's Community Health Centers.

Plenary sessions included presentations from David Litts, Director of Science and Policy for the national Suicide Prevention Resource Center (including the unveiling of a brand new, "Suicide Prevention Toolkit for Rural Primary Care"), Erika Lichter, Assistant Research Professor at the University of Southern Maine, Dr. Trip Gardner, Chief of Psychiatry at Penobscot Community Health Center in Bangor, Maine and Cheryl DiCara, MIPP Director and Coordinator of the Maine Youth Suicide Prevention Program.

Following the presentations, participants worked in six small groups to discuss the path to integration in more detail. Each group spent one hour considering the strengths, challenges, decision-makers, and next steps needed for more fully integrating behavioral health, including depression/suicide screening and assessment into Maine's Community Health Centers.

Themes clearly emerged within and between groups. Most groups believed that the Community Health Centers were strongest in their committed and diversified staff, their linkages to broader health systems, and their existing experience with other types of screenings. Several of the groups also pointed to the growing public and provider awareness of the impact of depression, as well as to the champions for integration that already exist on a few Community Health Center boards and among high-level staff.

There was considerable consensus regarding challenges, with all groups highlighting the need for improved training, formal protocols, and the importance of creating a supportive culture at all levels of staffing. Key decision-makers were identified and include board members, medical directors, and operations/executive directors. Most groups also noted the importance of engaging consumers in the planning and implementation process, as they could provide powerful influence over Community Health Center policy.

Participants worked as a group to identify actions needed in six key areas: education, training, communication, partnership-building, research, and advocacy. At the end of the day, the MIPP and MPCA were able to clearly identify next steps they could each take to assist in the efforts needed to fully integrate behavioral health, including the screenings, assessments, and referrals for depression/suicide, into Maine's Community Health Centers.

By all accounts, the symposium achieved its goals of educating, building relationships, improving collaboration, and charting a course towards full integration. Participants left the symposium feeling generally very positive and enthusiastic. A great deal of energy and interest was generated for continuing the conversations and establishing concrete plans for action.

Introduction

Every year, as part of the Maine Injury Prevention Program's (MIPP) CDC Core Injury Surveillance Grant #3U17CE124819-05W1, the MIPP conducts a symposium on a leading cause of serious injury and death in Maine for the purpose of providing education and data on the topic and engaging key stakeholders in defining actions to address the injury cause. The MIPP is a program of the Division of Family Health in the Maine CDC, DHHS. Prior symposia include unintentional poisoning, elder falls prevention, integrating injury prevention into Maine's Public Health Districts, teen driving, and child passenger safety.

In 2010, the symposium focused on suicide prevention, specifically on the integration of effective suicide prevention strategies within Maine's Community Health Centers. This symposium was facilitated by Carol Kelly of Pivot Point, Inc. Suicide and suicide attempts are tremendously costly, emotionally and financially. Suicide deaths have immediate and long-term financial, emotional, and social consequences. The cost of suicide is not limited to deaths. Many more people survive suicide attempts than die by suicide. Researchers estimate that for every person who dies by suicide, twenty-five to one hundred others attempted suicide.¹ Suicide is a leading cause of death in Maine. In 2007, the most current year that national data are available, Maine ranked 14th highest in suicide rate among persons of all ages, 10th highest among elders over age 65 and 6th highest among youth aged 15-24. The number of people who die by suicide in Maine has been fairly consistent through 2006. However, there has been an increase in the number of deaths, from an average of 166 per year between 2003 and 2007, to 191 deaths in 2007, 186 deaths in 2008 and 187 deaths in 2009.² Preliminary data for 2010 indicate a continuing upward trend. Although it is too soon to know whether the suicide rate increase will continue to trend upward in Maine, it is cause for concern and provides a strong impetus to focus on suicide prevention in Maine's Community Health Centers.

The Maine Primary Care Association (MPCA) was instrumental in the planning and delivery of the symposium and served as co-sponsor for the event. Participants included approximately 60 individuals representing eleven Community Health Centers, federal and state agencies, School-based Health Centers, a variety of relevant non-governmental organizations and suicide survivors. All participants were interested in learning more about reducing suicide and self-inflicted injuries through the integration of behavioral health, including screening, assessment, and referral protocols for depression/suicide, into Maine's Community Health Center services.

The symposium was designed to increase participants' understanding of 1) suicide in Maine, 2) effective suicide prevention strategies being used in primary care settings, 3) what's happening in Maine's Community Health Centers and statewide suicide prevention program, and 4) the information and resources available in a new primary care toolkit. At the same time, opportunities were created to build relationships, initiate collaboration, and identify realistic next steps for improving the integration of suicide prevention into the services of Maine's Community Health Centers.

The first half of the symposium included plenary sessions outlining the data behind suicide and self-injury in Maine; the resources available through the Maine Injury Prevention Program; a presentation by David Litts, Director of Science and Policy for the national Suicide Prevention

¹ McIntosh, JL (for the American Association of Suicidology). (2009). *U.S.A. suicide 2006: Official final data*. Washington, DC: American Association of Suicidology, dated April 19, 2009, downloaded from <http://www.suicidology.org>.

² Lichter E. "Suicide and Self-Inflicted Injury in Maine." Presentation at Suicide Prevention Symposium June 29, 2010.

Resource Center (including the unveiling of a brand new, “Suicide Prevention Toolkit for Rural Primary Care”, which provides a useful set of resources currently being piloted in several rural states); a case study of behavioral health integration from Dr. Trip Gardner, Chief of Psychiatry at Penobscot Community Health Center in Bangor, Maine and a brief description of the Maine Injury Prevention Program by Program Director Cheryl DiCara, who also serves as Coordinator of the Maine Youth Suicide Prevention Program.

In the afternoon, participants used the model presented by Dr. Litts to self-identify where their organization currently sits on the path to integration. Following this exercise, the full group broke into small teams to discuss what’s working, what the ongoing challenges are, and who the decision-makers are for advancing integration. The full group reconvened at the end of the day to hear the highlights of the small group work and identify the next steps needed at the local, state, and federal levels. The results of these discussions are summarized below.

Outcome Summary

Symposium participants were enthusiastic and engaged throughout the day. The plenary sessions generated a great deal of questions and participants were anxious to delve into ideas for integrating the new model and tools into Maine’s Community Health Centers. To help ground the small groups in the current environment, Community Health Center representatives self-identified their organization’s level of behavioral health integration using the following loosely defined criteria:

- Level 1: Separate sites - no communication between primary care and behavioral health staff
- Level 2: Separate sites with some information sharing (but not on every patient)
- Level 3: Same site but all other systems are separate
- Level 4: Same site and some systems are shared
- Level 5: Fully integrated - no difference between primary care and behavioral health

Representatives placed their organizations at the following levels and identified what they were most looking forward to as the integration process unfolds.

Health Center Self-Identified Level of Integration

<i>Health Center</i>	<i>Level</i>	<i>Representatives are most looking forward to:</i>
Penobscot/Summer Street	5	Toolkit protocol
DFD Russell	5	Suicidology toolkit
York	4	Prevention protocols
Sacopee	5	Care management; office layout
Eastport	3	New tools
Maine Migrant HP	3.5	Provider resources; consistent tools
Portland HC4 Homeless	4	Suicide prevention to PC
Health Access Network	3.5	Linkages between FQHCs
Aroostook	4 (Atlantic 3)	Toolkit structure and materials
Healthways - Lubec	2.5	Screening tools
Maranacook Student Health Center	4.5	

Six small groups were formed to discuss in more detail the path to integration. Each group spent one hour discussing the strengths, challenges, decision-makers, and next steps needed for

more fully integrating behavioral health, including depression/suicide screening and assessment into Maine's Community Health Centers.

Facilitators for the small groups were

- Carrie Horne, NAMI Maine
- Peter MacMullan, Veterans Administration
- Greg Marley, Medical Care Development, Inc.
- Joseph Riddick, Maine Injury Prevention Program
- Linda Williams, Medical Care Development, Inc.
- Katharyn Zwicker, Maine Injury Prevention Program

Themes clearly emerged within and between groups. Most groups believed that the Community Health Centers were strongest in their committed and diversified staff, their linkages to broader health systems, and their existing experience with other types of screenings. Several of the groups also pointed to the growing public and provider awareness of the impact of depression, as well as to the champions for integration that already exist on several Community Health Center boards and among high-level staff.

There was considerable consensus regarding challenges to integration, with all groups highlighting the need for improved training, formal protocols, and the importance of creating a supportive culture at all levels of staffing. Key decision-makers include board members, medical directors, and operations/executive directors. Most groups also noted the importance of engaging consumers in the planning and implementation process, as they could provide powerful influence over Health Center policy.

The full group reconvened and identified the following next steps in six key areas:

- Education
 - Create and distribute a DVD
 - Share information on billing (*Maine Primary Care Association will gather information from Trip Gardiner's presentation and distribute*)
 - Compile resource information necessary to support the Centers in accessing behavioral health services for patients in need of services. Resource compilation could include information such as Maine MH laws regarding hospitalization and commitment, state hospital locations, MH admissions procedures, hotline #s, etc.
 - Share the list of Community Health Centers that have integrated care. This will foster:
 - Referrals
 - Information sharing/networking
 - Better public information
- Training
 - Develop/share training manuals
 - Develop/share online trainings for providers (during off-hours for continuing education credits)
 - Create ways for all to learn from the most integrated Community Health Centers
 - Develop standardized protocols - including for children and teens
- Communications

- Create/share list-serves for staff and workforce development training
 - National
 - Maine (Maine Primary Care Association will explore)
- Provide 6-12 month update and reconvene participants
- Potential Partners
 - Office of Mental Health
 - Adcare
 - Crisis teams
 - More medical providers
 - Hospitals
- Research/Measures
 - Assess integration of behavioral health in Maine Health Centers (Maine Primary Care Association will follow-up)
 - Compile research/data on the effectiveness of integration
 - Develop fidelity measures, including
 - Peer review process
 - Behavioral Health integration
 - Depression/suicide
- Advocacy (policy changes to support)
 - Training mandate
 - Medicare to cover cost of
 - Groups
 - Substance abuse treatment
 - Crisis evaluation
 - Case management
 - Licensed Clinical Professional Counselors (LCPCs)
 - Provider incentives (e.g. blue ribbons)
 - De-stigmatization of treatment for MH professionals
 - Disallow discharges to homeless shelters

A great deal of energy and interest was generated for continuing the conversations and establishing concrete plans for action. The Maine Injury Prevention Program and the Maine Primary Care Association were able to clearly identify next steps they could each take to expand the education, training, communication, partnership-building, research, and advocacy efforts needed to fully integrate behavioral health into Maine's Community Health Centers.

Participants left the symposium feeling generally very positive and enthusiastic. In their evaluations of the day, 79% of participants said the program was "excellent", with the balance saying the program was "good". When asked about the practical value of the program when applied to their daily practice, 59% of respondents said "excellent", 38% said "good", and 3% said it was "adequate".

By all accounts, the symposium achieved its goals of educating, building relationships, improving collaboration, and charting a course that will lead to full integration of behavioral health services, including screening, assessment, and referrals for depression/suicide, into Maine's Community Health Centers

Appendices Index

1. Symposium Agenda
2. Goals for the Day
3. Participants
4. Speakers
5. Presentations
6. Evaluation summary

Appendix 1: Symposium Agenda

8:00 Registration

8:30 Welcome – Steve Meister, MD, DFH Medical Director, Maine CDC, and Ann Haas, Ph.D., National Director of Prevention Projects, American Foundation for Suicide Prevention

8:45 Review: Agenda and goals for the day – Carol Kelly, facilitator

8:55 Maine Injury Prevention Program (MIPP): Your Link to Training, Data and Resources
Cheryl DiCara, BSW, Program Director, MIPP and Coordinator, Maine Youth Suicide Prevention Program

9:10 Suicide and Self-injury in Maine - Erika Lichter, Ph.D., Epidemiologist, University of Southern Maine

9:35 Linking Together a Chain of Care: How Clinicians Can Prevent Suicide – David Litts, MD, Director of Science and Policy, National Suicide Prevention Resource Center

10:35 Break

10:45 How to Create a Fully Integrated Behavioral Health Model - Successes and Challenges Trip Gardner, MD, Medical Director, Behavioral Health Program, Penobscot Community Health Center and Valli Geiger, BSN, Director, Quality Improvement, Maine Primary Care Association

11:45 Discussion: – Where do Maine's Community Health Centers see themselves on the continuum of integration of behavioral health services? - Carol Kelly

12:00 Lunch

12:45 A Guided tour of the new SPRC/WICHE Primary Care Toolkit - Dr. David Litts

1:30 Small Group Discussions – Carol Kelly

Questions to be answered:

1. Who are the decision makers in the community health centers to be involved in deciding next steps for integration of behavioral health including suicide screening and assessment into health centers?
2. What are the current strengths in behavioral health/suicide screening and assessment in Community Health Centers?
3. What are the challenges to integrated behavioral health/suicide screening and assessment in Community Health Centers?

2:45 Report back - highlights of small group ideas

3:15 Large Group Discussion: What's next? - Carol Kelly

What help do Community Health Centers need to get started?

- What information is needed initially?
- What training in suicide is needed?
- What is needed from the MePCA?
- What else do you think might be needed?

How do we keep the discussion going towards integration of suicide screening and assessment?
(emails, second meeting in 6 months, website ...)

4:00 Closing

Appendix 2: Goals for the Day

Long-term Goal: Integrate behavioral health including depression/suicide screening, assessment, and referral protocols into Maine's Community Health Center services

Symposium Goals:

- Increase understanding of suicide and self-inflicted injuries in Maine
- Increase understanding of effective suicide prevention strategies in primary care settings
- Increase understanding of what's happening in Maine's community health centers and statewide suicide prevention program
- Build relationships and initiate collaboration between suicide prevention, mental health, community health center and other interested professionals
- Identify strengths, challenges, and key decision-makers and develop realistic next steps for the integration of suicide prevention into Maine's Community Health Centers

Appendix 3: Participants

First Name	Last Name	Agency
Olga	Alicea	Maine Migrant Health Program
Rita	Baron	Penobscot Community Health Center
Emily	Barrington	Penobscot Community Health Center
Catherine	Brodeur	York County Community Health Care
April	Clark	Sacopee Valley Health Center
Katherine	Cook	Eastport Health Care
Susan	Cross	Behavioral Health Services
Joanne	De Campos	Medical Care Development
Margie	Dickens	Penobscot Community Health Center
Melissa	Doughty	Penobscot Community Health Center
Angela	Fileccia	Summer St Community Health Center
Joleen	Fowler	Veterans Administration
Irene	McMahon	Maranacook Student Health Center
Diane	Geyer	Portland Healthcare for the Homeless
Barbara	Ginley	Maine Migrant Health Program
Laura	Giroux	Portland Healthcare for the Homeless
Kimberely	Gleason	American Foundation for Suicide Prevention
Mark	Griswold	Maine CDC, Office of Local Public Hlth
Carrie	Horne	National Alliance for Mentally Ill Maine
Sandy	Hunter	Maranacook Student Health Center
Leticia	Huttman	DHHS, Office of Adult Mental Health Services
Vera-Ellen	Lanaro	Spring Harbor Hospital
Stephanie	Lash	Neurology Associates of Eastern Maine
Peter	MacMullan	Veterans Administration
Penelope	Markle	Veterans Administration
Greg	Marley	Medical Care Development
Angel	Matson	United Way of Eastern Maine
Patrick	McFarlane	Health Access Network Behavioral Health
Christine	McGlinchey	Penobscot Community Health Center
Becky	McMahan	Penobscot Community Health Center
Judith	Metcalf	UNE Maine Geriatric Education Center
Geoff	Miller	DHHS, Office of Substance Abuse
Ashley	Pesek	Aroostook Mental Health Center
Virginia	Pond	Healthways/Regional Medical Center at Lubec
Michelle	Reinecke	Aroostook Mental Health Center
Joanne	Reinzo	Penobscot Community Health Center
Valerie	Ricker	DHHS, Maine CDC, Div Family Health
Joseph	Riddick	DHHS, Maine Injury Prevention Program
Kimberley	Roberts	Healthways/Regional Medical Center at Lubec

First Name	Last Name	Agency
Anne	Rogers	DHHS, Office of Substance Abuse
Phyl	Rubenstein	Portland Public Health
Darcy	Shargo	Maine Primary Care Association
Name First	Name Last	Agency
Steve	Sherretts	DHHS, Office of Adult Mental Health
Joan	Smyrski	DHHS, Office of Child Mental Health Services
Alessa	Thebarge	
Cherie	Wenzel	DHHS, Office of Adult Mental Health Services
Angela	Westhoff	Maine Osteopathic Association
Jim	White	DFD Russell Medical Center
Laura	Wilder	Wilder Consulting
Linda	Williams	Medical Care Development
Marianne	Wyer	York County Community Health Care
Caroline	Zimmerman	Maine Primary Care Association
Katharyn	Zwicker	Maine Injury Prevention Program

Appendix 4: Speakers

First Name	Last Name	Agency
Ann	Haas	American Foundation for Suicide Prevention
Steve	Meister	DHHS, Maine CDC, Div Family Health
Cheryl	DiCara	DHHS, Maine Injury Prevention Program
Trip	Gardner	Penobscot Community Health Center
Erika	Lichter	USM Epidemiology
Valli	Geiger	Maine Primary Care Association
Carol	Kelly	Pivot Point, Inc.

Cheryl DiCara

Answer Options	Excellent	Above Average	Average	Below Average	Poor	Response Count
Knowledge of the topic	20	11	2	0	0	33
Ability to communicate	18	9	6	0	0	33
Ability to stimulate interest	12	14	6	0	0	32
Responsive to audience	16	12	4	0	0	32
Clarity of materials	17	10	5	0	0	32
Able to utilize information and materials in work setting	17	11	5	0	0	33
<i>answered question</i>						33
<i>skipped question</i>						1

Appendix 5: Evaluation Summary**Comments:**

- Informative about the services/resources they provide. I am thankful for all of the training/conferences they put on.
- Great job putting this together with primary care focus.
- Useful information

Erika Lichter

Answer Options	Excellent	Above Average	Average	Below Average	Poor	Response Count
Knowledge of the topic	23	10	1	0	0	34
Ability to communicate	20	11	2	0	0	33
Ability to stimulate interest	20	10	4	0	0	34
Responsiveness to audience	22	10	2	0	0	34
Clarity of materials	21	12	1	0	0	34
Able to utilize information and materials in work setting	21	12	1	0	0	34
<i>answered question</i>			34			
<i>skipped question</i>			0			

Dr. Lichter Comments:

- More examples to link data of lives of persons in Maine – #'s being impersonal.
- The data will be super helpful in all of my work.
- Presented data in an informative and interesting way. Great to hear the most updated info.
- Good statistics.
- Excellent use of time. I liked that she addressed questions during the talk.

David Litts

Answer Options	Excellent	Above Average	Average	Below Average	Poor	Response Count
Knowledge of the topic	31	2	0	0	0	33
Ability to communicate	28	5	0	0	0	33
Ability to stimulate interest	27	6	0	0	0	33
Responsiveness to audience	26	7	0	0	0	33
Clarity of materials	26	7	0	0	0	33
Able to utilize information and materials in work setting	26	6	1	0	0	33
<i>answered question</i>						33
<i>skipped question</i>						1

Comments

- Very knowledgeable
- Offered great structure for sties integrating. Excellent material and ideas for moving forward. I liked this included ED info.
- Great speaker addressing issues around integration and suicidality.
- New information. Like the tool kit. Great.
- Extremely helpful information

Trip Gardner

Answer Options	Excellent	Above Average	Average	Below Average	Poor	Response Count
Knowledge of the topic	29	4	1	0	0	34
Ability to communicate	27	5	1	1	0	34
Ability to stimulate interest	27	5	2	0	0	34
Responsiveness to audience	28	4	2	0	0	34
Clarity of materials	24	7	3	0	0	34
Able to utilize information and materials in work setting	25	7	1	1	0	34
<i>answered question</i>						34
<i>skipped question</i>						0

Comments:

- Theoretical bases not clearly elucidated.
- Really liked Trip.
- Very engaging presenter.
- Wish he had more time to talk about his experiences.
- Very engaging, great presenter.
- Humor wonderful, gave me inspiration.

What is the overall evaluation of the program

Answer Options	Response Percent	Response Count
Excellent	79.4%	27
Good	20.6%	7
Adequate	0.0%	0
Poor	0.0%	0
<i>answered question</i>		34
<i>skipped question</i>		0

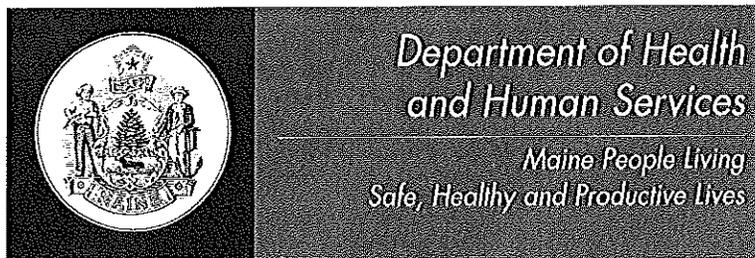
Practical value of the program to your daily practice		
Answer Options	Response Percent	Response Count
Excellent	58.8%	20
Good	38.2%	13
Adequate	2.9%	1
Poor	0.0%	0
<i>answered question</i>		34
<i>skipped question</i>		0

Comments:

- Look forward to integrating services more completely at our FQHC.
- Really like the Maple Hill Farm setting and food.
- Morning better than afternoon. Just have a ½ day conference and save money. I am so over small groups – use less.
- More breakdown of actual suicide protocol/toolkit.
- Good to discuss integration more but more practice with scenarios of suicide/crisis protocols would help us to convert/train others.
- Great facility, nice to meet with others doing the same work. Thanks for the opportunity.
- Wonderful conference. Excellent!
- This was great.
- More PCP's attending please!
- Need to get community mental health centers on board.
- Toolbox was the highlight of the conference – i.e. a practical, concrete tool that we can put into action.
- Need a subsection on “Convincing resistant staff.”

Suggestions and/or topics for future programs:

- Health Access Network would love to be a pilot.
- Follow-up to topic in 6 months.
- Specific training on David Jobes approach.
- Coordinated training on suicide intervention with the Maine Crisis Network.
- Trip Gardner did not discuss wrap around care as applicable with SI issues.
- Program directed at school based health centers or another program with primary care. I have attended school suicide presentation but as a provider of health care find needs are different.
- Update in a few months as part of another conference e.g. further information on suicide prevention and information 43: how other FQHC's are doing in carrying out “toolbox.”



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

DHHS - Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, 11 State House Station - 221 State Street, Augusta, Maine 04333, 207-287-4289 (V), 207-287-3488 (V), 1-800-606-0215 (TTY). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.