FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors

AGENDA

March 15, 2019 1pm-4pm
St. Bernard's School of Theology & Ministry, Rochester

- Call to Order – Ellen
- Approve Minutes – Ellen will ask for motion to approve
- Welcome New Board Members - Ellen
  - Nicole Speight – Villa of Hope, will be new Chair of Children and Families Subcommittee
  - Valerie Way – East House
  - Jennifer Morgan – MVP Health Care
  - Ivette Morales - Wellcare

- Finger Lakes RPC Board Elections – Ellen
  - Elections in December for Jan 2020 – Dec 2022 Terms
  - Affected Stakeholder Groups
    - CBO's – organizations are elected
    - HHSP's – organizations are elected
    - PFY – individuals are elected
    - Key Partners will be Appointed/Reappointed by Board in Jan 2020
  - Community Stakeholder Meeting – Late summer/Early Fall
  - Nomination Process will start at above meeting
  - Current Members may Run for Reelection

- State CoChairs Meeting Follow Up- Beth
  - Questions re CoChair Meeting Minutes?
  - Update re Issues
    - Physician Assistants and Article 31 Clinics
      - Ongoing conversations with OMH
    - Transportation to Same Day Appointments
      - Initial meeting with DOH and OMH- Occurred on 1/30/19
        - Definition of Urgent and Form 2015 (Who can sign)

            - For Problem Resolution re MAS Transportation
                - Can Request MAS Supervisor during calls
                - Dina Addario, DOH Medicaid Contract Manager at (518) 473-2160 - have received positive reports re contacts
        - Pharmacy Transportation- OMH Medical Directors Meeting
        - Housing Issue -Regional Housing Meetings (under-development)

- Children Services Transition – Beth & Nicole
    - General Update
    - Resource Sheet
    - How to Refer to CFTSS Services

- Workgroup Updates - Beth
    - SUD Bed Access Workgroup met Mar 8
        - Bed Board Demo
    - Clinical Integration met Mar 12
        - Symposium Scheduled for May 8
        - RHIO March 31 Go live for BH Data Inclusion in Explore (refer to TC notes)
    - Peer Role scheduled for Apr 19. 1-3pm in Canandaigua
        - Task Force has created resource Roadmap for employers of peers
    - C&F Subcommittee was cancelled for Mar 1, rescheduled for

- Break Out Groups (time permitting)

- Next Board Meeting - Beth
  Friday, June 14th, 1-4pm
  Ontario County Training Facility | 2914 County Road 48 | Canandaigua NY
  a. Upcoming Meetings
     i. C&F Subcommittee – March 28, 1-3pm, St. Bernard's
     ii. Education re Peer Role – April 19, Ontario County Training Facility
     iii. Critical Connections Symposium – May 8 - 8:30am – 3:00pm, St. John Fisher

- Wrap Up & Motion to Adjourn - Ellen

Finger Lakes RPC Board 2019 Meeting Schedule:

Q1: March 15 - St. Bernard's
Q2: June 14 - Ontario County Training Facility
Q3: Sept 20 - Ontario County Training Facility
Q4: Dec 13 - St. Bernard's

Questions about this process? Contact:

RPC Coordinator, Beth White, at *bw@clmhd.org* or (518) 391-8231 or
George Roets, RPC CoChair at *groets1@rochester.rr.com*

FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors

MINUTES

December 14, 2018   1pm-4pm
St. Bernard's School of Theology & Ministry, Rochester

George called the meeting to order at 1:15PM. Motion to approve the minutes made by Kim Hess. Seconded by Sally Partner. Unanimously approved.

New Board Members Introduced:

- HHSP - Deborah Salgueiro, Executive Director HHUNY
- Key Partner - Nathan Franus, Sr. Program Manager – Behavioral Health, FLPPS
- Family Advocate Open Seat - Ken Sayres leaving – got a position in Rochester City Schools and cannot fulfill both duties. Looking for nominations for family and youth positions. Please send to Beth – she will talk with whomever has interest.

Members of the Board and guests introduced themselves

1. RPC Special Events Summary
    - **BHCC's** presented to community – very dynamic and good dialog; United Way also presented as a community partner, looking at some of the same things and there is some overlap.

    - **Child & Family Subcommittee** – at request of subcommittee members, delivered presentation in November about new services, transition to MMC. Review of current system (start with what is, what will remain, and what is coming). New CFTSS services available January 1. Resource Sheet (attached) includes valuable resources regarding the Children's Transition.

    - **The RPC, HHUNY and GRHHN** hosted the RPC's 2nd large networking event for HH, HCBS, MCOs, CMAs. Had over 70 in attendance. Great opportunity for CMAs to network with provider agencies and MCOs. Excellent feedback from attendees.

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2. Workgroups - Quarterly Summary (see attached summary)
    a. **Clinical Integration** – has met twice since last BOD meeting. In October RRH did a presentation on their clinical integration efforts in 20 service sites. How they did it, what is going on, incremental changes. Good discussion. In December URMC presented about their CCBHC, their approach, barriers and hurdles, initial findings of their work. Group will next meet and discuss what will be the next step for this committee – so many are working on clinical integration – does it make sense to continue on the same path. Will continue as a planning group for their symposium in May 2019. St. John Fisher Department of Nursing is sponsoring the RPC's use of their auditorium. Speakers are confirmed.

    b. **Education re Peer Role** - met in November. Work at that meeting was to take previous identified issues and decide to what to work on next, decided to focus on education resources for employers and coworkers of peers. This group determined that they do not need to recreate educational materials re peer services, as so many already exist. Beth is receiving resources from many stakeholders – a subgroup of the workgroup will review, catalog, and determine what is best to send to employers. Will be doing a survey of employers of those who employ peers and see what they find most useful and helpful re information and education.

    c. **SUD Bed Access** – working on development of pilot web app re bed availability. Looking at having more detailed and up to date information and being more user friendly. RRH has its staff working on the app with group. Some issues re moving ahead with public access or just having for providers. This to be discussed at next meeting. Need to look at original intent of this group – taking a step back. Group is looking at demo of project. Also going to do education re over-referral issue. Provide information on what problems this causes in the system. One agency has a referral form that has education re referral process embedded in the form.

3. **Bylaws**: George opened this discussion. Due to not having a voting quorum present, gave group the option of deferring to next Board meeting or suspending quorum rules for voting. Jill Graziano moved, Sally Partner seconded to suspend voting quorum rules. George asked if there were any questions or discussion on format or bylaws as presented? No questions or concerns. All in favor – all, none opposed. Bylaws approved as written.

4. **CoChairs Meeting**:
    - shared about issues other regions brought to meeting (transportation – Southern Tier – open access centers – resolution that MAS agrees to work with RPC to identify BH programs with same day appointments so that they will put into their system to facilitate transportation to these programs). Lively discussion including problems faced in rural areas. Some suggestions came from meeting and DOH will follow through.

- Informed Dialog – access to transportation for pharmacy needs. MAS indicated this as a challenging area due to fraud concerns, but that they will consider authorizing stops at the pharmacy on a return trip from a treatment visit. Heard regional updates about what they are working on. Update on C&F committees from RPC perspective. North Country region discussed the general unaffordability of housing that impacts clients.

- Workforce issue re Article 31 clinics and use of PAs. Certification people were at the table. We do have a major issue with access to prescribers. Did not come to agreement on how this might be amended. OMH has some concerns re education level of PAs with regard to BH. Will look at in more detail. May look at PA training programs in NYS and see if there can be advisement on how to include more BH training.
- Sense that the state and RPC liked the change in the CoChairs meeting process. Dialog will continue and intensify. Jill asked if the state gave responses at the meeting; George explained that there will be formal minutes that will codify their responses and recommendations.
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5. **Status of other Referred Issues**:
    a. Telemental Health – formal conference call with state OMH in November. Ready to move on review of telemental health regulations. Comment period coming soon. Psychologist, social workers, and LMHCs will be authorized to provide services. Psychiatrists & NPs in PROS can participate. Psychiatrists can prescribe if licensed in NYS even if located out of state. Young adults can receive services if away at college. If have a hub can add spokes through field office. Will be a document released that identifies differences between OMH and OASAS regs. Jill shared that she was frustrated with call: wanted more clarity on timeline for implementation. She described the disadvantage to having OMH regulations re telemental health as opposed to DOH telemedicine. Big differences in level of flexibility. Question re oversight and regulation re service provision and who is paying for services? Payers had their guidelines; OMH wants different guidelines for how services are provided even if they are not paying for services. Need clarity re how telepsych can be provided into private homes. Dave Putney brought up that regulators have a specific role and cannot be eliminated from the discussion. Are problems related to service provision or payment? Have billing requirements in a separate document from service provision suggested by Jill. Beth noted that there was some good news – there are some things that have been requested are coming. State OMH did engage in collaborative discussion with RPCs. Chris Smith shared that technology requirements are changing. ACT is also included re having psychiatrists and NPs able to participate by telemental health. There is a statewide telehealth learning collaborative – January 14th next call. Beth will send email to BOD with more info.

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b. OASAS Redesign – complexity was not suitable to co-chairs meeting. FL RPC will have call with OASAS about this issue. Will be able to present new information about 820. Board members can be on the call – contact Beth if you are interested in being on this call. Will probably occur in January.

6. **MCO's Report on RCA Contracting**:

   RCA's Contracted- see info in packet. Andrea H-L gave a list of who is contracted for RCAs. She shared that she tracks reasons for declining HCBS but did not have any details at this time. Her reasons are similar to what other plans report. Fidelis is using RCA's as part of outreach calls to clients. Finding that these are effective, it is getting faster to get POC turned around.

   Curt Swanson from MVP shared that clients are asking why they need these additional services (health homes or HCBS) – recurring theme he is hearing from his staff. Deborah from HHUNY has looked at why people are refusing services – need to look at how information is being presented – this impacts people's interest and willingness to have assessment and accepting services. Might be looking at marketing training for HH managers on how to present the service.

   Chris Marcello noted need to look at difference between refusing assessment or getting assessment and refusing the service. Colleen from Excellus reported that RCAs are looking to employ engagement specialists. Margaret Morse asked about how much education is being given to providers of physical health care re engaging in HCBS? Jennifer Earl shared that they have specific training to physical health providers re engaging in HCBS. Curt shared that they do quarterly visits on educating physical health providers on this. Hank asked about having HCBS provider accompany care manager to discuss HCBS with client.

7. **Look Ahead – the RPC in 2019**: break into 3 group. Identify any new issues. Prioritize 1-2 most significant. Also look at how BOD could be more effective, how can RPC better work for you? Do you want to move some of Key Partners into ex officio status? Will have 2 seats open for key partners – can't be stakeholder group members but should be an organization what works with our clientele.

8. **2019 Discussion – Groups Report** Breakout Groups
   Group 1 (Room C) – PFY Group. 1st issue identified – turnover in peer representation on RPCs. If not employed in peer programs have difficulty in attending meetings. How can we go about

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recruiting new peer members and support them to maintain attendance. How do we develop a list of people who are interested in being on the Board? Peers may reach out to NAMI and MHA to recruit new members. 2nd issue – IT infrastructure – some providers do not have the ability to send encrypted emails. BHIT does not cover costs of software and support. Difficult to find IT people who understand the field. Expensive to develop software to support documentation. Care Managers needing to support multiple platforms – how can we utilize RHIOs in this discussion. What is value of BH providers to upload info to RHIO. Vision of what they want versus reality of what can be. Encouraged to look at Mid-Hudson confidentiality training on RPC website. Could be helpful to have a resource directory/site to find information. On-Boarding for RPC Board members – especially for peers. Sometimes don't know different kind of systems that are involved – diagram mapping. Key partners – educational system tapped into. State Ed? Early intervention also a potential.

Group 2 (Room D) – HHSP Group - Mary Vosburgh reported that housing an overarching issue. Great challenges in discharge planning for some OPWDD clients, also those facing criminal charges. Resources aren't there. Need help from RPC looking at innovative resources. Documentation – in conjunction with hospital EDs – legal implications. Can NP/PAs sign as well? Takes time if MD needs to sign the form and are not easily available. Documentation is taking a lot of time and contributes to people leaving the field. Timing of documentation is what is found on audits, not problems with care. Need to partner with state to develop what is needed to document quality care, not write to write.

Children's transition – some are worried about this coming soon – how does this step down into what the concerns are. New referral from Article 28 to the state psych centers for BH clients – how many people are referred and how many admitted into state hospitals. Referral through health commerce system. Needs to be hospitalized for 14 days before state PC will examine. More review at higher level and standardized rather than relationships between existing partners. This issue covers several hospital groups. Not sure if RPC is the right venue to address this concern – Dave Putney will take to CLMHD Mental Health Committee to see if they can discuss with state OMH. Key Partners – OPWDD or someone from faith based community.

Group 3 – CBO's - Children's transformation needs to have a place holder to discuss these concerns. OASAS transformation re 820. VBP preparation – lots of work going on. Need to focus on communication, demonstrating value. Colleen – BHCCs – looking at value of them in this process. Need to have this conversation continued. What are they doing to educate their providers. How are they relating to hospitals and MCOs? Key Partners: parole/probation – some organization from community corrections, Drug Courts. How to utilize some already existing BOD members – Villa of Hope, etc.

Jill – question re VBP. How to ensure during contracting that savings are distributing to partners. Right now dollars are sitting with state and MCOs. What is incentive to get to providers? There is

an expectation that money is encumbered and will go to providers. Need to renegotiate attribution to include new providers If MCOs do not use the money they will need to give back to the state. Beth suggests a special meeting to discuss this issue and have MCOs bring in those most appropriate to participate in this discussion.

9. **Next Board Meeting** Beth White
   a. Friday, March 15th, 1-4pm, St. Bernard's
   b. Upcoming Meetings – workgroups TBD

10. **Wrap Up & Motion to Adjourn** George Roets

Mary Vosburgh moved and Jody Walker seconded to adjourn at 3:30pm. Passed unanimously.

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RPC Co-Chairs Meeting
November 30th, 2018
10-2pm
Albany, NY

FINAL- Meeting Minutes

Agenda

10:00-10:15AM

Welcome- Kathy Alonge-Coons & Cathy Hoehn

Introductions

<u>10:15-11:00AM-Transportation</u>

1. **Issue Presentation- Southern Tier- Open Access hours/MAS Transportation** (10 mins)
   Feedback from State Partners (10 mins)
   Open Floor (5 mins)

2. **Informed Dialogue- Mohawk Valley-Pharmacy/ MAS Transportation** (5 mins)
   Feedback from State Partners (5 mins)
   Open Floor (5 mins)

   Review of Next Steps (5 mins)

<u>11:00-11:15AM- Complex Trauma Assessment</u>

3. **Informed Dialogue- Capital Region** (5 mins)
   Feedback from the State Partners (5 mins)
   Open Floor (5 mins)

<u>11:15-11:50- Regional Updates</u> (6 mins each)

- NYC
- Tug Hill
- Central Region/Statewide RPC Workforce Taskforce
- Mid-Hudson
- Western
- Long Island

11:50-12:20- Break for Lunch/Networking

12:20-12:50pm-Update on the RPC Children and Families Subcommittees—Alexis Harrington (15 mins)

Feedback/Questions from State Partners/Open Floor (15 mins)

<u>12:50-1:20-Workforce</u>

4. **Issue Presentation- Finger Lakes-Physician Assistant prescribing in Article 31 clinics** (10 mins)
   Feedback from State Partners (10 mins)
   Open Floor (5 mins)
   Review of Next Steps (5 mins)

1:20-1:50PM-Housing

5. **Informed Dialogue- North County/Southern Tier Region** (10 mins)
   Feedback from the State Partners (10 mins)
   Open Floor (5 mins)
   Review of Next Steps (5 mins)

1:50- Closing Remarks

2pm- Adjourn

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Attendees:

OMH-Donna Bradbury, David Close, Jeremy Darman, Victoria DiSimone, Nicole Haggerty, Brett Hebner, Keith McCarthy, Liam McNabb, Robert Myers, Claire Rudolph, Chris Smith, Melissa Staats, Michelle Wagner, Gary Weiskopf, Laura Zocco

DOH-Dina Addario, Heather Allen, Mark Bertozzi, Peg Elmer, Kara Fanniff, Faith Moore, Robert Schmit

OASAS- Pat Lincourt, Maria Morris, Ilyana Meltzer

OCFS- Mimi Weber

RPC Team- Maryam Zoma, Cathy Hoehn, Marcie Colon, Pete Griffiths, Alexis Harrington, Emily Hotchkiss-Plowe, Jacqui Miller, Katie Molonare, Beth Solar, Margaret Varga, Beth White, Melissa Wettengel

RPC Co-Chairs- Kathy Coons, Amanda Pierro, Mike Piazza, Susan Miller, Mike Stoltz, AnnMarie Csorny, George Roets, Mark O'Brien, Kirsten Vincent, Pat Fralick, Jennifer Earl, Jason Lippman, Lee Rivers, Rob York, Mark Thayer, Sharon MacDougall, Mary Maruscak, Susan Matt, Sandra Soroka

NYSCLMHD- Kelly Hansen, Jed Wolkenbreit, Courtney David

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Issue Number One:
Topic: Transportation
Issue Presentation: Non-Emergency Medical Transportation to Same Day Appointments at Mental Health & Substance Use Disorder Clinics
Region: Southern Tier Region
Co-Chairs: Sharon MacDougall, Director of Community Services, Tompkins County & Mary Maruscak, Family Advocate
RPC Coordinator: Emily Hotchkiss-Plowe

Issue: Open Access hours have been established in many Mental Health & SUD Clinics to allow same day appointments, to address crises, and reduce wait times. Medicaid recipients who rely on Medicaid Non-Emergency Medical Transportation (NEMT) struggle to access these clinics and appointments on the same day.

The Southern Tier RPC Co-Chairs and Coordinator presented this issue to the State Partners (see attached PPT slides for additional detail).

State Response- DOH:

- We do not want Medicaid transportation to be a barrier either
- Medicaid Transportation coverage operates under Federal and DOH policies -not by MAS directive.
- Regarding transportation to a Medicaid covered service – trips are assigned to Medicaid enrollees going to a Medicaid covered service utilizing the most cost effective, medically appropriate mode.

What Exists:

- A Medical justification form must be completed, reviewed and approved prior to allowing and justifying a higher mode of transportation (That form can be found here).
- The 2015 Form – Must be completed by a medical practitioner to justify the higher mode of transportation (see form listed above) – for example, how the enrollee's mobility affects their ability to ambulate.
- 72-hour rule- Preferred method is to set up transportation 72 hours in advance, but there are exceptions to this policy, especially for urgent care appointments.
- Urgent care trips – MAS has been directed to (abrogate) the 72-hour rule and provide the trip when justified
- Federal freedom of choice rules apply to fee-for-service transportation. This type of transportation is not found in a capitated model. In Fee for Service (FFS) NEMT, enrollees get to choose the transportation company they want to use, based on who has availability and is able to perform the trip within the most medically appropriate mode.
- The 2020 Form – This is a form that must be completed when an enrollee is seeking a Medicaid covered service outside their common medical marketing area (CMMA). Medicaid programs do not have to provide transportation services to a covered service outside the enrollee's CMMA if the service can be provided closer to proximity where member lives (That form can be found here).

Recommended Next Steps:

- Contact MAS and provide them a list of Medicaid enrollees who have a situation that would require abrogation of the 72 hour rule – DOH will reinforce that this trip be made; create an indicator on file ahead of time that people may need an "urgent care trip".
- There are 13 open access facilities in the Southern Tier Region – It was suggested that this list of clinics be sent to regional MAS Liaisons, including the hours of operation. This will easily identify that enrollees are going to an open access site within the open access hours.
- Suggestion that RPC set up follow up conversation with DOH Transportation team after today's meeting to discuss additional next steps and to broker a conference call with MAS.

Additional Comments:

- It was noted by DOH the importance of indicating that a Medicaid service was provided when people have accessed MAS- In the past there have been cases of Medicaid fraud.
- When contacting MAS, staff can request to speak to a manager who may be able to accelerate the request for transportation.
- There is a misconception that MAS contracts with the transportation providers, which is not the case; this is not a capitated model; transportation providers are enrolled in eMedNY and bill Medicaid directly
- MAS is contractually obligated to record and investigate every complaint filed. Cab companies are placed on corrective action plans if there are overwhelming complaints (ex: showing up late).

Open Floor Discussion:

Questions:

- 2015 forms – Is there any way we can have some guidance on these forms and examples of completion?
  DOH Response: It is difficult to provide an example, but overall the form must note the need that demonstrates (in a medical professional manner) why this person needs a higher mode.
  For example: A Medical diagnosis that affects ability to ambulate or behavioral health diagnosis that this person cannot go on public transit or a group ride, etc. Has to be credible and signed by a medical practitioner. Ones that are turned down in that past have not been written properly and generally just list, "anxiety" or "depression".

- MAS has a utilization unit – RNs and medical practitioners are in this unit; if there is a trend and these forms are denied, field liaisons at MAS will try to isolate challenges and work with providers to resolve.

- It has been reported that there is often a fear of retaliation if a Medicaid member reports a transportation issue, especially in a rural area where there may be one 1-2 cab companies.
  - Response from DOH: There should be no fear of retaliation

- OMH encouraged the use of Telemedicine may be an alternative to meet some service needs, if transportation is an issue.

- Question around what is defined as *Urgent care* – and how is this defined in relation to behavioral health?
  - DOH agreed this would be beneficial to review
  - Will suggest setting up a follow up call to discuss further with Southern Tier region and DOH. Conference *Call has been scheduled for late Jan 2019*

Issue Number Two:

Topic: Transportation
Informed Dialogue- Transportation to Pharmacy and Non-Emergency Medical Transportation (NEMT)
Region: Mohawk Valley
Co-Chairs: Susan Matt, LCSW-R, CASAC DCS Otsego County & Sandy Soroka, Executive Director Neighborhood Center
RPC Coordinator: Jacqueline Miller

Issue: Lack of available NEMT for members to access the pharmacy

The Mohawk Valley Co Chairs and Coordinator presented this issue (see Supplemental Information Packet for additional details). This region asked the State Partners two follow up questions, their responses are listed below.

Response from the State:

Question One- Why is medication not considered a Medical Necessity, as medication is a key factor in successful treatment outcomes?

Question Two-Viability of this issue – has the state looked into this? Is there active dialogue? If there has been prior discussion - has there been a pilot program?

DOH response:
There are no pilot programs currently to look at this issue, there is a long history of this discussion. The reason this is currently not allowed can be summed up to one word- "fraud". There needs to be very tight control. There are certain situations in which a cab company will go to the pharmacy on the "B" leg of the trip. DOH is in agreement that medication should be considered medically necessary. State is willing to reconsider, but again would need to discuss preventing fraud.

OMH response: Suggested that providers engage with their regional MCO to discuss planned delivery practices.

Another consideration is to talk with MCOs and pharmacies, to encourage discussion about packaging and compliance. Some pharmacies are offering "bubble packaging" and there is an increase in compliance seen with this method. The discussion around this topic should include packaging as well as the delivery.

Central RPC reported that public transportation is either nonexistent or very scarce in many parts of the state. Asked the State Partners to share what conversations, if any, are occurring regarding transportation in rural counties. Mark Thayer, DCS, shared an example of a barrier in Cortland County, where there is only one bus that circles the entire county in a day. People get on it in the morning then have to sit around all day to get back home at night. Even for people that can do it, it is still a barrier. Is there some way we can support the conversation or how we can enhance these services?

DOH response:-We are aware of the challenges of rural communities. There is a whole mobility management initiative around the state. They have worked to develop volunteer driver associations and allow private vehicle usage, etc.

Regarding the public transit issue, at one time DOH allowed "lump sum" Medicaid funding to cover the Medicaid portion of total cost of the county's rural public transit system. This payment method was determined to be a violation of federal rules when the state assumed the administration of Medicaid transportation from the counties. MAS works very closely with the transit providers to try to get all Medicaid recipients on covered as much as possible. Again, if there is an individual that has a medical condition, including a behavioral health diagnosis, and is somehow jeopardized by going by public transit (or the public transit cannot get them there quick enough) they can utilize a cab. The taxi company is generally a default mode in the rural counties.

DOH response: In rural areas the volunteer drivers are often utilized to supplement the public transit system. There are also group rides that are often set up to get to common medical destinations.

Issue Number Three:

Topic: Children's Behavioral Health Transition
Informed Dialogue: Children's Health Homes: Complex Trauma
Region: Capital Region
RPC Co-Chairs: Kathy Alonge- Coons, DCS Rensselaer County and Amanda Pierro, Peer Representative
RPC Coordinator: Alexis Harrington

Barrier to Access:

- There is confusion about the complex trauma eligibility assessment process, specifically related to the current guidance for reimbursement for this process. The option between enrolling a child into Health Homes via complex trauma or Serious Emotional Disturbance (SED); the SED determination is much easier to obtain, being a known billable intake assessment, than completing the complex trauma determination process, a process providers are unsure of how to be reimbursed for.

The Capital Region Co-Chairs and Coordinator presented this issue to the State Partners (see the Supplemental Information Packet for additional details).

State Response:

OMH response- Donna Bradbury

- OLP can be used to assess children for complex trauma, as a diagnosis is not required to access OLP
- If a child is assessed and determined to be SED, that child would meet a HHSC qualifying condition
- From a clinical perspective most children who meet the complex trauma determination would most likely also have a mental health diagnosis
- Article 31 Clinics are able to do the assessment –and asked the regions for feedback if there is a concern that the Complex Trauma assessment is not being utilized, but instead clinicians are utilizing a SED assessment?
- It was noted that there is guidance on DOH website re: Complex Trauma

Capital Region response: There remains confusion from Children's providers around this process and the need for more clarification around the guidance. The State Partners asked for additional details, the Capital Region RPC will work to gather more additional specifics.

Both DOH and OMH stated that they are open to any feedback on how to improve the process.

DOH reported that they do have the CT directory and a grid on how providers can bill Medicaid for assessments, which includes Complex Trauma. DOH is open to hearing feedback to make this a helpful assessment and will take back the discussion around OLP to the DOH leadership team.

DOH previously shared the following resources:

Under what circumstances can Complex Trauma identified Licensed Professionals bill Medicaid for Assessments

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/medicaid_billing_article_clinics_lp_ct_updated.pdf

Complex Trauma Provider Directory- Updated November 2017

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/complex_trauma_provider_directory.pdf

Health Home Serving Children website- Note the Section specific to Complex Trauma
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm -

Southern Tier Co-Chair Sharon MacDougall encouraged that the State Partners consider the ACES study when thinking about the Complex Trauma Assessment.

The RPCs will continue to work with the State Partners reading this topic to continue provide feedback related to this issue.

RPC Children and Families Subcommittees Update:
Alexis Harrington, Capital Region RPC Coordinator provided the following update on the RPC Children and Families Subcommittees from across NYS.

Scope – Main focus has been components of the children's BH transition to MMC (HHSC, CFTSS, HCBS)

Level Set – Who has been invited to attend these meetings:

- HHSC
- Children & Families
- Children & Youth Advocates
- DCS
- SPOAs
- LDSS
- CFTSS and HCBS providers (designation lists)
- HH CMAs
- VFCAs
- Early Intervention Providers
- MH/SUD Tx Providers
- Adolescent Probation/PINS
- MCOs
- Educational Providers
- State Field Office Staff
- Hospitals

Subcommittee Rollout – The subcommittees have been using the State designation list to add to the subcommittee attendance and membership. All regions are active and scheduling future meetings – regions meeting at minimum, quarterly, maximum every other month. Started with two pilots, in the Mid-Hudson & Capital Regions.

Common Themes
A lot of collaboration – there are various tables with same stakeholders who are addressing similar topics. The RPC is working with these other forums to help inform one another – Some of these forums include: The statewide HH/MCO workgroup – children's committee, the HH Coalition, The Council for Children & Families, Youth Power, Families Together NYS.

Training & Education – especially readiness for the transition:

- RPC has put together a one page resource guide compiling all helpful information about the transformation in one place- Click here to Access
  - Reiterating the importance of claims testing and contracting between providers and MCOs
- Working with the State Partners to provide feedback and questions to inform the resource toolkit for families and providers (Tracking questions, prioritizing, looking to address in various mechanisms).
  - Looking to host Networking events in the future – to get an understanding of questions that are still out there post go-live and allow the providers to be in the same room together, regionally.
- Education for families and providers, including potential HH referral entities (re: Health Homes, county resources such as the children's SPOA and the Medicaid Managed Care transition)
  - Fireside Chats/Partnering with Families Together in NYS – piloted in the Capital Region.
  - Educational component & measured the success through evaluations

- 100% would recommend to their colleagues; 80% better understood HH referrals and expectations.
- Hearing about what the needs are in the region and receive feedback from the families.

Work Force/Retention:

- Paperwork within first 60 days of HH enrollment – working with the HH/MCO workgroup – Children's subcommittee & HH Coalition – being looked at in both these avenues. Both forums are open to hearing feedback from families that is being collected at the RPC Children and Families Subcommittee.
- Comprehensive Assessment
- Complex Trauma (Was addressed above)

Next Steps for RPC C&F Subcommittees: Support for Chairs and Leads of C&F Subcommittees

- These will be held quarterly - first call is scheduled for December 20, 2018, will schedule calls quarterly, but will evaluate frequency as needed.
  <u>Purpose of these calls:</u>
- Connect with other Chair and Leads from across the state
- Review any major updates regarding the transition (will work with our state partners to confirm these updates)
- Identify common themes that are emerging across the regions
- Provide an opportunity for regions to share updates/best practices occurring at their regional subcommittees
- Provide an opportunity to get feedback from other regions across the state re: any barriers/questions regarding the transition or process
- Share resources to distribute to the subcommittees
- Hear from the Chairs and Leads with what questions they have around the transition

NYC –Maryam Zoma provided an update on their Children and Families Steering Committee

- Steering Committees are slightly different from ROS. HH Steering Committee has all six HHSC with adult at the table; discuss issues impacting both.
- Have Children's Care Management steering group as well.
- MCO steering group – ACS did a presentation on the medically fragile population.
- Will be looking to form a SPA/HCBS and Children & Families Steering Group as well.

Questions/Response from the State Partners:

OMH response:

- Like how the RPCs are looking at children's transition holistically from provider's perspective in particular.
- Any training needs that aren't being addressed, please feel free to let the state partners know.
- Early Childhood in an area of interest for the state. Currently working with the Schuyler Center for Analysis and Advocacy to receive technical assistance from Zero to 3 to advance their agenda. Open invitation to discuss those needs – perfectly in line with the first 1000 days initiative out of DOH. It's an opportunity to collaborate with MCOs to incentivize prevention.
- Question- Are the regions thinking about Early Childhood needs?
  - RPC Response: Have started to talk about EI. The transition to HHCM is very difficult. It is hard for the systems to conceptualize. Not a lot of traction. Those who have, do not have issues. Hard to get started.
  - Finger Lakes – Critical situation regarding access – A key agency in this region delivering the required Service Coordination element of EI services has discontinued those services as the rates do not cover the cost of delivering the services. Clients must have a Service Coordinator in order to access EI services.
  - Mid Hudson – Have not had a real conversation yet, but is a topic that they want and need to address. Focus on HH now, but will be coming as next steps.

OASAS response:

- Important to remember that the under 18 yr. old population with SUD often get lost in the conversation. New SPA services can afford an opportunity that was not there previously for this population. Many SUD providers do not think about coming to the table.
  - RPC C&F Subcommittees will continue to make sure that the SUD provider population are including at the table; OASAS offered their support if needed.
- Jennifer Earl, Co-Chair from the Tug Hill, reported that United HealthCare is having a dialogue/training around prepping providers for this transition.

Regional Updates

Six RPC regions provided a brief verbal update on the regional efforts of the RPC region- Please see the supplemental information packets for additional detail.

Questions from the State Partners Regarding some of the regional updates:

Western- Reported that regionally they have had discussion around local planning involvement:

  - I.e. provider brought in from NYC that local DCS/providers were not consulted on. There were objections made about this from DCS and county execs but provider moved in anyway.
  - Hoping that there is time for this to be discussed – critical to have the right people at the table for these conversations
- Pat Lincourt from OASAS reported that it is important to balance needs of localities with the planning process – open to further dialogue on this topic

NYC-Following report by Maryam Zoma of the NYC RPC region Gary Weiskopf encouraged working together around VBP. ROS RPCs will look to replicate a similar VBP event that was held in the NYC region.

Mid Hudson- An additional conference call with State Partners will be set up to address the Financial Sustainability of Article 31 and 32 clinics issue that has been identified in this region (*Conference Call has been scheduled for late Jan. 2019).*

Number Four:

Topic: Workforce
Issue Presentation: Issue Presentation: Current OMH 599 Guidance prohibits Physician Assistants(PAs) from assessing patients and prescribing medications in Article 31 clinics
Please see attached PPT for supplemental information (Slides 18-30)
Region: Finger Lakes
RPC Co-Chairs- George Roets, DCS Yates County & Ellen Hay, Director of Clinical Services-Finger Lakes Community Health
RPC Coordinator- Beth White

State Response:

OMH clarified that they do not prohibit PAs from working in Article 31 clinics

  - They will consider PAs with specific Behavioral Health experience

    - PAs are reviewed with the same standard as non-Psychiatrist physicians
    - 19 waivers were approved by OMH to allow PA's to practice in Article 31 clinics in the last 6 years
    - The PA dilemma is that there is no credentialing track like Psychiatric Nurse Practitioners
    - OMH shared that the OMH Field Office staff are familiar with the regulatory waiver process and can assist with answering questions around the process
- OMH reiterated that the regulations around this issue were developed in 2010. The concern around these regulations were due to poor prescribing patterns conducted in unregulated settings without specially trained professionals in the past.

- Finger Lakes RPC suggested:
    - PAs could work closely under the supervision of Psychiatrists in the clinic to gain experience.
    - It could be beneficial for a PA school program to work closely with OMH to develop a specific BH track that would be approved by OMH.

- It was mentioned that FQHCs hire PAs and can assess and prescribe in these settings, followed by a question around why Article 31 clinics can't do the same. It was suggested that a series of checks and balances be set in place to assist PAs in their training.

- OMH suggested utilizing Telehealth/Telepsych as an alternative. There are currently now roughly 100 approved sites in NYS.
    - Mohawk Valley reported that using Telehealth is not sustainable for smaller, rural agencies as it can cost up to $400/hour to hire a psychiatrist.

- OMH mentioned that they will bring this issue back to review the suggestions/feedback of today's conversation

Number Five:

Topic: Housing
Informed Dialogue: Lack of housing supports (i.e. supportive living and transitional living) in the rural North County and Southern Tier regions, with an emphasis on safe, affordable housing, is causing continuous psychosocial stressors. Housing is a critical social of determinant of health with far reaching implications for a person's recovery and overall well-being.

Regions: Southern Tier and North Country
Peter Griffiths, North Country RPC Coordinator
Lee Rivers, Executive Director, Franklin County Community Connections
Rob York, Director of Community Services, Warren/Washington Counties
Emily Hotchkiss-Plowe, Southern Tier RPC Coordinator
Sharon MacDougall, Director of Community Services, Tompkins County
Mary Maruscak, Family Advocate, Southern Tier RPC Co-Chair

The Southern Tier and North Country RPC region co- presented on this issue (please see the supplemental packet for additional information). They asked OMH three questions listed below:

Q1: How are state partners working across agencies, and with managed care organizations to increase housing access?

Brett Hebner from OMH response:

- Regarding managed care: There is one potential pilot program downstate, but is still in the early stages. Currently Medicaid does not cover the cost of housing.
- Regarding cross agency work:
    - OMH is in the process of setting up cross system dialogue, and having regional meetings of the continuums of care to discuss housing. It is important to get the right people at table to talk about collaboration and communication between each coordinated entry system, including SPOA, HUD.

Gary Weiskopf, OMH reported:

- Right now Medicaid prohibits paying for housing, although it might be considered in future.
- CDPHP, a local MCO, funds a few beds, another MCO might be doing so soon.
- Some hospitals are considering an investment into housing to prevent psychiatric boarding.

Q2: Is there any housing work or investment planned specific to rural areas?

OMH response-Brett Hebner:

- OMH is trying to coordinate investments around supported housing with DOH, other entities.
- OMH is trying to balance this need with organizational capacity.
- Supported housing in mixed-use development. Can be harder to scale in rural communities.
- [OMH housing] workgroup has been approached for training new developers to discuss the capacity for this organizational development.
- Want to leverage other organizations for development, putting together a supportive housing network.
- Dollars are not specifically targeted to rural areas; applicants show the need in their community.
- Housing Initiatives have been focused across NYS, but the largest homeless population is located in NYC.
- We are in collaboration with the Association for Community Living on a regular basis to best advocate within system for additional resources.

Q3: We are losing high intensity supports for people with the highest need as the continuum of care in system shifts. SROs are not continuing moving forward and we see a gap in crisis beds. What are support structures will be in place?

OMH response-Brett Hebner:

- The theory is that as we try to transform the system to higher levels of independence, the wraparound of HCBS services will be an enhancement.
- In terms of erosion of Level 2 housing we take on case by case basis.
- As an example, Onondaga County pushed back on a request to open apartment treatment in favor of supported housing.
- We are not trying to move away completely from CRs, this is a needed level of care.
- Regarding crisis respite, right now these are up for public comment; this comment period ends in mid-December

There will be an RFP for $50m in capital to support crisis respite beds. The RFP has not been released yet, but will be in the future.

- Other option might be a conventional mortgage- which is something OASAS has looked into.

OMH response-Chris Smith:

- As we shift from congregate to community housing, there is potential for managed care to be helpful in paying for rehabilitation that will keep people in housing.
- But one of reasons not moving toward scattered sites is that people do need more support. Medicaid can cover some of those supports.

Kelly Hansen, CLMHD:

- When moving people from CRs to lower level of care, the wraparound services are great, but they are time-limited; more than 4-5 weeks is needed.
- The state budget last year traded 200-400 CR beds to supported living beds.
- Glad to hear say keeping CR access is a priority.

OMH response- Gary Weiskopf:

- In lieu of services (ILS) are terribly underused. The only applications OMH has seen are telehealth, which did not need to be approved. These can be cost-effective services for people in mainstream who cannot stay in housing and become homeless. Plans can submit to state.

Next Steps:
Look to continue to have focused conversation on this topic with regions and state partners to hear update on regional meetings and inquire to learn more about opportunities through ILS.

Children and Families Subcommittees – Update

- Utilizing C&F Subcommittees to hear feedback related to the children's transition. Finger Lake C&F Subcommittee 126 on distribution list/ typically ~50 attendees at meetings
- Subcommittees focused on conversations regionally such as readiness, understanding State policy updates, discussions about contracting and claims testing, sharing best practices and approaches for accepting referrals and recommendations
- Stakeholders have reported feeling overwhelmed with the amount of information coming to the field and number of moving parts for transitioning children
- Chair & Lead Support: RPC leadership holding quarterly support calls for the statewide RPC C&F Chairs and Leads

Finger Lakes Regional Planning Consortium

Brief Summary – Referring to CFTSS Services

Pathways to Care

The Difference between a Referral and a Recommendation

The following information is from:
Utilization Management for CFTSS: OLP, CPST, PSR - Webinar - September 18, 2018

Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services | Office for People With Developmental Disabilities

Overview of CFTSS:

Other Licensed Practitioner
Community Psychiatric Treatment and Supports
Psychosocial Rehabilitation

For this and the following slides:
Source: Utilization Management for CFTSS: OLP, CPST, PSR - Webinar - September 18, 2018

Pathways to Care

- **Referral:** when an individual or service provider identifies a need in a child/youth and/or their family and makes a linkage/connection to a service provider for the provision of a service that can meet that need.

- **Recommendation:** when a treating Licensed Practitioner of the Healing Arts (LPHA) identifies a particular need in a child/youth based on a completed assessment and documents the medical necessity for a specific service, including the service on the child/youth's treatment plan.

Who are Licensed Practitioners of the Healing Arts (LPHA)?

An individual professional who is licensed as a:

Registered Professional Nurse,
Nurse Practitioner,
Psychiatrist,
Licensed Psychologist,
Licensed Psychoanalyst,
Licensed Master Social Worker (LMSW),
Licensed Clinical Social Worker (LCSW),
Licensed Marriage & Family Therapist,
Licensed Mental Health Counselor,
Licensed Creative Arts Therapist, or
Physician

AND are practicing within the scope of their State license to recommend Rehabilitation services. Clinical Nurse Specialist, Licensed Master Social Worker, and Physician Assistants who are licensed and practicing within the scope of their State license may recommend Rehabilitation services, only where noted in the approved State Plan and manual. Approved LPHAs who can refer and recommend may vary for each service are defined in the service description.

Definition from p. 91 of CFTSS Provider Manual -
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf

Authorization Summary

- The first 3 service visits with OLP, CPST and Psychosocial Rehabilitation do not require authorization. However providers must notify MMCPs before providing services to ensure proper payment
- If more services are needed and individual meets medical necessity, must perform concurrent review and MMCPs must provide a minimum of 30 service visits
- 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit.

Example of Obtaining Concurrent Authorization

- Referral
- Recommendation from LPHA with medical necessity documentation
- Up to 3 visits to determine the need for ongoing services
- Conducting concurrent review: Before the 4th visit, provider must request authorization from MMCP to continue providing services.
- If medical necessity is met, MMCP will authorize 30 visits.
    - MMCPs must make a service authorization determination and notify the provider/enrollee of the determination by phone and in writing no more than three business days after receipt of the request

Other Licensed Practitioner (OLP) Overview

- OLP services include: Licensed Evaluation/Assessment, Treatment Planning, Psychotherapy, Crisis Intervention Activities
- OLP services may be provided to children/youth in need of assessment for whom behavioral health conditions have not yet been diagnosed.
- These non physician licensed behavioral health practitioners (NP-LBHP) include
  - Licensed Psychoanalysts, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, Licensed Masters Social Workers when under the supervision of licensed clinical social workers (LCSWs), licensed psychologists, or psychiatrists
- These practitioners must operate within a designated agency

Community Psychiatric Supports and Treatment (CPST) Overview

- CPST is intended to assist the child/youth and family/caregivers to achieve stability and functional improvement in daily living, personal recovery and/or resilience, family and interpersonal relationships in school and community integration. The family/caregivers is expected to have an integral role.

- Service Components: Intensive Interventions, Crisis Avoidance, Intermediate Term Crisis Management, Rehabilitative Psychoeducation, Strengths Based Service Planning, and Rehabilitative Supports

Psychosocial Rehabilitation (PSR) Overview

- PSR is designed to restore, rehabilitate and support a child's/youth's developmentally appropriate functioning as necessary for the integration of the child/youth as an active and productive member of their family and community

- Service Components: Building Personal and Community Competence through Social & Interpersonal Skills, Daily Living Skills, and Community Integration

Resources Related to Children's Health and Behavioral Health Transition to Medicaid Managed Care (Compiled 11/20/18)

Overview

- ***Children's Managed Care Design***
- ***Provider Designation***
- ***Children and Family Treatment and Support Services (CFTSS) Provider Manual***
- ***Draft Children's Home and Community Based Services Provider Manual***
- ***Children's Health and Behavioral Health Billing and Coding Manual (Includes both CFTSS and Home and Community Based Services (HCBS))***
- ***Supplemental Billing Guidance (Transitional period)***
- ***Billing Guidance and Rates***

Helpful Trainings

- ***Children and Family Treatment and Support Services (CFTSS) – Service Review***
- ***CFTSS Refresher***
- ***CFTSS FAQ***
- ***CFTSS Billing and Revenue Cycle Management***
- ***CFTSS Utilization Management***
- ***Aligned Home and Community Based Services***
- ***Find a Designated Provider***

Receive Updates and Submit Questions

- ***Subscribe to the children's managed care listserv***
- ***Subscribe to the DOH Health Home listserv***

- ***NYS OMH Managed Care Mailbox:*** OMH-MC-Children@omh.ny.gov
  - Please include Kid's system/managed care in the subject line

- ***Provider Designation:*** OMH-Childrens-Designation@omh.ny.gov
- ***OASAS:*** picm@oasas.ny.gov
- ***DOH:*** managedcarecomplaint@health.state.ny.us
- ***Email DOH about Health Homes through their bureau mail log or call 518-473-5536***

- ***MCTAC Mailbox:*** Mctac.info@nyu.edu
  - Logistical questions usually receive a response in 1 business day or less.
  - Longer and more complicated questions can take longer.

Visit www.ctacny.org to view past trainings, sign-up for updates and event announcements, and access additional resources

Finger Lakes Regional Planning Consortium

Workgroup Activity - Quarterly Summary

March 15, 2019

Clinical Integration Workgroup – met March 12

Dr. David Kaye presented Project Teach to the group, a program that delivers child psychiatry training and consultation services to pediatricians and family practice physicians to help them manage the mild and moderate mental health issues of their pediatric patients.

Dr. Kaye and RPC Coordinator have worked to identify the pediatricians and FP's in the Finger Lakes region who have not yet connected with this valuable service, and the group discussed various means of performing targeted outreach to help them learn about and utilize Project Teach's services. MVP, Excellus, Common Ground and the Monroe County Medical Society will assist in the outreach efforts.

The RHIO presented an overview of the March 31 go live for the release of Part II SAMHSA data through RHIO's Explore portal. They have been meeting with SUD providers to explain the change and provide them with materials to help explain it to affected clients.

Plans continue for the spring symposium addressing the sharing of clinical information between behavioral health and other providers. Event scheduled for Wednesday, May 8, 2019. Melissa Zambri and Andrew Philip are confirmed as presenters. Contract has been executed with St. John Fisher College for use of their venue. Many thanks to SJFC's Department of Nursing for sponsoring the event! Due to their support, there will be no facility charge for the use of their auditorium.

Education re Peer Role Workgroup – will meet April 19

During this quarter, a small task force of volunteers met several times to review and catalog the many resources that are available regarding the employment of peers in behavioral health programs. They have created a Roadmap that includes an organizational self-assessment that will guide employers to the most pertinent resources based on their organizational capabilities and where they are in the peer employment process.

Many thanks to Matthew Petitte, Peer Liaison at Excellus, for leading this group and to Rita Cronise from the Academy of Peer Services, Jason Teller from Monroe County Mental Health and Cameron Farash from Liberty Resources for bringing their insights and skills to the effort!

RPC Coordinator is meeting with several employers of peers to hear from their peer supervisors and HR staff what their experiences, successes and challenges have been in the integration of these new team members in their programs, and how the workgroup's activities may be of use to them.

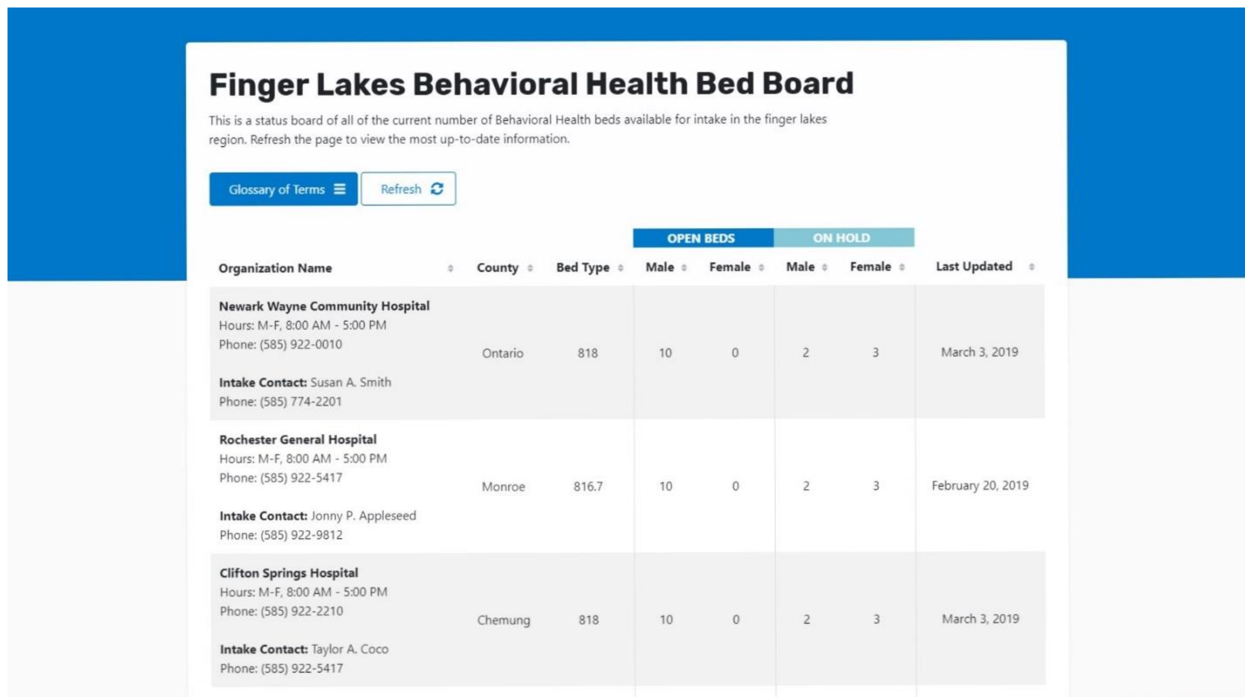
SUD Bed Access Workgroup – met March 8

Group received a demo of the proposed web-based app for accessing regional information regarding SUD IP Rehab and Detox bed availability. The intent of the 3 month pilot will be to provide Finger Lakes region SUD Intake Coordinators and those referring to their programs' beds more timely information on availability of those resources.

The group discussed the staging of the implementation and tasks needed for the roll-out. They also identified metrics for determining the success of the pilot.

- ***Higher bed utilization***
- ***User Satisfaction***
- ***Number of Viewers who Used the App***
- ***Decreased number of people on waiting lists***
- ***Time to Access Beds? (Don't know if we can get baseline data on this)***
- ***Compliance with updating frequency***

RPC Coordinator will be meeting with RRH team March 18 to confirm implementation steps and timeline.



Finger Lakes Behavioral Health Bed Board

This is a status board of all of the current number of Behavioral Health beds available for intake in the finger lakes region. Refresh the page to view the most up-to-date information.

Glossary of Terms | Refresh

Organization Name	County	Bed Type	OPEN BEDS Male	OPEN BEDS Female	ON HOLD Male	ON HOLD Female	Last Updated
Newark Wayne Community Hospital Hours: M-F, 8:00 AM - 5:00 PM Phone: (585) 922-0010 **Intake Contact:** Susan A. Smith Phone: (585) 774-2201	Ontario	818	10	0	2	3	March 3, 2019
Rochester General Hospital Hours: M-F, 8:00 AM - 5:00 PM Phone: (585) 922-5417 **Intake Contact:** Jonny P. Appleseed Phone: (585) 922-9812	Monroe	816.7	10	0	2	3	February 20, 2019
Clifton Springs Hospital Hours: M-F, 8:00 AM - 5:00 PM Phone: (585) 922-2210 **Intake Contact:** Taylor A. Coco Phone: (585) 922-5417	Chemung	818	10	0	2	3	March 3, 2019

Would You Like to Join one of these Workgroups? All workgroups will be scheduled to meet again in the second quarter of 2019. Board members wishing to attend any of these groups for the first time or send staff to participate should contact RPC Coordinator to be added to the invite list.

Questions? *Contact Beth White, RPC Coordinator at bw@clmhd.org or 518-391-8231*

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			OPEN BEDS		ON HOLD		
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Catholic Family Center							