CODAC CONNECTS

January /February 2021

I am happy to introduce you to the secretary of our Board of Directors.

Noah Benedict brings a deep, insightful and comprehensive understanding of the health field to me, to our board and to our future. Thank you, Noah, for all you give us, all you do and all you are. Linda

Noah Benedict is the Chief Executive Officer of Rhode Island Primary Care Physicians Corporation (RIPCPC), the largest multi-specialty Independent Practice Association (IPA) in Rhode Island. RIPCPC represents 150 primary care physicians and over 300 specialty providers.

Noah is responsible for establishing the organizational vision and strategy, lead payer contracting, and directing clinical care model development.

He has over 20 years' experience in healthcare, and his efforts primarily focus on developing systems that support a value-based care delivery model.

Noah was also one of the chief architects of the state's largest Accountable Care Organization (ACO) named Integra. Through organizing a virtually integrated healthcare system, Integra aims to improve the patient experience by effectively managing its patient members across the entire care continuum. The ACO cares for over 150,000 patient lives, manages over a billion dollars in premium, and boasts some of the region's highest quality scores.

He currently resides as the Integra board chair. He is also a board member of the Care Transformation Collaborative of Rhode Island, CODAC Behavioral Healthcare, and an adjunct professor at the Brown School for Professional Studies.

Noah holds a Bachelor’s from the University of Rhode Island and a Master's from Brown University. He lives in North Kingstown with his wife and three wildly active daughters.

codac
Behavioral Healthcare

RECOVERY FRIENDLY WORKPLACE INITIATIVE

January 28, 2021
From: CODAC Leadership
To all CODAC employees:

CODAC leadership is pleased to announce that we are participating in the Governor's Recovery Friendly Workplace Initiative, a program that offers state certification to agencies committed to supporting and serving the principles of Recovery in Rhode Island.

As stated in our Personnel Handbook, CODAC has always been committed to providing a safe, healthy and supportive environment for our staff and our patients, and to maintaining a recovery friendly workplace. Over the years, we have also strived to manifest this commitment outside of the walls of our facilities by supporting the work of the Recovery community.

As an organization that serves individuals with substance use disorders, we have a keen awareness of the challenges of recovering from addiction. Our work is based on the principle that people in recovery—and their families—are worthy of respect and support, not judgement and stigma. This applies to our staff, as well as to our patients.

We encourage anyone working for CODAC who is struggling with an SUD to seek help safely and confidentially by talking with their supervisor. For those who feel more comfortable with anonymity, CODAC has contracted with Coastline Employee Assistance Programs (EAP) to provide services for both staff and their family members. Coastline EAP provides confidential support 24/7 and does not track individual user information. You can access Coastline resources at https://www.coastlineeap.com or call them directly at: 1-800-445-1195/401-732-9444.

CODAC's participation in this statewide effort demonstrates our ongoing commitment to working with our employees and clients, their families, and the larger community to create positive change, eliminate barriers, and reduce stigma for those impacted by substance use disorder

You can log onto www.RecoveryFriendlyRI.com to learn more about the Recovery Friendly Workplace initiative.

Sincerely,

Rebecca Boss
Chief Operating Officer

carf

1052 Park Avenue, Cranston, RI 02910 401-275-5037

Career advancement opportunity!!

SPACE IS LIMITED –

LET YOUR DIRECTOR KNOW IF YOU ARE INTERESTED BY

February 5th , 2021

In an effort to keep up with the ever changing telehealth and technology world - we have partnered with MIRAH, an online platform that is specifically geared toward supporting measurement-based care (MBC).

This exciting opportunity is a chance for you to grow in your career and to lead your peers in supporting our patients in their recovery.

What is measurement-based care (MBC) you ask?

Formally, it is an evidence-based practice that consists of the routine administration of client-reported outcome measures and the clinician's review of resulting data to inform ongoing treatment.

In layman's terms – our patients will take short self-assessments, like the PHQ-9 or Brief Assessment of Recovery Capital, before each treatment session. You, their counselor, will be able to view the assessment results prior to or during your scheduled session. Those results can be used to help guide the conversation and make it more meaningful for both you and your patient.

Some benefits of utilizing this platform include: alignment with patient-centered care – an initiative that CODAC feels strongly about and is already working towards for 2021, improved use of session time, faster patient goal achievement, and overall improved outcomes at both the clinic and leadership level.

This all sounds great but what about the "career advancement opportunity"?

The implementation of MIRAH includes the chance for you to become a part of the *MIRAH training team* for CODAC.

Some goals of this training opportunity include, but are not limited to:

- Getting a more in depth look at the MIRAH platform
- Learning how to support your fellow colleagues with making MIRAH a part of our everyday work flow
- Developing and strengthening your leadership skills
- Continued emphasis on the important person-centered work we do!

Interested in knowing more?

Click the link below to meet Susan Casey, MIRAH Trainer. She provides a great overview of the MIRAH platform.

https://www.youtube.com/watch?v=0RV-7jo2yis&feature=youtu.be

MIRAH

What you bring

- Excitement to bring MBC into your organization to improve patient care
- Enthusiasm to engage and inspire others within your organization
- Effective communication skills and a willingness to reflect and accept feedback
- Commitment to your organization's mission and vision

What you get

- Earlier, deeper look at MBC and how your organization will be leveraging it
- Access to MBC experts to answer questions or discuss new developments
- Enhanced communication skills
- Opportunity to lead your organization forward
- Connection to your coworkers and broader organization community

The commitment we need from you

~12 hours over 4-8 weeks, when you attend your 8-session Train-the-Trainer course

- ~8 hours of class time
- ~4 hours of homework and practice

\+

~14 hours over 8 weeks, when you lead your 8-session MBC Clinical Practice course

- ~8 hours of class time
- ~6 hours of preparation and trainee support

Please talk to your organization's leadership about how they plan to ensure your success as an MBC Trainers with additional support, reduced workload, or other changes.

Interested in becoming a trainer?

Please reach out to Aldrine (Al) Ashong-Katai (aashongkatai@codacinc.org), Director of Project Management, to reserve your spot!

Monthly Security Corner

Submitted by Jason Alexandre,
Director of Quality Improvement

A significant part of the work we do involves the creation and use of confidential and sensitive information. In recognition of this fact, CODAC has decided to create a forum for sharing best practices and notable news relating to information security. Each month, we will use this venue to highlight information security tips, upcoming changes in regulatory practices, enhancements within CODAC (e.g. technology, policy, etc.), as well as newsworthy issues (think Hall of Shame) related to the field we work in.

January Security Tip: Change Your Router Password

It is widely reported that using default passwords on routers while working from home is a security risk. This, coupled with the increase in COVID-related telecommuting, necessitates taking action sooner than later to ensure the security of data on your home network. Wireless routers are an easy gateway for hackers to get into our systems, and manufacturer's default passwords on routers are freely accessible on the Internet. Therefore, it is important to change your router's password to a unique security password from the default password when you set up your router. To assist, Lifewire has a tutorial that is easy to follow and can be accessed at: https://www.lifewire.com/how-to-change-your-wireless-routers-admin-password-2487652

Health Insurer Pays $5.1 Million to Settle Data Breach Affecting Over 9.3 Million People

Excerpted from: https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/excellus/index.html

Excellus Health Plan has agreed to pay $5.1 million to the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) and to implement a corrective action plan to settle potential violations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules related to a breach affecting over 9.3 million people.

Excellus Health Plan reported that the breach began on or before December 23, 2013, and ended on May 11, 2015. The hackers installed malware and conducted reconnaissance activities that ultimately resulted in the impermissible disclosure of the protected health information, including names, addresses, dates of birth, email addresses, Social Security numbers, bank account information, health plan claims, and clinical treatment information.

A copy of the resolution agreement and corrective action plan can be found at https://www.hhs.gov/sites/default/files/excellus-ra-cap.pdf

CODAC Monthly Policy Round-Up

Submitted by Jason Alexandre, Director of Quality Improvement

Due to the dynamic nature of the work that CODAC does as an organization, changes to how we do business often necessitates the creation of new, and or changes to existing, policies and procedures. In an effort to better communicate these changes we've created this venue for sharing information as a supplement to our current channels (e.g. all-staff emails, team meetings, etc.).

In preparation for our CARF accreditation visits that occurred in November, a number of new and revised policies were implemented, all of which can be found on the CODAC Shared Drive at: Y:\Policies Procedures and Regs\NEW POLICIES. Some recent changes that have occurred during the past month include revisions to the following three (3) policies:

1.2 – Subpoenas, Court Orders and Actions of Law Enforcement (rev. 1/12/2021)
2.2 – Incident Reporting (rev. 1/20/2021)
5.1 – Client Concern and Complaint Resolution Process (rev. 1/11/2021)

Please take the time to review these documents as they contain important information that may directly impact CODAC operations and patient care.

For questions, comments or suggestions related to these items, please contact:

Jason Alexandre – Director of Quality Improvement by email at jalexandre@codacinc.org

A PIECE OF MY MIND

Shared Grief

Karen Alexander, PhD, RN
Jefferson College of Nursing, Thomas Jefferson University, Philadelphia, Pennsylvania.

In the neonatal intensive care unit, acuity is high. As nurses, our shifts are typically 12 hours during which we generally care for only 2 or 3 patients. Nurses are the constants and stay at the bedside with those few infants the entire 12 hours, only leaving to take a quick lunch break or to use the bathroom. A shift can be a chaotic flurry of activities, sounds, and lights. Or it can be somber and quiet, dark, with just the glow of the digital monitors showing each child's heartbeat and breathing, like a silent news feed passing the time.

Ten years ago, I gave birth to my oldest child, a daughter named Molly. She had a genetic condition that resulted in her death shortly after she was born. I knew the nurses in the delivery room, and they cried with me after the resuscitation. I'll never forget the nurse who said, "I'm so sorry, my dear, we lost her." I see her above my head, covered in a gown, mask, and cap, still able to communicate love and sympathy. My obstetrician choked back tears as she stitched me up, taking her time to stitch me twice instead of using staples.

My grief was deeply physical. Each time I got out of bed, or even stretched in bed, I would remember the pain of losing Molly. I would look in the mirror, and there she was. I felt as if I had died. In fact, I wished many times that I had been the one to die. I was sliced open in an effort to give her life. Instead, I was left empty. My arms were empty, my belly was empty.

> What happens when we forget that we all experience loss, that we all long to be loved, and that we all need each other?

I wanted to run away from my body, which I felt bore death, reminded me of death, and reminded everyone else of death. I guess it could remind people of her life, brief as it was. But, to me, my body symbolized a shell that Molly left behind.

I was in the room but was not able to hold Molly before she died. There had been a hurry of activity, efforts to save her, but then she was gone. It was then that the nurse asked, "Do you want to hold Molly?"

The answer seemed obvious to my husband, but out of my mouth I heard the words, "No, I can't."

The nurse didn't push it, and she said, "Well, only if you are ready, it can really help for you to see her." My body and mind felt as if they would explode. I thought, *I cannot hold her*. But in that very moment, the death of a prior patient came to my mind so clearly, even though I had not consciously thought it remarkable at the time. In fact, I am ashamed to admit, I had remembered that death with disgust.

She had black streaks of mascara trickling slowly down her face, meeting somewhere near her chin. She was weeping, heaving her whole body with each cry. She was alone in her grief at the bedside of her premature son, cradling his thin, mottled body against hers. We had worked all night to try to save him, but his tiny body could not tolerate intervention any longer. At delivery, the mother's medical history included testing positive for opioids and several sexually transmitted infections, in addition to preeclampsia. The medical chart said she was a sex worker.

Her line of work and her drug use complicated things. Even though we often ask about drugs and sexual practices as health care professionals, when such behaviors present themselves, we tend to have a conscious or unconscious reaction. We may become noticeably tense, or distant, or lose a bit of friendliness. A darker shadow comes upon an already stressful event. For the mother, it made the tears that flooded her face, and her cries which pierced the room's silence, different.

We would never say we don't have empathy for the mother as a result of her past. Yet we don't do some things because of it. We don't stand as close, we don't make as much eye contact, and we don't identify or draw close.

I should say, I don't or I didn't, at least that night. I was the infant's nurse the night he died. I didn't draw near to his mother. In the recovery room after Molly's death, I remembered all these things about the mother and her experience at her son's bedside. And then I thought, "She had done this."

She who looked discarded, weak, and almost silly in her grief. She who was all alone, without a partner, without a stable job, and without sympathy. She had done the incredibly heroic thing of loving a baby who was about to die and held him close. What a strong woman, what a woman to admire, and what a woman to be like.

A little girl in my son's second grade class approached me recently at a birthday party and asked if I had a baby who died. My oldest daughter's existence had apparently gone around the schoolyard as a whispered rumor. She asked where I had put her, if she was really buried in the cemetery next to the school (she is), and if I was sad. She was sincerely curious, and I thought very brave indeed.

I finally felt brave standing there, trembling, but able to tell her, "Yes, Molly did exist." And "Yes, I was sad." But also, I had been surprised by the incredible joy it was to meet my beautiful daughter, that I felt loved by so many people during that time, and that I am grateful to have gone through such a difficult, sad experience because I came out of it with a stronger network of support.

Corresponding Author: Karen Alexander, PhD, RN, Jefferson College of Nursing, Thomas Jefferson University, 130 S Ninth St, Ste 844, Philadelphia, PA 19107 (karen.alexander@jefferson.edu).

Section Editor: Preeti Malani, MD, MSJ, Associate Editor.

When I remembered Molly this year, in a year when we are distanced by a public health crisis, I couldn't go to the cemetery where she is buried because it is closed to visitors. Flowers showed up at my door. Texts and video chat messages dinged on my phone all day. As I went through her memory box that the nurses had put together for me, I touched the lock of her hair they kept for me. I looked through the cards the health care team signed, the books dedicated to her memory that my children now read, listened to the music a friend wrote for her, and I grieved supported by love.

I think of the mother at the bedside of her son often. I wonder if she is still living. I wonder if she had anyone to cry with later that week, or month, or year. I wonder if her year in a pandemic had any moments of rest. I wonder if she is in prison, if she is in recovery, and if she has other children. I look for her on the subway and on my walk home from work.

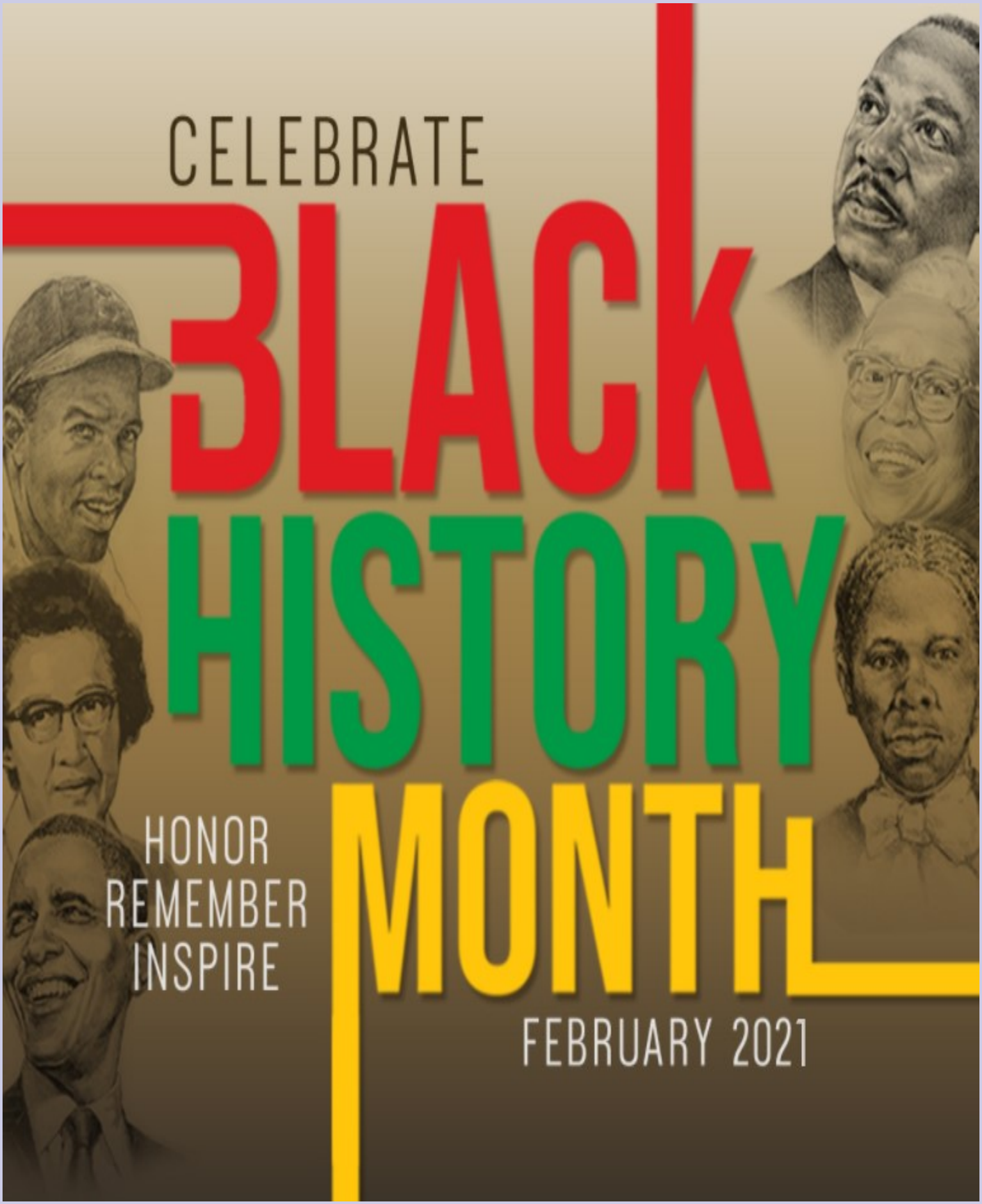
It has been argued that stigma in health care is a critical factor in population-level health disparities for marginalized populations. Our assumptions about a patient and the relational distance that we create between ourselves and a patient substantially affect the patient's well-being. Once experienced, stigma may also keep someone from seeking or maintaining health care in the future.

In addition to the global pandemic this year, we have developed into a more deeply divided population at large. Most of us do not identify with the "other side," in any way whatsoever. We are sticking with those who are like us, and that is the end of the story.

In the city where I live and work, people have access to several nationally ranked, academic medical centers. No one turns you away if you show up in the emergency department or in labor without insurance. You will have a hefty bill, but you will get health care. Quality health care. But what we don't do matters.

What happens when health care and society more broadly keep you at a distance? What happens when we all keep each other at a distance? What happens when we forget that we all experience loss, that we all long to be loved, and that we all need each other? The weeping woman was always much more than someone who was grieving, but I never really knew her as a person until I mourned the loss of my own child. She is my sister. Of course she is. Who is yours?

Conflict of Interest Disclosures: None reported.


CELEBRATE
BLACK
HISTORY
MONTH
HONOR
REMEMBER
INSPIRE
FEBRUARY 2021

Congratulations to Nicole Hutto and her husband Michael on the birth of their son Salvatore , who arrived on December 26, 2020

Congratulations to Darryl Walker Jr and his wife Elizabeth on the birth of their son Darryl Walker III , who arrived on January 14, 2021

Congratulations to Mary Musical and her husband Christopher on the birth of their son Lucas , who arrived on January 18, 2021

Human Resources

Open Positions

- OTP Counselors in East Bay, Pawtucket, and Newport
- Medication Nurses in Providence, Wakefield, Hampden County and East Providence
- Clinical Supervisor at the ACI
- Assessment Clinicians at the ACI and Hampden County
- Medical Assistant split between Thrive and Cranston
- Health home Nurse split between East Providence and ACI
- GOP Counselor Newport
- Part time Peer Specialist at ACI
- Part time Office Assistant at Pawtucket Ave

Quote

I never learned anything from talking….Larry King

Kelsey Buchanan, Clinical Supervisor—Hampden County

Valentina Castrillion, Intern—Pawtucket

Melissa Mejia, Intern—Pawtucket

Katie Roy, Intern—Wakefield/Newport

Deborah Young, OTP Counselor—Newport

All extra bonus days MUST be used by April 1, 2021

CARF DAY (RI) - Personal Day

NCCHC DAY (MA) - Personal Day

When entering these days in your timecard, please choose the appropriate dropdown code and add a note indicating whether it is a CARF or NCCHC day

If you have any questions, please reach out to Lisa Nichols