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CT BEHAVIORAL PARTNERSHIP - PROVIDER NEWSLETTER

YOU'VE GOT MAIL!

The Provider Relations Department of The CT Behavioral Health Partnership maintains a CT BHP Provider email distribution list for rapid notification of policy changes, procedures, Provider Alerts and EDS Provider Bulletins; as well as news, upcoming trainings and events. If you or a member of your staff is currently not a part of this distribution list, please email us at ctbhp@valueoptions.com.

ASO (Administrative Service Organization)

Utilization Management - Member & Peer Services - Provider Relations—Quality & Systems Management

Website: www.ctbhp.com

Phone: 1-877-552-8247 or 1-877-55 CTBHP

E-mail: ctbhp@valueoptions.com

EDS

Provider Enrollment—Member Eligibility—Claims/Billing

Phone: EDS Provider Assistance Center: Local (Farmington, CT) **(860) 409-4500** Toll Free **(800) 842-8440**
EDS Electronic Data Interchange (EDI): Local (Farmington, CT) **(860) 284-9700** Toll Free **(800) 688-0503**

Website: www.ctmedicalprogram.com

Paper Claims:

UB-92 Claims:
EDS
P.O. Box 2961
Hartford, CT 06104

CMS-1500 Claims (Formerly HCFA-1500) :
EDS
P.O. Box 2941
Hartford, CT 06104

CONNECTICUT
Behavioral Health Partnership

CT Behavioral Health Partnership

Partnership in Print

VOLUME I, ISSUE II — DECEMBER, 2006

INSIDE THIS ISSUE:

EVENTS

Grand Opening of the CCAR Hartford Recovery Community Center

Thursday January 25, 2007

3:00 pm – 6:00 pm
198 Wethersfield Ave.
Hartford, CT 06114

RSVP by calling CT Community for Addiction Recovery (CCAR)

1-800-708-9145

www.ccar.us

A Year in Review

by Mark Schaefer, Ph.D, DSS Director of the CT BHP & Karen Andersson, Ph.D, DCF Director of the CT BHP

As the CT BHP concludes its first year of operation, the Departments continue to work together with our corporate partner, ValueOptions to achieve the goals we envisioned when legislation for this reform was passed in July 2005.

Over the past year, we have introduced authorization and registration processes for many of the behavioral health services funded under the Partnership. This helps ensure that members receive the appropriate levels of care designed to meet their individual needs, while also enabling us to track and monitor the care provided to our members. Ultimately, this data will inform network development and quality management activities undertaken by CT BHP and local systems of care.

Local Area Development plans have been written by the CT BHP Systems Managers with significant input from DCF area office staff, providers and consumers. These plans will serve as blueprints for local system development and service expansion or reform. By focusing on strengths within existing communities we hope to build upon what is working well and target areas that require improvement.

We know that systems change is difficult, and we have been working closely with the CT BHP Oversight Council and its various subcommittees to ensure that, as we proceed, the concerns and suggestions of the provider and consumer communities are reflected in our work. We have provided technical assistance and training to providers as they navigate the new authorization and claims systems and have

RCT: Residential Care Team Kickoff

On December 1st, the CT BHP kicked off the inauguration of a new Residential Care Team (RCT). The RCT is composed of CT BHP, DCF and CSSD staff members. As of December 1st, all referrals for CT DCF or Juvenile Services youth being referred to residential or group home care are managed by the RCT. Information about the Residential Care Team can be located on the CT BHP website: www.ctbhp.com.

The website provides an overview of the RCT process, links to the forms and assessments necessary to complete the referral process to residential (RTC) and group home (GH) levels of care and answers to many Frequently Asked Questions. It is our hope that Connecticut Department of Children and Families (DCF) and Juvenile Services' staff members, as well as our residential and group home provider networks find the site useful.

We also have provided the following overview of the RCT process:

Step 1: The first step in the process is to fax in a registration form for the requested level of care. **The fax number for registrations is 1-866-584-4194**.

Step 2: Once CT BHP notifies the referral source (DCF area office, Parole office or CSSD office), that the referred child meets the requested level of care, the referral source should fax in a completed Child and Adolescent Needs and Strengths (CANS) assessment to CT BHP. * **The fax number for CANS assessments is 860-263-2181**.

Step 3: CT BHP staff member telephonically reviews the assessment with the referral source.

Step 4: CT BHP and DCF Central Office staff completes a prioritization work-up on the child/youth. If the child/youth is deemed urgent or high need of the requested level of care his/her case is reviewed in the twice weekly RCT rounds to determine appropriate placement.

Step 5: After a potential placement match has been made, the referral source arranges for the potential RTC or GH to receive the completed CANS assessment and relevant supplemental materials (see FAQ for list of supplemental materials). Additionally, the referral source coordinates the pre-placement interview (if requested by the RTC or GH) and the actual admission of the child/youth to the agency.

Step 6: The proposed facility and the referral source notifies CT BHP as to the outcome of all referrals. This is to highlight target admission dates if the referred child is "match" for the facility or to identify why matches are not successful and figure out next steps if a child is not an appropriate match.

If you have any questions or comments, please feel free to contact the RCT at 1-877-552-8247

Officers Try New Tack To Face Mentally Ill

By GARY FIELDS

MESA, Ariz. -- The black visor wrapped around police officer Johnny Lopez's head made him look like a comic-strip character. As he peered at a computer screen, he felt his brain filling with murmurs and whispers calling him worthless and crazy. "They're after you," said one voice. Hallucinations flitted in and out of his line of sight.

Mr. Lopez and a group of 30 police officers from the Phoenix area were undergoing a simulated schizophrenic episode. It lasted just five minutes, but the officers were clearly relieved when it was over. One officer ripped off the headset broadcasting the voices. "This would drive me crazy," said Sgt. Barbara Alexander, "if I had to listen to it all the time."

The officers' taste of psychosis was supposed to give them new perspective on an increasingly common part of their work -- dealing with mentally ill people on the streets. The problem follows the shuttering of state-run mental-health facilities a generation ago. Prisons helped pick up the slack. The Justice Department estimates that about 330,000 of the nation's 2.2 million inmates are mentally ill. When released, they usually end up back in prison, in part because of a lack of outside treatment options.

Traditional police training runs counter to the tactics sometimes needed in encounters with sick people. Young recruits in police academies, for instance, are taught to take immediate command of unstable situations by shock and awe, issuing loud commands.

Mentally ill patients often react adversely to that. A Los Angeles study found that between 1994 and 1999, officers there shot 37 people during encounters with the mentally ill, killing 25.

Now, hundreds of police departments nationwide are trying to change their approach. In San Diego, officers are paired with mental-health professionals on some calls. In Arlington, Texas, all patrol officers and new recruits are given training that ranges from identifying symptoms to knowing what services are available. Some departments direct calls that appear to involve mentally ill people to officers with special training.

"This would drive me crazy," said Sgt. Barbara Alexander, "if I had to listen to it all the time."

The training began here in 2001 and was patterned after a program created in Memphis, Tenn., following the fatal shooting of a mental patient by local police. Five years later, about 1,000 officers have been trained, and now even 911 dispatchers and some detention officers are getting some instruction. The program here is one of the largest in the country.

In Mesa, officers learn to use softer, more conversational language less likely to agitate someone who is mentally ill. They also learn about psychiatric disorders and listen to firsthand accounts from mentally ill patients. A student at Arizona State University told the officers he had heard voices "every waking moment" for nearly 10 years. "It wasn't about the weather. They say your life's not worth living, kill yourself," said the student who asked not to be named. "The voices told me to kill a friend once. I told him. It made him nervous."

The student was quickly peppered with questions. "What words really piss you off?" asked Phoenix police Lt. Mark Hafkey, echoing the thoughts of other officers there. "Nutcase," responded the college student. "I had an officer call me that." He added that while he was suffering a breakdown, trying to use physical force with him would only escalate a situation. Questions that make him focus his attention are best. " 'Have you eaten? Have you seen a case manager? Are you on medication?' Those questions bring me back to reality," he said.

Two of the officers instructing the classes went on patrol later that evening through Phoenix neighborhoods with a high concentration of homeless residents, some of them mentally ill. Both men do much of the outreach for the program. Over the next several hours, they patrolled areas and conducted home visits with a number of mentally ill residents to make sure that they were attending therapy sessions, getting medical care and taking their medication. They urged the homeless mentally ill to move to shelters and voluntarily accept help for their illnesses. Because there is little bed space for the mentally ill outside prisons, the two officers see the stops as preemptive visits to head off potential crimes. They even drive some patients to doctors' visits.

Mental-health advocates like to see officers involved but worry that governments are shifting the responsibility for caring for mentally ill people to the criminal-justice system. Police officers are also wary of their new role.

"Doctors, lawyers and now mental health professionals -- they want us to be everything," says Chuck Canterbury, the national president of the Fraternal Order of Police, which represents more than 300,000 street level officers. He supports the training but cautions that the public "cannot expect or anticipate law enforcement will be mental health professionals." The training shouldn't change how police react when confronted with life-threatening situations, he added.

The first visit of the night was with a regular who frequents places near the airport, including a bank where he has parked five grocery carts of trash and trinkets. Wheelchair-bound because of a leg infection, he tried to outrun the patrol car when he spotted the officers, until Officer Beauchamp got out. The officer had tried several times to get the man into a shelter, but he refuses because he doesn't want to give up the grocery carts and one of his prized possessions, a 20-year-old stuffed animal.

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Year in Review

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outreached to providers who have

(cont. on Pg2)

experienced difficulty. We value our provider community and remain committed to addressing their concerns as we continue to move forward.

We remain aware at all times of the needs of the CT BHP members for whom the Partnership was designed. Although parents and consumers have participated actively in helping to implement the new system, we have missed consumer participation in some of our activities. We have begun to outreach to Connecticut's family advocacy organizations and to the Children's Behavioral Health Advisory Council to further engage parents in our various committees and to solicit ideas and comment from those who understand the service system the best.

Finally, in the coming year, we look forward to establishing our first network of Enhanced Care Clinics, which we believe will set a new standard for access and quality. We will also begin to develop plans for improving the care provided to youngsters involved with the child welfare system. We are looking forward to inviting providers and consumers to participate in this important

Buy Now and Pay Later: The Hidden Addiction of Compulsive Shopping

by Holly E. Dreger, LCSW, Clinic Director, Catholic Charities

I bumped into a woman at the grocery store last week. Betty* (not her real name), who appeared to be about 50 years old, stood in front of me, poised and ready to write out a check for her groceries, which consisted of two cans of cat food and a light bulb. When the clerk totaled up her order, Betty asked for 'cash back'. She smiled as she handed the clerk the check for $45.00. Betty offered that her husband 'doesn't need to know' that she sometimes needs 'a little more money' for 'retail therapy'.

This kind of secretive behavior is less uncommon than you might think. In fact, it

"Many patients relate feeling a sense of power and control when able to shop and obtain the material things that secular society tells us we 'must have'".

is a hidden addiction for many. Known as "retail therapy" by the initiated or oniomania, (the scientific term for compulsive shopping), spending more than you should is an addictive and ultimately destructive process, where 'shoppers' continue to spend despite knowing adverse consequences, such as difficulty paying the bills incurred during fits of spending. It is also a progressive addiction and tends to worsen over time.

It might start out subtly, such as when someone finds that they temporarily 'feel better' after making a purchase. The sense of well being might be fleeting, but the shopper soon learns that whenever they might feel disappointed, angry, or sad; going out and buying some simple item, temporarily transports them away from their uncomfortable feelings.

Some signs and symptoms of compulsive shopping include:

- shopping or spending money after you've been feeling angry, lonely, depressed or worried
- finding yourself spending more and more time trying to pay bills to accommodate your spending (e.g. using one credit card to pay another; selling personal items to make payments or to impulse spend)
- Getting into arguments with significant others about your spending and shopping habits
- Actually feeling a 'high' or rush of euphoria at the time of purchase
- Lying to others about how much you are really spending
- Feeling ashamed or guilty after spending money
- Feeling literally lost without your credit cards
- Going shopping for a gift for another but always buying something for yourself
- Charging items that you probably would not have purchased with cash

If you can identify with three or more of the above, you might have a problem. Often, the reason why someone becomes 'addicted' to shopping is related to an underlying issue, such as feeling out of control, being depressed, or being angry. Many patients relate feeling a sense of power and control when able to shop and obtain the material things that secular society tells us we 'must have'. This sense of power, however, is an illusion with extremely destructive consequences on self, relationships, and financial futures. Additionally, many compulsive shoppers also have other co-occurring issues, such as eating disorders, substance abuse issues, or mood disorders.

Please know that if you do recognize that you or someone you love has a compulsive shopping problem, that you shouldn't feel ashamed or seek to hide the behavior. Hiding the behavior will only make it grow worse, and further trap ou in the addiction. The most important thing you could do is admit that you might have a problem and seek help. Gently confronting one you love with a compulsive shopping problem can help them know that they can get help for this addiction.

Catholic Charities offers counselors skilled in treating difficulties stemming from addiction, mood disorders and stress related to daily life. If you would like information regarding the services we offer, do not hesitate to contact me at (860) 889-8346 ex. 280. ■

Officers

(continued from page 2)

Later, they ran across another of their former contacts, a schizophrenic pushing a grocery cart. He became agitated when he heard one of the officers describe him as homeless. He has in fact been homeless for 27 years and said, "I don't want to be off the street."

Normally officers stay together in a show of force, but here Mr. Margiotta stayed several feet away, but within sight so the man wouldn't feel overwhelmed.

At another stop, the officers spotted an emaciated man sleeping on a grate behind an electrical-supply business. Mr. Margiotta hung back while his partner approached the man gingerly and talked to him softly. "Hey, we're not here to cause you any problems. We're just checking on you. You alright?" he asked.

Both officers noticed that the man had begun twitching and hitting his leg -- a sign, Mr. Beauchamp said, of mental illness and stress. "He's calibrating himself, doing that to keep himself on an even keel. We're making him uncomfortable."

His partner took a step back, giving the man more space and assessed his situation. Both realized the big toes on each of his feet were gone, probably the result of diabetes. It was difficult for him to walk. He carried no ID, but said his name was Smith. He said he was 30 but appeared to be in his fifties or sixties. Not once during the 20-minute encounter did he look at either officer, even as they reassured him repeatedly that he had done nothing wrong.

Because the man wasn't suspected of a crime and didn't appear to be an immediate danger to himself or others, the police couldn't take him into custody or order him to get a psychological assessment. The man reluctantly agreed to cooperate with social service and mental health groups if the officers contacted the organizations,

- Originally published in the Wall Street Journal - 9/26/06

Provider Spotlight - Wheeler Clinic

Wheeler Clinic is a non-profit community organization providing a comprehensive continuum of behavioral health care, special education, early childhood, community justice and wellness services to over 14,000 individuals and families each year. Founded in 1968, the clinic's mission is to foster positive change in the lives of individuals and families, as well as in its communities.

The clinic has achieved outstanding growth tripling in size since 1998. Today 700 staff, including 200 clinicians, working in 20 facilities in Bristol, Farmington, Hartford, New Britain, New Haven, Plainville and Waterbury, serve clients across Connecticut. This includes: a highly-respected special education program serving more than 200 children each day; outpatient services with 70 new assessments completed weekly and 2,000 clients actively receiving treatment at any point in time; and more than 250 in-home treatment slots.

Executive Director David J. Berkowitz, Ph.D. and directors Susan Walkama, LCSW, Michael Russo, Psy.D. and Nic Scibelli, LCSW, have developed a progressive approach to the adoption of evidence-based models of care and comprehensive outcomes analysis using standardized measures to monitor client progress and inform program development. They embrace a solution-focused, strength-based approach and are committed to implementing empirically-supported methods of intervention across treatment modalities.

"They embrace a solution-focused, strength-based approach and are committed to implementing empirically-supported methods of intervention across treatment modalities."

The Adult Services Department provides state-of-the-art mental health and addictions treatment including motivational enhancement and cognitive behavioral approaches. DMHAS has named LifeLine, a substance abuse treatment program for pregnant/parenting women, a Center of Excellence for person-centered planning and gender-specific, trauma-informed care. Adult Services has developed expertise in integrated psycho-educational intervention models serving the community justice population, launching the New Britain Adult Risk Reduction and Alternative Incarceration Centers using a range of evidence-based approaches.

The Children's Outpatient Services Department incorporates the broadest array of evidence-based models available in Connecticut. These interventions are employed across outpatient, intensive in-home and juvenile justice services. The department has piloted unique models of integrated family substance abuse treatment, combining Multi-Systemic and Reinforcement Based Therapies, Multidimensional Family Therapy and Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT); and offers standard MST, II-CAPS and MDFT models. Outpatient programs have introduced DBT, Aggression Replacement Therapy, Parent Effectiveness Training, VOICES and TARGET. They have also developed a primary care integration model placing a psychologist in a pediatric office, enhancing access to and continuity of care.

Children's Residential Services provides care for children in six residential programs, through an array of foster care programs, and most recently through the addition of Birth to Three services. The group homes have adapted to support children with increasingly complex clinical needs while maintaining a nurturing environment and linkages with the children's families and communities. The foster care programs have grown substantially, adding 15 new slots bringing the total number to 60.

Wheeler Clinic's progressive approach and capacity to achieve positive outcomes has contributed to the growth of its services and its reputation in the community. The clinic is known as a dynamic place to work where staff receive training from state and national experts, a generous tuition support program and the opportunity to participate in a management training program.

Bulletin Rewind

We here at the CT BHP wanted to take the opportunity to keep providers abreast of recent communications, alerts, bulletins and policy changes. With such a varied and robust network of providers, it is always a challenge to ensure that each provider is made aware of any and all updates.

Bulletin rewind will be a continuing feature of Partnership in Print and will highlight recent provider alerts and bulletins. Please note that all CT BHP Provider Bulletins and Alerts can also be found on the CT BHP and EDS websites.

PB06-96 & PB06-92 (December)
Subject: National Provider Identifier (NPI) Updates to Hospitals (PB06-96) & All Providers (PB06-92)

PB06-94 (December)
Subject: EDS Schedule of Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule.

PB06-93 (November)
Subject: EDS is Moving: Important "New" Contact Information for the Connecticut Medical Assistance Program

PB06-89 (November)
Subject: CT BHP Coverage of Case Management Services for MH Clinics, School Based Health Centers, Medical Clinics and Independent Practitioners.

(Reserved - Favor Article)

Web Registration

Firstly, the CT BHP would like to thank our providers for their patience, dedication and continued efforts with the CT BHP web registration system.

The registration of services will continue to provide essential information our state's behavioral health programs and services.

The following list contains helpful hints and reminders when registering your CT BHP services:

- **Timely Registration**
  CT BHP providers must register all registered* services within 21 days of the member's initial visit. Registrations cannot be backdated more than the 21 days.

- **Password "Logouts"**
  Web registration users that incorrectly enter their login information (id or password) will be disabled after the 3rd attempt. Users must contact our Technical Support Line @ 1-866-817-6306 to have a technician reset your password.

- **Group Practices**
  Provider Group Practices must complete a registration for "each group" that a member is utilizing. For example, a client participating in therapy sessions under the LCSW group but receiving Medication Management under the MD group will need to be registered under both of these groups.

*A complete listing of services that require registration can be found on the CT BHP website: www.ctbhp.com. "Authorization Schedules"

We'd Love to Hear From You!

Do you have an article, opinion or provider event that you would like to submit to the CT Behavioral Health Partnership Newsletter? We would love to hear from you.

We want to ensure that our newsletter includes articles that are of interest to our providers, covers topics about our providers' work with children and adults and highlights special features that reflect what is happening in our communities, families and state.

Please feel free to contribute your thoughts, ideas, comments, suggestions, upcoming events and community developments to us. You can submit your ideas and comments to the Provider Relations Department via email at ctbhp@valueoptions.com or fax your suggestions to 1-860-263-2036.