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RECOVERY TIMES

Healthy People, Healthy Communities. Let's Make It Happen!
State of Connecticut Department of Mental Health and Addiction Services
Thomas A. Kirk, Jr., Ph.D., Commissioner

Emphasis on: Collaborative Ventures with Other State Agencies and/or Community Public/Private Partners

COLLABORATION LEADS TO IMPROVED SERVICES

One of the often overlooked aspects of research is called the Hawthorne Effect, which is the way in which the research or evaluation process itself can cause change. When this is applied to the review of programs and services it is also true. It is therefore important that the manner in which services are measured or evaluated is very intentional, and done in a way that helps agencies and services to be the best they can be, in order to be responsive to consumers/individuals in recovery, families and community need.

Region V as a whole values and emphasizes collaboration--in services, among providers, and with consumers/individuals in recovery and families. This is reflected in the way programs are evaluated. There is intentional, strong and effective collaboration in the review and evaluation process between Northwest Regional Mental Health Board (NWRMHB), DMHAS' Western CT Mental Health Network (WCMHN), and DMHAS' Regional Monitoring Team.

How did this come about? NWRMHB has had a strong and active program evaluation process over its decades of operation. With the advent of local mental health authorities, and the Regional Monitoring Teams, it was agreed that the evaluation process would be the most effective, and the most efficient, if it was done not in isolation but in a collaborative manner. So we "make it happen." We coordinate our planning, and cooperate in the program evaluation itself. Each entity "plays to its strengths." For site visits, the Board/Catchment Area Council has the program complete a written self assessment, and answer targeted questions. Then with the support of the Board's on-staff Evaluation Coordinator, teams of consumers/individuals in recovery, family members and community representatives review those materials and conduct focus groups of consumers/individuals in recovery served by the programs, as well as administrative and direct care staff. DMHAS' WCMHN and Regional Monitoring staff look at and report on outcome measures, contract compliance and utilization, and together they perform a substantial chart review that assures adherence to practice models and services that are person-centered and recovery-oriented. The reports are presented at the local catchment area council meetings, with all stakeholders present to assure a complete and inclusive discussion of the issues. At that point merits, concerns and recommendations are adapted as needed.

Through this collaboration, consumers/individuals in recovery are assured of the best and most responsive services, and providers receive the support they need to succeed. In one situation, this meant the development and presentation of system-wide training in recovery-oriented treatment planning. When necessary, the collaborative and concerted approach also assures that necessary changes are made. This has included agencies changing services in both small and major ways. Most agencies respond because of pride in their mission and work. The results have been high quality, responsive services which strive for success and self-improvement. This kind of evaluation partnership is not easy to maintain, but has been highly successful because the three entities meet regularly, address challenges when they arise and continue to work on the process. We all share the same goal, and we each value the strengths and integrity of the other. It works because we make it work!

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COLLABORATIVE VENTURES TO ADDRESS SYSTEM GRIDLOCK

A collaborative comprised of participants from DMHAS' Capitol Region Mental Health Center (CRMHC), Hartford Hospital, St. Francis Hospital, Community Health Resources, InterCommunity Mental Health Group and staff from the Office of the Commissioner was convened to improve access to services for uninsured individuals and for persons who need extended hospitalizations. This coordinated approach is well-aligned with the Governor's Task Force, which designated Hartford as one of CT's cities

with the highest Emergency Department (ED) volume. A weekly workgroup was established to:

- Track origin, referral and admission patterns at EDs;
- Identify processes through which individuals are prioritized for state beds and delays in accessing those beds;
- Better utilize available mobile crisis and related resources needed to divert individuals from EDs;
- Monitor of Public Safety;
- Determine new or expanded service needs with expanded resources;
- Provide oversight and movement of long-term inpatient lengths of stay;
- Use of data from all sources to make decisions; and
- Discuss and identify solutions for issues from the local system.

The workgroup's expected outcomes include:

- Local provider entities will understand the complicated system demands and help to manage client flow;
- Local partners contribute to the decisions; increase the sense of investment and are more motivated to improve the process;
- Strengthen the understanding of the comprehensive statewide service system, thereby improving utilization of multiple types of service such as CVH or Cedarcrest; and
- Strengthen concepts regarding "community back-door movement" so that discharge planning at lower levels of service is highly managed, thereby improving client flow through the entire system

To date the project has identified a high number of individuals who have had repeat admissions to EDs (more than 3 times) and have developed strategies to work with these individuals. As of a result of improved communication with CRMHC, hospitals are more willing to admit challenging individuals. The workgroup has also developed strategies to better utilize substance abuse treatment programs when clinically appropriate, i.e., Recovery Houses and residential treatment. Substance abuse treatment providers, including Blue Hills and Alcohol/Drug Recovery Centers, participate periodically in the weekly meetings, which have improved relationships and admitting process to these agencies. Positive Results include better collaboration, more clinical attention to individuals with multiple readmissions, and more client movement locally.

For more information, contact Karen.Evertson@po.state.ct.us or (860) 297-0903.

COLLABORATIVE WORKGROUP

DMHAS' Western CT Mental Health Network (WCMHN) and all other state-operated facilities have been participating weekly in the Collaborative Workgroup involving discharge planning at CT Valley Hospital (CVH) for the past 6-8 months. The Collaborative Workgroup is helping to better coordinate efforts to transition individuals from CVH back to their community of choice.

There have been several layers to the workgroups discussions: 1) Identifying from the community provider's perspective whom may be a candidate to transition out of CVH in the near future (next 90-180 days); 2) Having outpatient liaison staff integrated with the inpatient unit to collaboratively work on behavioral plans if necessary; 3) Bringing all parties together early on to discuss challenges for the individual as they begin the transition process; and 4) Generating and detailing potential areas for continued improvement with this process. This has included some "out of the box" thinking about what might be possible both from the inpatient and outpatient treatment teams.

This process has begun to work effectively to maintain an ongoing dialogue about creating mechanisms for better flow from inpatient units to the community. It has been very helpful to have a consistent group of individuals come together weekly from across all of the state outpatient sites and to develop and nurture those collaborative relationships. It has also been extremely valuable to have a weekly method to identify and track the flow of these discharges, to gain a perspective on the process and how this mutually affects all of us. Creating flow from DMHAS' inpatient units is a complicated and iterative process between CVH and outpatient settings, one that necessitates collaboration and mutual understanding. This workgroup is a positive step towards that process.

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COORDINATED EFFORT BETWEEN COLLEGE AND COMMUNITY HOSPITAL TO SUPPORT SERVICE CONTINUITY

The CT Youth Suicide Prevention Initiative (CYSPI), funded by the federal Center for Mental Health Services, is working with the CT State University System (CSU) of Central, Eastern, Southern and Western CT State Universities, to provide a quality, sustainable infrastructure and expertise in the implementation of innovative programs utilizing the SMH College *Response* Model (SOS-Signs of Suicide and NDSD-National Depression Screening Day) and

the Question, Persuade, Refer (QPR) Institute Gatekeeper Model.

In addition to the work directly related to the CYSPI grant and the services each Center provides, the Counseling Centers at the CSUs are also responsible for making contact with students who return to campus following a critical incident (i.e. transport to the hospital for either a mental health or substance abuse-related issue), in order to provide follow-up services. Follow-up with these students is a challenge for the Centers as it is not always clear when these incidents occur; and due to Acts protecting patient and student privacy (HIPPA and FERPA) it is difficult to obtain information from the hospitals unless authorized by the student. However, Central CT State University has developed a contract with New Britain General Hospital in order to formalize their relationship and encouraging hospital staff to attempt to acquire consent from the student, as a patient, to contact the Counseling Center for appropriate follow-up services. Through this relationship, more of these students' needs are met on a timely basis.

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DMHAS' STATEWIDE SERVICES COLLABORATIVES

Summary of several collaborations and partnerships through DMHAS' Statewide Services include:

- DMHAS Statewide Services Housing and Employment staff are collaborating to train housing case managers on employment strategies. Four workshops have been offered to date through the DMHAS Recovery Institute, with two scheduled for the spring. The trainings address a range of employment-related issues including best employment practices, the role of case managers in promoting and supporting successful employment outcomes, and local employment resources.
- The Hartford and Norwich/New London were pilot sites for a project that links the One Stop Employment Centers with their local DMHAS supportive housing providers. Under the leadership of the Office for Workforce Competitiveness, staff from supportive housing worked closely with their local CT Works, Department of Labor and Workforce Investment Board staff to raise awareness of the employment needs of tenants and develop joint strategies to deliver and track services to tenants. Both sites organized interagency staff training regarding local resources and referral protocols. Most importantly, staff from the participating agencies built relationships that will encourage future teaming. The project was cited by the Advocates for Human Potential and will be expanded to other regions in the spring.
- DMHAS is partnering with the Corporation for Supportive Housing (CSH) and Department of Social Services Bureau of Rehabilitation Services (BRS) to build an innovative collaborative service infrastructure that improves employment outcomes for residents of supportive housing with behavioral health disorders. The two-year Medicaid Infrastructure Grant builds on the efforts described above to integrate employment within supportive housing programs, identify successful employment strategies and build capacity throughout the housing system. Key elements of the grant are as follows:
  - Focus on systems/infrastructure change that would enable agencies such as the CT Works One Stop Centers to better serve individuals;
  - Identifying best practices in linking employment and housing;
  - Developing a comprehensive data system to measure and document effective practices as well as employment-related outcomes;
  - Staffing that includes a Project Coordinator, who will oversee the project and facilitate partnership and capacity building with participating agencies; a Benefits Coordinator who will train the DMHAS and housing systems regarding the impact of work on benefits; and two tenant peer facilitators who will engage and train residents and partner agencies on supportive housing, viable employment methods and resources.
  - Activities that initially focus on the three regions (Bridgeport, Hartford and New Haven) but will eventually be disseminated throughout CT; and
  - Grant achievements that are sustained through permanent infrastructure changes.
- DMHAS and the Bureau of Rehabilitation Services (BRS) have a number of projects underway that link the employment services of the two agencies to achieve improved outcomes for persons with behavioral health disorders. DMHAS' Mental Health Employment Coordinator, Ruth Howell, occupies a shared position with DMHAS. In her liaison position she works with staff of agencies, transferring resources and best practices between the two agencies, promoting local collaboration, organizing staff training and trouble shooting systemic problems that arise. Three BRS counselors are co-located in DMHAS LMHAs (Capitol Region

Mental Health Center, Greater Bridgeport Community Mental Health Center and CT Mental Health Center). With clinical treatment teams including DMHAS employment staff, the BRS counselors coordinate BRS services and resources with those of the DMHAS system. Both agencies have found that this partnership results in improved outcomes and a broader array of services.

- Linda Guillorn, DMHAS' Addictions Employment Coordinator, is working closely with the Recovery-Oriented Employment Services (ROES) Guide Team to promote employment opportunities and outcomes for persons with addiction disorders. The ROES Team has identified best practices and developed recommendations for making employment services available throughout CT.
- Through a DMHAS grant, the Alcohol and Drug Rehabilitation Center (ADRC) has teamed with the CT Community for Addiction Recovery (CCAR) to pilot best practices for assisting individuals in recovery to obtain and keep jobs. ADRC staff provides job placement services and CCAR staff provides telephone support retention services.
- DMHAS has worked closely with the Central CT State University (CCSU) ACCESS Program and several community-based education provider agencies to create a supportive education infrastructure for the state. A supportive education subcommittee has been meeting for over four years to develop strategies for assisting persons in recovery to access education and training. Following a statewide conference that offered extensive training, educational resources and a blueprint for organizing local community educational collaborative, CCSU, in partnership with Laurel House and DMHAS, continues to provide technical assistance to sustain local collaborative in all regions. The collaborative convene local college, adult education and DMHAS provider staff to facilitate relationships among staff, clarify services and articulate shared protocols for supporting consumers who are returning to school.

For more information, contact Barbara.Geller@po.state.ct.u or 860-418-6813.

INFORMATION SHARING: KEY TO BETTER CARE

Lack of information coordination across state agencies regarding addiction, mental health and primary health care has a profound influence on both the effectiveness and efficiency of these services. It can hamper efforts at assuring continued care from prison to community, hinder a sustained recovery once in the community, and ultimately costs the state in poor outcomes such as re-involvement with the criminal justice system. The sharing of data across state-funded systems is essential for care coordination, public safety, program evaluation, cost containment, and policy and program development.

Most often the concern that inhibits sharing of information is confidentiality requirements. This includes state statutes, federal laws and agency regulations. Many of these limitations on disclosure are in the interest of the person receiving services, as should be. At the same time, attempts at sharing clinical information for improved care coordination have met with limited success. One clearly identified problem has been the lack of standardized behavioral health and medical Release of Information form(s).

In an effort to move beyond these barriers while adhering to state and federal confidentiality laws and regulations (e.g., Health Insurance Portability and Accountability Act-HIPAA and 42, Code of Federal Regulations, Part 2), the CT Alcohol and Drug Policy Council (ADPC) and the Criminal Justice Policy Advisory Commission (CJPAC) have joined efforts to streamline the transfer of clinical care information. The APDC Information Coordination Committee and the CJPAC Behavioral Health Subcommittee are crafting a Memorandum of Agreement (MOA) across four state agencies and the Judicial Branch in which all parties will attest to having a Release of Information that meets standard confidentiality requirements. Once executed, all agency and Judicial staff involved with transfer of substance abuse, mental health and primary care information will be informed of the MOA and trained in the proper transfer of Personal Health Information.

While the MOA is an important and critical first step in the process to enhance care coordination, improved methods of transfer are also needed. The Institute of Medicine's 2004 report on Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series highlighted the need for providers to obtain patient health information quickly. The report continued by noting that timely information, shared across care providers is essential to the delivery of safe, patient-centered, coordinated, and effective health care. As a first step, the ADPC and CJPAC are recommending that a secure platform for the exchange of state-operated behavioral and primary health information be implemented. Through the application of a secure state e-mail network, such as Tumbleweed Secure E-mail, content filtering, policy management, and audit capabilities can prevent inappropriate disclosure of client information and ensure compliance with federal and state confidentiality regulations. This

approach provides an immediate low-cost and secure solution for the transfer of confidential behavioral and primary health information while, over the ensuing years, state systems move toward the ultimate standard of electronic health records.

For more information, contact Alfred.Bidorini@po.state.ct.us or 860-418-6868.

INTEGRATING BEHAVIORAL AND PRIMARY HEALTH CARE

Crossroads, Inc. in collaboration with the *Hill Health Corporation* has launched a satellite clinic within Crossroads' facility to provide primary healthcare services to persons served by all programs of Crossroads. Crossroads has established space for two examination rooms, an office, and a phlebotomy room in the treatment facility. Hill Health has agreed to provide a phlebotomist and internal medicine clinician. Most often, individuals admitted to residential programs such as Crossroads, do not have local primary care providers and have not adequately addressed chronic medical concerns that may compromise their health and interfere with their efforts to recover from substance abuse. This collaborative initiative streamlines access to essential medical intervention and wellness care through on-site primary care services including physical examinations and tuberculosis screening of applicants to Crossroads, enhances service coordination for clients with chronic or acute medical needs, and diverts care from unnecessary and costly emergency room visits.

For more information, contact Dr. Miguel Caldera at 203-387-0094.

NEW PSYCHOSOCIAL SCHOOL

During the last two years, persons in recovery and staff at DMHAS' CT Valley Hospital (CVH) have devoted much of their time and resources to develop improved psychosocial skill-building activities at the hospital. Under the guidance of Robert Liberman, MD, and his colleagues at the UCLA Center for Research on Treatment & Rehabilitation of Psychosis, a series of nine user-friendly modules for training social and independent living skills have been introduced. The modules cover a variety of life concerns including basic conversation, recreation for leisure, independent living skills and community re-entry.

More recently, CVH staff have worked together with staff from two Local Mental Health Authorities (LMHAs), River Valley Services and Capital Region Mental Health Center, and from their not-for-profit community affiliates to develop a psychosocial skill-building "school." The goals of the school are to: 1) Make it easier for persons in recovery to transition from CVH to the community by utilizing common psychosocial skill-building techniques; 2) Assist persons in recovery and staff in the community to develop improved skill-building activities in their own programs; and 3) Develop a faculty of persons in recovery and staff who can increase the breadth of the skill-building training statewide.

The first class at the Psychosocial School will begin in March. Approximately sixteen people (persons in recovery and staff) will begin a twelve week semester during which they personally will experience the medication management module. Their teachers will be persons in recovery and staff at CVH and the trainees will represent a variety of community agencies: community support, respite, psychosocial, residential support, group home and assertive treatment programs.

The expectation is that these "trainees" will then become teachers in their own communities. CVH teachers will be available to help the community implementation to go forward and there will also be "faculty" meetings to explore ways to improve the training. The treatment mall in Page Hall at CVH will be the home of the School as it permits a variety of classes to be held at the same time.

In the fall, a new semester will begin in which additional people will be trained to lead other modules. As the school gains experience, students from LMHAs will also be encouraged to attend. In this fashion, the hospital and the community will grow together to assist persons in CVH to return and to remain in their towns and cities.

For more information, contact Eric.Persky@po.state.ct.us or 860-262-7030.

RECOVERY PARTNERS INITIATIVE (RPI)

On February 11, 2009, DMHAS' Cedarcrest Hospital announced the onset of its RPI before an enthusiastic crowd of supporters. This event mobilized over 50 friends and family members of individuals served, as well as, current and former clients, and service providers to discuss and collect information useful in *promoting mental wellness* among consumers/individuals in recovery. RPI aims to strengthen alliances between the treatment teams and the familial-community ties that inform care and improve prognosis for recovery. A written summary describing the responses obtained at this event will be distributed to staff, patients and to their families and/or other contacts. This information will be used to shape events that enhance therapeutic collaboration, communication and support.

For more information, contact Teodoro.Anderson-Diaz@po.state.ct.us or 860-594-5736 or Kate.Maldonado@po.state.ct.us or 860-666-7607.

THOUSANDS OF PEOPLE ON MEDICARE PART D IN CT ARE ELIGIBLE FOR ASSISTANCE BUT HAVE NOT APPLIED

What is the Low-Income Subsidy? The Low-Income Subsidy, also known as "Extra Help," provides financial assistance for some Medicare Part D beneficiaries who have limited income and resources. Those who are eligible for this low-income subsidy will get help paying for 75% or more of their monthly premium, yearly deductible, prescription co-insurance and co-payments and no gap in coverage. The Centers for Medicare and Medicaid Services (CMS) encourages all Medicare Part D beneficiaries to apply for the Low-Income Subsidy, which in 2009 is estimated to be worth $3,923 at the pharmacy and as much as $298 in annual premiums. The Low-Income Subsidy can be critical for persons with mental illnesses who struggle to pay their Medicare Part D premiums and purchase needed medications.

Why does the Low-Income Subsidy matter to Medicare Part D beneficiaries with mental illnesses? Best treatment guidelines for mental health conditions require that individuals have access to a wide array of available medications. Significant scientific and clinical evidence demonstrates that mental health medications are not generally interchangeable. Many drugs, even those within the same class, target different areas or chemicals in the brain and individual responses to medications may differ greatly and a drug's effectiveness and side effects hang on many factors, including the individual's race, ethnicity, gender, and other illnesses and medications. Because psychiatric drugs have unique and individualized effects on a person's health, the Low-Income Subsidy can be critical for those who are struggling to pay for their prescriptions, and can provide significant help in assuring that individuals have access to the specific medications recommended by their physicians. It is dangerous to the individual's health when psychiatric drugs are disrupted or discontinued, and is also costly to public health systems.

Who is eligible to receive the Low-Income Subsidy? Some people are automatically eligible for the low-income subsidy. Those include people who are: full benefit dual eligibles (on Medicare and Medicaid); Supplemental Security Income (SSI) recipients with Medicare; and Medicare Savings Programs participants. Some people must apply through the Social Security administration (SSA) to become eligible for the subsidy. Individuals who make less than $16,245 and married couples who make less than $21,855 may qualify for the subsidy, and if you support other family members, this income limit may be higher. Eligibility also depends on an applicant's resources, including bank accounts, stock and bonds—NOT your house or car. Individuals should have resources less than $12,510 and married couples should have resources less than $25,010 to qualify. Generally, those eligible for the low-income subsidy pay no Part D plan premiums or deductibles, but pay $1.10 or $2.40 for generic drugs and $3.20 or $6.00 for brand-name drugs, depending on their income.

Connecticut's Dept. of Social Services (DSS) estimates that *there are approximately 13,000 CT residents that are eligible for the low-income subsidy who are not currently receiving any "Extra Help."* DSS wants to raise awareness of the Low-Income Subsidy in the mental health funded by the DSS community, because access to medications for this population is so important, and for some access can be a life or death issue.

How can I apply for the Low-Income Subsidy? People who are not automatically eligible have to fill out an application and send it to SSA or apply on-line at www.socialsecurity.gov. You can obtain applications from SSA by:
- Calling (800) 772-1213 or (TTY) (800) 325-0778
- Going to your nearest Social Security Office

For more information or to obtain applications, contact Amy O'Connor at NAMI-CT at policyassistant@namict.org or 800-215-3021.

TIMELY MENTAL HEALTH SCREENING AND EARLY INTERVENTION FOR MIDDLE SCHOOL-AGED YOUTH

The CT Youth Suicide Prevention Initiative, funded by the federal Center for Mental Health Services, is working with the Saint Francis Hospital and Medical Center Adolescent and Young Health Program and the Quirk Middle School School-Based Health Center in Hartford, CT to provide a comprehensive prevention program which increases the availability and timely accessibility of mental health treatment to middle school-aged youth by embedding services in these locations as part of the well-child check. Services are performed with youth who have active parental consent for the early screening and intervention and evaluation. A positive score of 77 or higher on Reynolds' Adolescent Depression Scale (RADS), a noted critical item(s) such as self-injury, or justified clinical judgment allows immediate access to mental health services for six to eight sessions at the end of which the youth is

evaluated once more for progress. If identified as still needing counseling services, the youth is assisted in being referred for longer-term counseling. Follow-up checks are performed at three, six, and twelve months for youth found in need of services at the time of the original assessment. These services provide early screening and immediate intervention services to a population who may have gone undetected, underserved, or not served at all.

For more information, contact Dianne.Harnad@po.state.ct.us or 860-418-6828.

WORKING TOGETHER TO REDUCE GRIDLOCK AND FACILIATE TRANSITION OF INDIVIDUALS

DMHAS' Southwest CT Mental Health System (SWCMHS) has initiated several important initiatives to work more closely with other DMHAS agencies and community providers to reduce gridlock and facilitate the transition of individuals from CT Valley Hospital (CVH), other DMHAS inpatient facilities and community housing providers.

Over the past six months the Director of Community Services for SWCMHS has conducted an assessment of the relationship between the inpatient units at CVH and the state and community providers in the greater Bridgeport area. Identified areas for improvement include: a) accessing transitional housing; b) obtaining supervised housing and group home beds; c) timely application for entitlements; and d) communication during the discharge process.

Attention has been paid to improving the management of beds on the Transitional Residential Program (TRP) in Bridgeport, reducing gridlock so that these beds are more accessible to clients who are ready to be discharged from CVH. Bi-weekly Recovery meetings composed of clinical staff and experts in housing and entitlements has increased emphasis on effective dispositions for TRP clients. As a result there has been a reduction of length of stay at TRP and improved responsiveness to CVH clients.

In addition, work has been in process assessing the make up of waiting lists and reviewing the criteria for admission to residential programs in Region 1. It is recognized that the management of a responsive and organized system of housing services is essential to insure that clients have places to live and optimal supports available to insure quality of life. However, it can be a challenge to create a system that supports the large network of private providers, and coordinates movement of consumers throughout various levels of support, and across agency boundaries. SWCMHS has maintained ongoing coordination and referral meetings in the region. These meetings provide a forum for DMHAS and PNP agencies to discuss common needs, address problems and make decisions regarding effective utilization of the housing system. The Care Coordination Committee is the central clearinghouse for all referrals into the system as well as functioning as a utilization management committee to insure that individuals are given the change to progress in recovery by making use of various housing resources with a variety of supports.

In January 2009, a new CVH Liaison from SWCMHS was hired. She will be assessing all Region 1 individuals who are hospitalized at CVH and developing community plans for all appropriate individuals. She will assure that there is a single point of accountability for transition coordination and also improve follow through when individuals are released to the community. She will focus on improving the coordination of entitlement applications and assure that effective communication is occurring between CVH and community providers.

For more information, contact George.Hagman@po.state.ct.us or 203-579-7406. For more information on SWCMHS, contact James.Pisciotta@po.state.ct.us or 203-579-7368.