

## **Regional Community, Agency, and School Alliance (RCASA) Minutes- January 16, 2019**

1. Welcome and Introductions

2. Presentations:

**Kristen Garrasi- OPWDD**  
**Care Coordination Liaison**  
**[Kristen.r.garrasi@opwdd.ny.gov](mailto:Kristen.r.garrasi@opwdd.ny.gov)**  
**716-608-2733**

Kristen spoke about changes in Medicaid service coordination since July 1, 2018. The position of MSC does not exist and were replaced by Care Coordination (CCO) agencies. Previous MSC positions are either Care Coordinators or Care Managers depending on which CCO they are affiliated with. There are two Care Coordination organizations in this region: Prime Care or Person Centered Services. Kristen is available for any questions regarding Care Coordination at 716-608-2733.

**Person Centered Services and Prime Care presented on Care Coordination.**

**Alan Vanesky- Person Centered Services**  
**Community Relations Manager**  
**[avenesky@personcenteredservices.com](mailto:avenesky@personcenteredservices.com)**  
**716-324-5100 ext 1917**

**Megan Griffin-Adams- Prime Care**  
**Individual/ Family Engagement**  
**Coordinator**  
**[megan.griffinadams@primecareny.org](mailto:megan.griffinadams@primecareny.org)**  
**585-347-1904**

Megan and Alan spoke about the role of Care Coordination in replacement of Medicaid Service Coordination. Care Coordination is a Health Home. Care Coordinators have an expanded roles and responsibilities and they are connected with Department of Health. Care Coordination enhances case management and promotes integration of primary and behavioral healthcare to better meet needs of OPWDD individuals.

Care Coordination Organizations provide:

- Conflict free care management by removing agency employers.
- Medicaid Reform
- Improve health, improve individual experience of care (quality satisfaction)
- Help control costs

Health Home Core Services provide:

- Comprehensive Care Management
- Care Coordination and health promotion
- Comprehensive Transitional Care
- Individualized and family/advocate support
- Referral to community and social supports
- Use of Health info technology to link services

Eligibility: Developmental disability that is described by certain qualifying diagnosis or condition before the age of 22. Developmental disabilities include: intellectual disability, autism, cerebral palsy, epilepsy, familial dysautonomia, and neurological impairments.

Both Prime Care and Person Centered Services provide Care Coordination in this region.

Families can call either organization with questions or for assistance. Or call the Front Door at 800-487-6310 to start the process of obtaining Care Coordination.

**Person Centered Services: 888-977-7030 (toll free) or phone: 716-324-5100**

**Prime Care: 1-844-347-3168**

**Jennifer Mruk- Children's Health Home Clinical Manager**

**Niagara Falls Memorial**

**Jennifer.Mruk@nfmmc.org**

**716-278-4647**

Jennifer spoke about services offered through Children's Health Home. Children's Health Home provides:

- Comprehensive Care Management
- Health promotion
- Follow up from inpatient care
- Patient and family support
- Referral to community and social support services

Eligibility: Children under the age of 21

- Children who have Medicaid or are Medicaid eligible (And)
- Have two medical conditions like diabetes, asthma, obesity, substance abuse, alcohol abuse, etc

Or have one of the following:

- Serious mental illness
- HIV/AIDS
- Complex trauma

If a child does not have Medicaid, a navigator can meet with a family to see if they would qualify for Medicaid. If a child ends up with OPWDD eligibility, Children's Health Home would be handed off to OPWDD and Care Coordination. Jennifer is available for any questions at 278-4647.

**Kari Schultz- Niagara County Children's Single Point of Access (SPOA)**

**Mental Hygiene Practitioner**

**[Kari.schultz@niagaracounty.com](mailto:Kari.schultz@niagaracounty.com)**

**716-438-3071**

Kari spoke about services offered and updates within Niagara County SPOA. Eligibility for referral: Niagara County resident, ages 5-20 years old, and have a diagnosis of severe emotional disturbance.

SPOA's services provided:

- Case Management (former intensive and supportive case management)
- Community Crisis Intervention
- Mobile Integration team
- Multisystem therapy
- In-Home Respite
- Family Support

Individuals need to have Medicaid, or be working towards obtaining. There are non-Medicaid spots for children if they have mental health needs. Kari mentioned people can call her at if there are any questions, or if unsure about a referral. The 24-hour crisis line: 285-3515.

**Announcements/sharing of information:**

**RSE-TASC-** Liz Loughran-Amorese discussed transition assessments for students. Liz mentioned that student feedback/ self-assessment, parent assessment can count for transition assessment.

Julia Duerr spoke about Mentoring Day at Niagara Falls Memorial on March 28, 2019.

Registration is open and there are 75 slots. Fifteen departments at the hospital will be included for this program. Time is from 9 am until 1 pm. Lunch will be provided. Schools will need to provide transportation.

**Youth Power-** Carly Congilosi ([carly.congilosi@youthpowerny.org](mailto:carly.congilosi@youthpowerny.org)) spoke about several events. Family Empowerment Day in Albany will be held on February 12, 2019. At this event, families will be able to speak to legislature on issues that concern them. The 2019 Conference, Family Together will be held on May 5 & 6.

University of Youth Power will be held on June 22-25, 2019. This is for ages 18-30. At this event, participants can experience college and choose a major during this event.

**Next RCASA meeting will be March 20, 2019**

