



## Integrated Behavioral Health Strategies Report

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Neighborhood Health Plan of Rhode Island  
Affordability Standards  
230-RICR-20-30-4.10  
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## Integrated Behavioral Health Requirements Report

Please find included in the following documents, Neighborhood Health Plan of Rhode Island’s (Neighborhood) response to the Officer of the Health Insurance Commissioner’s (OHIC) inquiry of Neighborhood’s compliance with OHIC’s Affordability Standards Integrated Behavioral Health and Primary Care Alternative Payment Model- Qualifying Integrated Behavioral Health Primary Care Practice (QIBHPCP) requirements.

**a. Financial barriers [§ 4.10(C)(2)(a)(1)]:**

*By January 1, 2021 health insurers shall eliminate copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a Qualifying Integrated Behavioral Health Primary Care Practice as defined in § 4.3(A)(19). **Note:** For the duration of the COVID-19 public health emergency, telemedicine visits are to be considered office-based visits for fulfilling the “same location” requirement in the regulations.*

- Please describe or attach your behavioral health co-pay waiver policy.

**Neighborhood Response:**

See Appendix A- Optum’s QIBHPCP Billing Guidance.

**b. Billing and Coding Policies [§ 4.10(C)(2)(a)(2)]:**

*Health insurers shall adopt policies for Health and Behavior Assessment/Intervention (HABI) codes that are no more restrictive than Current Procedural Terminology (CPT) Coding.*

- Please describe or attach your HABI code policy.

**Neighborhood Response:**

Neighborhood includes all Health and Behavioral Assessment Intervention (HABI) codes per current guidance from the Center for Medicare and Medicaid Services.

**c. Out-of-pocket costs for Behavioral Health Screening [§ 4.10(C)(2)(a)(3)]:**

*Health insurers shall adopt policies for the most common preventive behavioral health screenings in primary care that are no more restrictive than current applicable federal law and regulations for preventive services.*

- Please list or attach the codes that your plans cover, including the details on any frequency limitations.

**Neighborhood Response:**

Neighborhood includes the below behavioral health screenings at no member cost share:

Code	Description	Age Restriction	Frequency Limitation
96161	Edinburg (Post Partum) Depression Screening	Age up to 2 years of age (This screening is performed on the mom by the pediatrician and billed on the baby’s claim)	4 per year
96127	PHQ9-mod adolescents	12-17 years of age	1 per year
96160	CRAFFT	11-21 years of age	1 per year
99408, 99409	Alcohol Misuse Screening	18+	No Limit

**d. IBH Strategies Reporting Requirement [§ 4.10(C)(2)(c)]:**

*Health insurers shall submit a report to the Commissioner...that delineates strategies, in addition to the requirements in § 4.10(D)(3)(c) of this Part, to facilitate and support the integration of behavioral health care into the primary care setting.*

- Beyond what is required in OHIC’s Affordability Standards, what strategies are your organization using to expand the integration of behavioral health (IBH) into the primary care setting?
  - Please describe any current or past pilots to facilitate IBH.
  - How does your organization support delivery of evidence-based practices for behavioral health conditions in primary care?
  - How does your organization support the coordination of behavioral health and general medical care?
- Is your organization using any quality metrics specific to IBH? If so, please provide information on the specific measures.
- Does your organization have any planned, current, or past pilots to support integrating primary care into behavioral health settings?
- Does your organization have payment policies supportive of integration beyond what is required in OHIC’s Affordability Standards?

**Neighborhood Response:**

Please find included Neighborhood’s, *Integrated Behavioral Health Strategies Report*.

**e. Primary care alternative payment models (APM) [§ 4.10(D)(3)(c)]:**

*For primary care practices recognized as a Qualifying Integrated Behavioral Health Primary Care Practice under § 4.3(A)(18)...health insurers shall develop and implement a prospectively paid alternative payment model for primary care that compensates practices for the primary care and behavioral health services delivered by the site.*

- Please detail your progress on the APM requirement, including: the number of provider groups under contract; patients attributed to the model; and a description of how the payment model satisfies the requirement that the payment compensate practices for the behavioral health services delivered by the site.

**Neighborhood Response:**

Per OHIC’s approval of Neighborhood’s waiver request for 230-RICR-20-30-4.10(D)(3), Neighborhood will provide a plan to OHIC on the Neighborhood’s Alternative Payment Model strategy and pathways due to OHIC on 7/1/2021.

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## **Integrated Behavioral Health Strategies Report**

Neighborhood Health Plan of Rhode Island (Neighborhood) has been a proponent of ensuring Rhode Island's at-risk populations have access to high-quality healthcare for the last 27 years. Neighborhood's partnership with the Community Health Centers and provider network is an essential component in supporting our members. Neighborhood understands that for us to expect our provider community to integrate behavioral health into their care settings, we Neighborhood, need to work in partnership to support their integration. Neighborhood's exceptional team of innovative leaders continues to think "outside the box" to develop programs and initiatives to support members in their overall health and well-being. Neighborhood understands the stigma around behavioral health conditions and works at removing barriers for members through education, collaboration and outreach.

Neighborhood supports the delivery of evidence-based practices for behavioral health conditions in primary care settings by providing educational material and annual trainings to primary care practitioners. Neighborhood provides educational information on the Healthcare Effectiveness Data and Information Set behavioral health measures to the primary care practitioners through several avenues including but not limited to the organization's website, email blasts as well as via quality improvement committees. Examples of such material is included as Appendices B-D.

Annually, Neighborhood hosts educational trainings for the provider community on hot button behavioral health topics. The trainings offer continuing education credits (CEUs) and focus on topics that providers may not have access to within their own practices.

In 2019, Neighborhood partnered with the Rhode Island Health Center Association (RIHCA) to host the Caring for Families Coping with Neonatal Abstinence Syndrome (NAS) program. This program provided an overview of NAS and discussed the challenges and strategies provider, health care systems, community service providers and policy makers can take to improve the continuum of care for mothers and NAS infants.

In 2020, Neighborhood partnered with The National Council for Behavioral Health to deliver a 3-day training on Trauma-Informed Care. Seventy-five primary care medical staff attended the training that included topics such as the impacts and effects of trauma, trauma and addictions and infusing trauma-informed concepts into daily work.

Neighborhood recognizes that investing in the wellness of our provider community directly affects the quality of care our member's receive from their providers. For the 2021 annual training, Neighborhood's behavioral health department has collaborated with the Massachusetts and Rhode Island Medical Societies and Providence Business News to create a two (2) part wellness series for healthcare professionals focused on addressing burn out and promoting self-care strategies during and after the COVID-19 pandemic. The first of this complimentary series will be on June 15, 2021.

In conjunction with the training and in collaboration with RIHCA, Neighborhood publishes an annual paper with policy recommendations to support a behavioral health topic. Please find included as Appendices E-F, the Issue Briefs from 2019 and 2020. Neighborhood will be producing a policy paper on health equity recommendations for 2021 that is due to be released in Q3.

In partnership with our behavioral health (BH) delegate, Neighborhood launched two programs in 2020 and 2021 with the goal to support members with co-occurring disorders in accessing and engaging in meaningful behavioral health treatment. As these programs are new, Neighborhood continues to evaluate their impact through monitoring member engagement, utilization and cost-trends. Due to the Public Health Emergency (PHE), implementation of some components of the programs have been delayed.

The first program, Behavioral Health Emergency Room Pilot (BH ER), launched in July 2020. This program identifies members that have high emergency room utilization and a mental health disorder, alcohol use disorder or chronic pain diagnosis. The overall goal of the program is to reduce non-medically necessary emergency room visits, increase outpatient treatment and improve member access and engagement in treatment. A member identified as a high BH ER utilizer is assigned to a Neighborhood Community Behavioral Health Coordinator (CBHC) for outreach and engagement in the program. The CBHC implements targeted interventions via telephonic or in-person visits based on the member's goals identified through the development of an individualized plan of care (POC). The CBHC utilizes motivational interviewing techniques to establish a positive relationship and works with the member to assess readiness to change, barriers to accessing treatment, identify gaps in Social Determinants of Health (SDoH), and educates the member on medication assisted treatment (MAT). The CBHC coordinates and collaborates with the member's care team, which can include a primary care provider, behavioral health providers, and community care management programs to discuss the POC and collaborate on supporting the member's goals. Due to the impact of the PHE, Neighborhood has been unable to implement a key component of this program, the deployment of CBHC's to Rhode Island Hospital's emergency room to identify and engage members prior to discharge. Neighborhood looks forward to beginning this work in the near future as Neighborhood moves through the "Return to Work" plan.

In January 2021, in collaboration with Neighborhood's BH delegate, Neighborhood launched the second program, Medical Detoxification Transition Initiative (MDTI). Neighborhood recognized that members who are admitted for medical detoxification do not routinely follow up with appropriate behavioral health aftercare, placing them at higher risk for relapse and readmission. This initiative establishes three (3) pathways to engage the member in accessing behavioral health follow up care prior to a hospital discharge. One (1) of the three (3) pathways has been initiated at this time. Neighborhood's utilization management team and the BH delegate established a referral process for members identified as having a substance use detoxification (SUD) admission to a medical facility. The BH delegate then outreaches to the discharge planner at the facility to provide and coordinate on a behavioral health aftercare plan for the member. Due to the impact of the PHE, implementation of the two (2) additional pathways has been delayed: 1. Coordination with medical providers on contacting the SUD Helpline and 2. Education to medical providers on creating a prior authorization for services such as MAT. The BH delegate is planning to implement these pathways in Q2 2021.

Neighborhood recognized an opportunity to improve members' access to MAT within the medical provider network. In 2020, Neighborhood established a vetting process to allow substance use disorder providers to join Neighborhood's network. As of today, Neighborhood has five (5) contracted substance use disorder providers in-network.

Neighborhood continues to explore opportunities to enhance behavioral services and supports to our members. In Q3 2021, Neighborhood will launch a mobile application and compassionate support center program targeting members that have an increased prevalence for loneliness, anxiety and depression. Neighborhood will be targeting members that have had a significant event such as an inpatient admission or discharge (medical or behavioral health), a new member to the plan, care management identifications such as job loss, loss of loved one, as well as high-risk members such as those with comorbidities of medical and behavioral health. Neighborhood will also be mining SDoH data to identify potential high-risk geographic areas. The program features in-application screenings including but not limited to loneliness, depression, anxiety and SDoH. Members that trigger a high screening score receive telephonic outreach from the compassionate support center to follow up on their concerns and to refer to Neighborhood for further assistance as appropriate. The program also includes unlimited telephonic companionship support for enrolled members. Neighborhood's Medical Management Team will work in collaboration with the support center to follow up with members identified as having urgent SDoH or behavioral needs to mitigate gaps in the members care.

In 2021, Neighborhood is collaborating with a local hospital and primary care network to facilitate more immediate access to substance use treatment for members presenting at one of the hospital networks emergency departments with a substance use disorder diagnosis. These two (2) projects are under development and currently coined the Emergency Department (ED) project and Fast Track MAT access. Neighborhood's behavioral health team is supporting the ED project in identifying members that are most in need while they are in the ED and collaborating with the hospital to create an aftercare

treatment plan. The plan is to include interventions such as starting the member on MAT treatment for ethanol alcohol (ETOH) while in the ED, creating a warm handoff of the member to a community mental health center Peer Specialist and ensuring the member has an appointment for aftercare prior to discharge. Neighborhood is supporting the Fast Track MAT project by providing financial funding to the hospital network primary care practice (PCP). PCP patients that have an ED visit with a diagnosis of ETOH use are provided immediate same day access to the PCP for follow up care and to start MAT upon ED discharge. The program provides case management level support and includes community follow up to provide MAT in the community for patients that no show for appointments. These projects are early in their inception and will continue to develop throughout 2021.

Neighborhood continues to serve as a strong community partner with the hospital and provider networks. Neighborhood is currently serving as a member of an interdisciplinary workgroup through a major hospital network to address access to care issues for children within the foster care system. Neighborhood also continues to strengthen the partnerships and build programs with the Accountable Entities in service of ensuring Rhode Islanders have access to holistic care. Neighborhood will continue to leverage these relationships and explore opportunities to expand these programs and services to our Commercial membership.

As demonstrated through Neighborhood's collaboration and contribution to innovative, targeted programs with providers, hospital networks and our BH delegate, Neighborhood prioritizes improving member access to the continuum of services to benefit their health and well-being by meeting the member where they are. Neighborhood is dedicated to supporting providers in broadening their knowledge on behavioral health issues, best practices and expanding behavioral access to within their practice. Neighborhood is committed to working with OHIC to develop solutions to remove barriers in support of improving access to appropriate and timely behavioral health services for Rhode Islanders.





## Provider Alert

### Qualifying Integrated Behavioral Health Primary Care Practice (QIBHPCP)

#### Billing Guidance for Single Member Copay

Effective 01/01/21

In accordance with Rhode Island OHIC Regulation effective 01/01/21 we eliminated the behavioral health (BH) copay when a fully insured commercial plan member sees a behavioral health specialist and a primary care physician (PCP):

On the same day (even if one of the visits is a telehealth visit)

- At the same Rhode Island location that is a Qualifying Integrated Behavioral Health Primary Care Practice (QIBHPCP)
  - To confirm if your practice is a certified QIBHPCP, go to [ohic.ri.gov](http://ohic.ri.gov).

#### Billing Guidance effective 05/31/21:

- The billing BH Provider must be a participating provider in the Optum Behavioral Health Commercial network and linked to the QIBHPCP practice in the Optum system. If you have an eligible licensed provider who meets criteria, please utilize provider express to complete the New Provider Registration Form (NPRF) or provider add/change as appropriate.
- The following CPT and modifier combinations must only be billed for the BH component of the claim that corresponds to the medical PCP visit portion performed on the same day.

QIBHPCP Eligible Billing Code and Modifier Combinations					
90791 HK	90837 HK	90847 HK	96158 HK	96167 HK	99408 HK
90792 HK	90839 HK	90849 HK	96159 HK	96168 HK	99409 HK
90832 HK	90840 HK	90853 HK	96164 HK	96170 HK	
90834 HK	90846 HK	96156 HK	96165 HK	96171 HK	

- Behavioral health NPI/Taxonomy billing rules apply.
- All other Practice Management System Protocols will remain in force.
- Qualifying claims processed 01/01/21 through 05/30/21 will be reprocessed according to the single copay guidance without additional provider action.

If you have any questions, please contact our Provider Services line at **1-877-614-0484**.

Sincerely,  
Cristina Almeida  
Optum, Director of Provider Services RI





[Date]

[Provider First Name] [Provider Last Name] [Credential]

[Provider Agency]

[Address 1]

Address 2]

[City], [State] [ZIP Code]

Dear [clinician name],

As you may know, there has been concern about the rising prevalence of young children taking psychotropic medications, particularly antipsychotic medications. The American Academy for Child and Adolescent Psychiatry, the American Psychiatric Association and the National Committee for Quality Assurance; HEDIS® specification recommends psychosocial care as a first line of treatment.

The HEDIS® specification specifically targets children who are prescribed antipsychotic medications but do not have a diagnosis of schizophrenia, bipolar disorder or other psychotic and developmental disorders. The HEDIS® specification measures if those children received psychosocial care at least 90 days prior to prescribing antipsychotic medication or within 30 days of starting an initial prescription.

Examples of psychosocial care include:

- Behavioral Health Services - individual and group psychotherapy
- Crisis intervention services
- Peer services
- Activity Therapy - music, art or play therapy not for recreation

You can request help with referrals by calling the number on the back of the member's insurance card.

**Helpful patient and provider resources:**

- [providerexpress.com](http://providerexpress.com)
- [liveandworkwell.com](http://liveandworkwell.com) (Access code "clinician")
  - See *Mind and Body*
- [aacap.org](http://aacap.org) (*American Academy for Child and Adolescent Psychiatry*)
  - See *Recommendations for Medications*
- Center for Medicare and Medicaid Service
  - See *Antipsychotic medication in pediatrics*
- National Committee for Quality Assurance 2020 HEDIS® Specifications, see HEDIS® and Quality Measures at [NCQA.org](http://NCQA.org)

If you would like an informal consultation about your patient you may contact me at (630) 324-9740. Thank you for taking the time to review this letter,

Sincerely,

Theodore Allchin, MD  
Medical Director  
Board Certified Child and Adolescent Psychiatrist  
Optum

[Date]

[Provider First Name] [Provider Last Name] [Credential]  
[Provider Agency]  
[Address 1]  
Address 2]  
[City], [State] [ZIP Code]

**Re: Your Recent Claims for Clients with a Substance Use Disorder**

Dear [Provider Name]:

We've noticed you often treat Neighborhood Health Plan of Rhode Island patients who are diagnosed with substance use disorders (SUD). It is important that you have a conversation with your patients about substance use.

There are tools available to help providers screen, provide brief interventions and referrals for substance use treatment. The National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration recommend following the Screening, Brief Intervention and Referral to Treatment (SBIRT) guideline at [samhsa.gov/sbirt](http://samhsa.gov/sbirt).

**When newly diagnosing individuals with a SUD:**

- Please schedule follow up treatment within 14 days of the diagnosis and two or more additional services within thirty-four (34) days of the initial visit. \*
- Follow-up appointments can be with any provider as long they include a SUD diagnosis on each claim.

\*Per Healthcare Effectiveness Data and Information Set (HEDIS®)

You also can provide support by:

- Encourage your patient to schedule routine follow-up visits
- Reach out to patients if they do not attend their appointment
- Obtain release of information (ROI) to involve the patient's family and support system as well as other providers
- Listen and work with the patient's existing motivation to change
- Help patients identify challenges to receiving care and have ideas for how to overcome them

There is a **SUD Helpline: 1-855-780-5955** available for patients and providers who need additional information. For general questions about this letter please contact Jennifer Rootberg, Optum Behavioral Health, QI Specialist at 1-763-732-8863. We appreciate the care you provide and hope this information is helpful.

Sincerely,



Andrew Martorana, MD  
Senior Behavioral Medical Director  
Optum Behavioral Health

## Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

### Provider Newsletter - March 2020

<https://www.nhpri.org/providers/communication/provider-newsletter/neighborhood-news-2020/spring-2020/claims-corner/initiation-and-engagement-of-alcohol-and-other-drug-dependence-treatment/>

Neighborhood Health Plan of Rhode Island (Neighborhood) requests your help in improving access to substance use treatment as measured by the HEDIS measure: *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)*.

#### How IET is Measured

The IET measure has two separate components. It is based on all members 13 years of age and older with a new episode of alcohol or other drug use or dependence.

*Initiation of Treatment:* The percentage of members 13 years of age and older with a diagnosis of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis.

*Engagement in Treatment:* The percentage of members 13 years of age and older with a diagnosis of alcohol or other drug dependence who initiated treatment as described above and who had two or more additional AOD services or medication assisted treatments (MAT) within 34 days of the initiation visit.

#### What is Happening Around the Country

According to an article published by the Substance Abuse and Mental Health Services Administration (SAMSHA), “In 2016, 20.1 million Americans over 12 years of age (about 7.5% of the population) were classified as having a substance use disorder involving alcohol or other drugs (AOD).” The article also stated, “Despite strong evidence, less than 20% of individuals with substance use disorders receive treatment.” Neighborhood’s Behavioral Health partner, Optum, has specific resources available to all providers that will help you identify Substance Use Disorder treatment providers and schedule appointments for your patients.

#### What is Neighborhood’s Performance

Neighborhood’s Medicaid HEDIS Rate for 2019 is 40.48% for initiation and 17.21% for engagement. Both of these rates are well below the National Medicaid Quality Compass 90<sup>th</sup> percentiles. Neighborhood’s rate for the INTEGRITY-MMP population for initiation is 38.19% and 11.59% for engagement. These rates are below the performance incentive benchmarks for these measures established by CMS and the State for the Integrity program.

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## How You Can Help

For your patients newly diagnosed with Substance Use Disorder (SUD), it is important to begin treatment with a substance abuse provider within 14 days of diagnosis and have two additional visits within 34 days after their first visit.

## Resources That Can Help You

Neighborhood's Behavioral Health partner, Optum, has specific resources available to all physicians that will help you identify SUD treatment providers and schedule appointments for your patients.

- **Substance Use Disorder Helpline:** 1-855-780-5955 – Provides 24/7 support for providers and patients – Once a member calls the help line, the member then speaks directly with a licensed clinician who takes the time to understand the member's needs, educate the member on appropriate treatment options, and then arranges a face-to-face evaluation by a licensed substance use treatment provider.
- **Request coordination of care and referrals** for your patients by calling the number on the back of the member's health plan ID card to speak to a licensed clinician or by searching [liveandworkwell.com](http://liveandworkwell.com) using access code "clinician."
- **Screening tools** are available on [providerexpress.com](http://providerexpress.com) > Clinical Resources > Alcohol or Other Drug Disorders.
- **You can also find additional tools and information about behavioral health issues** on [providerexpress.com](http://providerexpress.com) > Clinical Resources > Behavioral Health Toolkit for Medical Providers.
- **Patient education information** is available on [liveandworkwell.com](http://liveandworkwell.com) using access code "clinician." See "Mind & Body" at the top, scroll down to find the links to specific topics.

## ISSUE BRIEF

# Neonatal Abstinence Syndrome: Considerations for Rhode Island

## Highlights

- › Neonatal Abstinence Syndrome (NAS) can occur in opioid exposed infants, even infants exposed to medication assisted treatment (MAT) in-utero.
- › Reducing stigma, improving coordination of care, and addressing the social determinants of health are crucial components to combating opioid addiction.
- › Rhode Island resources for mothers, caregivers and families should align to reduce burden and maximize effectiveness.
- › Opportunities exist to leverage federal resources and experiment with new models of care delivery.

## Introduction

In Rhode Island, chronic misuse, addiction and dependency on opioids, sometimes referred to as opioid use disorder (OUD), has created a public health crisis. OUD related overdose deaths in Rhode Island reached an all-time high at 336 in 2016, almost doubling from the 183 deaths in 2012.<sup>1</sup> OUD and related overdose deaths shatter individual lives and leave damaged families and communities in its wake.

Since the late 1990s, OUD has been on the rise in reproductive age and pregnant women.<sup>2</sup> For pregnant women, OUD can have serious consequences for herself and her infant including maternal death, preterm, stillbirth, and NAS and neonatal opioid withdrawal syndrome (NOWS). Nationally, the incidence rate of NAS has increased by 300 percent from 1999 to 2013.<sup>3</sup> Studies of NAS estimate that every 15 minutes a baby is born suffering from opioid withdrawal symptoms in the United States.<sup>4</sup> In Rhode Island, the incidence of babies born with NAS has doubled since 2005, increasing to a high of 106 per 10,000 in 2015.<sup>5</sup>

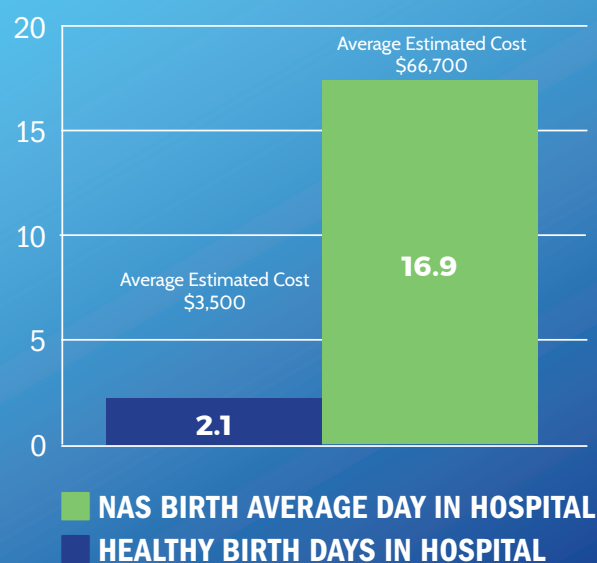
Health needs and associated medical care costs are greater for those infants with NAS. The average length of stay for a healthy birth is 2.1 days at a cost of \$3,500; an infant with NAS may spend up to 16 days at an estimated cost of \$66,700.<sup>6</sup> Nationally, 82 percent of the known NAS cases were covered under Medicaid, costing approximately \$462 million in 2014.<sup>3</sup> Beyond their hospital stay, NAS infants may also require early intervention, child welfare, and other supports. OUD is associated with an increase in children becoming involved with child welfare services

and other assistance, estimated to cost a \$6.1 million per year.<sup>7,8</sup> The total cost of NAS in Rhode Island is currently undetermined, but resources such as the state All Payer Claims Database (APCD) may provide some insight for policy makers.

This paper seeks to raise the profile of NAS in our state, provide an understanding of the impact of NAS on mothers and families, explore potential barriers to treatment for OUD mothers and families, share possible models for reducing NAS, and outline considerations for how Rhode Island can move forward to address the issue.

## National Average Duration of Stay and Cost:

### Healthy Compared to NAS Births



The Governor’s Overdose Prevention and Intervention Task Force has brought together elected officials, policy makers, community groups and medical professionals to address the rise in OUD and overdoses in Rhode Island. Improvements to accessing lifesaving medicines, reducing opioid prescriptions, and expanding treatment efforts have begun. Neighborhood Health Plan of Rhode Island (Neighborhood) and the Rhode Island Health Center Association (RIHCA) have a vested interest in reducing the number of individuals at risk and with OUD. We believe a critical next step is to improve support for families with opioid exposed newborns.

## Understanding Opioid Withdrawal In Newborns

NAS is a specific condition within the broader concern of substance exposure in newborns known as Substance Affected Newborns (SAN). A variety of substances taken during pregnancy are understood to have physical and developmental impacts on an infant. These can include prescribed medications, illicit drugs, tobacco, and alcohol, and in many cases, a combination of these substances is being used. NAS and NOWS are specific to opioids use<sup>10</sup> and risk is present with the use prescribed or illicit opioids as well as MAT. MAT, while it creates some level of opioid exposure, is still the preferred standard for treating OUD in pregnant women and poses less risk of NAS causation as compared to heroin or oxycodone.<sup>11</sup> Not every opioid exposed infant will receive a diagnosis of NAS, but many should still be considered at-risk for negative impacts.

NAS is a clinical diagnosis, meaning it is diagnosed based on symptoms and other evidence rather than a medical test. Symptoms may be seen within 48 to 72 hours or as late as 15 days after birth.<sup>12</sup> NAS infant withdrawal may include tremors, increased muscle tone, high pitched crying, seizures, gastrointestinal dysfunction, and respiratory distress.<sup>3</sup> Infants are diagnosed using an assessment tool known as the Finnegan scale. This is a point-based determination calculating the presence of any of these symptoms while considering other factors measured over time. Accurate assessment is susceptible to variability due to the scoring nature of the tool.<sup>13</sup> One clinician may subjectively score higher than another, leading to variance in who receives a NAS diagnosis and treatment.



The standard treatment for an infant with NAS is often a combination of medication and non-pharmacological care. Infants may begin with an initial stay in the neonatal intensive care unit (NICU) of the birthing hospital and may remain longer if there are other complicating factors.<sup>14</sup> The medication-based treatment for NAS can include doses of methadone or morphine to manage withdrawal and minimize complications. Non-pharmacological treatments may include rooming-in, minimized stimuli, skin to skin, frequent small volume breastfeeding, and other comforting techniques.<sup>15,16</sup> Federal recommendations are that pharmacological intervention should only be used when necessary to abate severe NAS symptoms.<sup>17</sup>

## NAS Impact on Infants and Families

NAS and at-risk opioid exposed infants can face significant and lasting challenges. Untreated pregnant women with OUD face greater risk of premature birth, preeclampsia, maternal death, cesarean section, and intrauterine death—increased more with heavy opioid use. Barring these risks, NAS is unlikely to cause death in infants if withdrawal is properly managed.<sup>18,19</sup> Once discharged from the hospital, medical care for an NAS infant shifts from symptom abatement to a focus on achievement of developmental milestones and the mitigation of risk factors. NAS infants may have lingering symptoms for months after birth including difficulty feeding, sleeping, and loose stools.<sup>20</sup> Broader studies point to increased prevalence of motor and cognitive impairments, attention deficit disorder, and hyperactivity among others issues. More research is needed to understand the full impact of NAS on children, particularly long term. Many of these

adverse outcomes are thought to be mitigated through early intervention and the presence of strong familial and societal support.

Studies have demonstrated that the year after giving birth is a vulnerable time for women with OUD, both increasing the risk for discontinuing MAT as well as potential overdose.<sup>21,22</sup> Caring for an infant experiencing both initial and extended symptoms makes normal caregiving more complex and enhances the risks that are already present in non-exposed infants. Challenges including the stigma associated with a substance exposed child, lack of access to gender sensitive resources, hormonal changes, and postpartum depression can also make caring for newborns with NAS difficult.

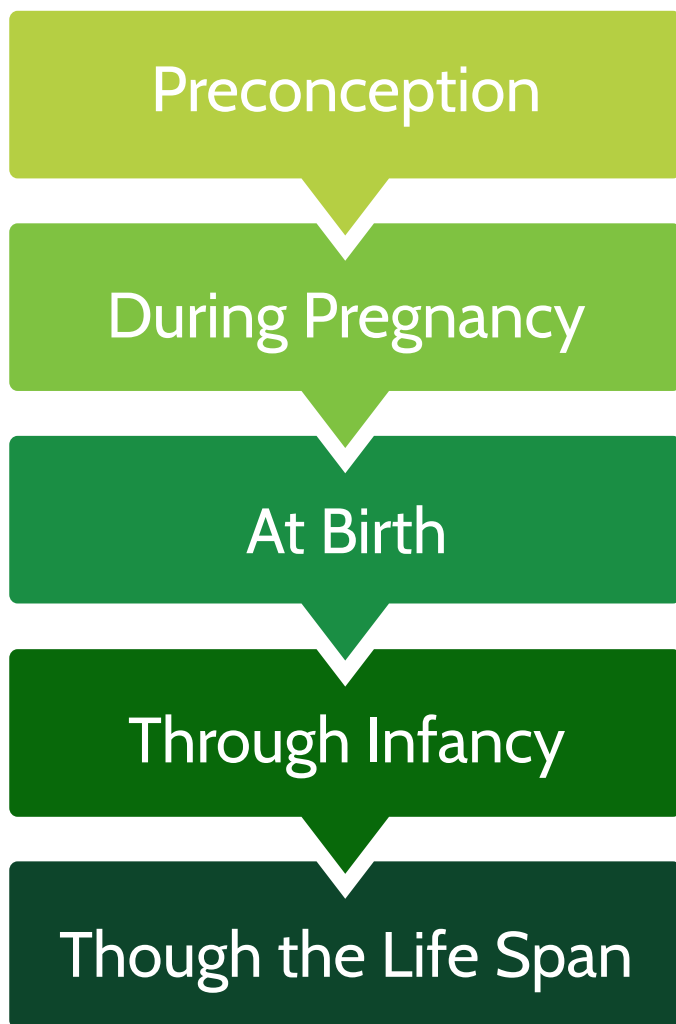
Caregivers of NAS infants are not always the biological mother or father. Foster parents, grandparents or other relatives may assume the role, often due to temporary removal of the child from birth parents for which uncontrolled OUD is present. Such caregivers may be unprepared emotionally or financially to care for the infant. They may find themselves navigating a myriad of social services and medical appointments. Properly supporting the needs of this familial structure, in whatever form it takes, may be vital for the long-term health and development of NAS infants.

## Rhode Island NAS Resources

The scope of Rhode Island resources needed to reduce the incidence rate and care for NAS infants is significant and requires intervention at a variety of critical stages starting before conception and throughout the child's life. The entities involved in this support structure include hospitals, health plans, community health centers (CHCs), community mental health



centers, opioid treatment providers, obstetricians and gynecologists (OB-GYNs), and social service agencies, to name a few. Using a framework developed by the Massachusetts Health Policy Forum, the section below provides a high level overview explaining how these resources can play a role in supporting NAS impacted families in Rhode Island.<sup>23</sup> The resources described below are not an exhaustive account of all available, and like many health care services, are not uniform in their delivery of services. There are also significant gaps and access to care, predominately driven by geography. The framework does, however, provide an avenue for considering future improvements to the spectrum of NAS care.



## PRECONCEPTION

Rhode Island infrastructure to support treatment during the phase before a pregnancy overlaps with the broader efforts to address OUD, to promote safe sex and to increase healthy pregnancies. Because much of the later education is delivered as part of primary care, Rhode Island has the advantage of projects that have fostered the growth of Patient Centered Medical Homes (PCMH) and the integration of behavioral health resources into the primary care model. Some primary care entities have benefited from the addition of models such as Screening, Brief Intervention, Referral and Treatment (SBIRT) as well as peer recovery coaches.<sup>24</sup> Entities like CHCs have been early leaders in this work, and have established a vital role in transitions of care for individuals struggling with OUD by providing access regardless of insurance status. There are also additional providers focused more closely on MAT at community mental health centers and other substance abuse treatment providers. Additionally, the Rhode Island Department of Corrections is now screening all inmates and offering MAT.<sup>25</sup>

[ RHODE ISLAND INNOVATION ]

### Providence Community Health Centers (PCHC)

is one of the most well-equipped to serve this population. The model utilizes universal screening for OUD and has an obstetrician on staff trained to provide MAT.<sup>26</sup>

## DURING PREGNANCY

Health plans, OB-GYNs, and MAT providers can all play a role in delivering the correct services for the women and their families during pregnancy. Some prenatal care providers are trained in MAT, but indications are that more are needed. When OB-GYN and MAT services are handled by

different providers, the health plan can play a role in helping to connect the care team to create an effective treatment plan to address both successful prenatal care and OUD. In some cases, Rhode Islanders can access long-term support from family home visiting models, like Early Head Start and Healthy Families America, who work with expectant families and identify unique needs.<sup>27</sup> The full collaboration of resources is currently more effective when a pregnant woman with OUD is empowered to discuss all relevant aspects of her care with her entire provider team.

[ RHODE ISLAND INNOVATION ]

### Neighborhood's Bright Start Program

The program leverages a network of obstetrician providers to administer prenatal risk assessments to determine potential risk factors. Members identified as having a risk factor are referred to Neighborhood case management. Case management collaborates with members' providers to support positive birth outcomes. Ongoing efforts are underway to strengthen the ability of the program to identify members in need.

## AT BIRTH

While there are several birthing hospitals in Rhode Island, data shows that 97 percent of NAS births took place at Women & Infants Hospital in 2015.<sup>28,14</sup> As a result of this concentration of cases at a single site, the hospital has advanced protocols on how to care for infants with NAS and their families or caregivers. The Women & Infants Family Centered Care Model has been successful by leveraging interventions like family care rounding, keeping babies in the room with the mother, including the families in the plan of care, and others. A comparative study conducted on the model demonstrated shorter length of stay and treatments such as reduction in the total number of morphine doses required.<sup>14</sup>

Hospitals in Rhode Island are required to complete a Plan of Safe Care (POSC). The POSC is a federally mandated requirement that a hospital gauge the safety and ability of the caregiver to support the substance exposed infant, including a determination regarding if the case should be referred to Rhode Island Department of Children Youth and Families (DCYF). A care team, that can include the caregivers, is engaged in developing the list of resources the caregivers should consult.<sup>29</sup> Hospitals like Women & Infants are increasingly looking for programs that wrap around the clinical model with other support resources.

[ RHODE ISLAND INNOVATION ]

### Medication Assisted Treatment to Enhance Recovery (Moms MATTER)

Affiliated with the Women & Infants Hospital is a new program linked to their Center for Women's Behavioral Health designed to provide supportive services before and after birth. Centered on the use of the MAT drug buprenorphine, the program will engage a multidisciplinary team of providers who will receive additional training in substance use treatment.<sup>30,31</sup>

## THROUGH INFANCY

Specific NAS resources during infancy can include skilled nursing, family home visiting, and early intervention. Often children with NAS are deemed automatically eligible and referred directly to programs. Through a range of assessment and intervention, they can help children reach developmental milestones. Care may focus on the needs of the infant, but also include support for family or caregiver as well. The duration of these programs can vary and spans anywhere from three months to multiple years.<sup>32</sup>

[ RHODE ISLAND INNOVATION ]

### **Family Care Follow-Up Clinic**

After discharge from the hospital, the clinic's program aids new parents with opioid exposed infants. It provides families medical, psychosocial and developmental evaluation, family therapy, and milestone assessments. The program is part of the Women & Infants' Center for Children and Families, and provides both a clinical support and, through its association with Brown University, research opportunities.<sup>33</sup>

[ RHODE ISLAND INNOVATION ]

### **SSTARBirth**

SSTARBirth is the only residential substance abuse treatment program in the state designed for pregnant and postpartum women and their children. On site is a multi-disciplinary staff who offers gender-sensitive services ranging from substance abuse counseling, daycare, vocational support, early intervention services, and transportation. This intensive model does have limited capacity, allowing for six months of treatment for up to 12 women and 24 children.<sup>34</sup>

## **THROUGH THE LIFESPAN**

Access to NAS specific resources begins to taper as the child ages. As with the preconception, resources shift from addressing acute symptoms towards a more standard holistic approach focused on normal growth and development. Continued attentiveness by pediatric and family care providers and resources that can identify and respond to the needs of the NAS family is important. As more long-term studies on NAS infants are done, it will be easier to accurately judge if Rhode Island's medical and social support is adequate to meet the needs of children and families through the lifespan.

## **Barriers**

A variety of barriers tied to gender disparities and stigma, social determinants of health and lack of care coordination can deter individuals from seeking treatment for OUD and impede positive outcomes for NAS families. Studies have shown that women suffering from OUD may also be less likely than their male counterparts to receive care, more likely to have low paying jobs and lack childcare, and be less educated as compared to men with OUD.<sup>37</sup> To further complicate, denial of addiction, psychological issues, and a history of trauma may keep women from seeking treatment for OUD.<sup>34</sup> Studies report that domestic violence and post-traumatic stress may contribute to the initiation of drug use in women, and abuse of opioids may also be a form of self-medicating for untreated psychiatric illness. This further compromises the health outcomes of infants whose mothers suffer with OUD.

While pregnancy may present a motivating factor to quit opioids, the fear of judgment, maltreatment, and punitive measures are other issues that can prevent women from seeking treatment. Societal stigma of addiction remains consistent as a difficult barrier to circumvent in addressing OUD treatment and recovery. Despite progress in understanding mental illness and addiction, its related stigma is still present in some medical professionals and throughout the healthcare system. As a result, women may delay prenatal care, MAT, or be reluctant to disclose their use of opioids, which can impact an unborn child's outcomes. Additionally, socioeconomic factors can also limit access to care for NAS families and treatment.

For example, housing instability can impact home-based NAS services and complicate coordination of care for families. Or, limited public bus service and unreliable non-emergency medical transportation, like we have in Rhode Island, can weaken access to MAT and other recovery programs for women with OUD. A limited number of treatment facilities and

half-way houses and insurance coverage complexities can cause gaps in the continuity of recovery services for expectant women and mothers with NAS infants. All of this puts NAS families in even more precarious situations.

Lastly, the coordination of care and services for women, NAS infants, and families can be complex, fragmented and overlap to create another obstacle. The weight of multiple appointments and the number of individuals involved in providing services may result in a burden on families. Understanding what resources may be most valuable can be difficult. Providers may fail to communicate with one another and this fragmentation can lead to overlapping and inefficient care. A care team's awareness of the of barriers may prove instrumental in making sure the right connections are made and the family is properly supported.

## National Opportunities

Continual efforts are underway to support states in addressing the opioid crisis, and Rhode Island should continue monitoring closely for grant opportunities and legal framework changes that may aid in improving care for NAS impacted families. There are two federal opportunities for Rhode Island to consider.

One is the Centers for Medicare & Medicaid Services (CMS) Maternal Opioid Misuse (MOM) grant. MOM is an opportunity for state Medicaid programs to apply for more than \$60 million in funding to pilot projects specific to treating NAS. The goals of the grant are to improve quality of care, reduce costs, improve access, improve state specific infrastructure, and create sustainable coverage and payment strategies. The applications can be submitted by state Medicaid agencies in conjunction with other care delivery partners. CMS will execute up to 12 of these funding arrangements with states.<sup>38</sup>

The second opportunity is to support refinements to federal privacy laws regarding communication

between health care providers. A refinement to rules, originally proposed as part of the SUPPORT Act, would permit easier transmission of substance abuse information between treating providers. Concerns about improving ease of access to this sensitive information prevented its inclusion in the final version of the law.<sup>39</sup> Despite this setback, there are some indicators this issue may be addressed through federal rulemaking in 2019.<sup>40</sup> If achieved, this change in policy would improve opportunities for care coordination regarding OUD.

## Models to Consider

**Nationwide Children's Hospital (NCH)**—Nationwide Children's Hospital (NCH) operates out of Columbus, Ohio and participates in a full-risk pediatric Accountable Care Organization (ACO) for about 330,000 Medicaid covered children. They have used the flexibility of the ACO global payment structure to take a unique approach to NAS and other conditions.<sup>41</sup> Key to the model at NCH has been the willingness to move interventions “upstream” by reaching out to women with OUD before pregnancy. NCH works with non-traditional providers such as MAT providers, department of corrections personnel, and others. By connecting with these resources and developing relationships, they have made strides in reducing the overall incidence rate of NAS among their population. In addition, NCH has a dedicated NAS clinic on-site at the hospital. NCH continues to build upon their work through participation in quality improvement initiatives and outreach to additional non-traditional provider sites.<sup>42</sup>

**Magee-Women's Hospital of UP**—The Magee-Women's Hospital of UPMC is part of Pennsylvania's Centers of Excellence Model of treatment. It is based on a “hub and spoke” style concept with a single site that serves as central resource with “spokes” including other medical practices, the criminal justice system, or other referral sources. The hospital's Pregnancy Recovery Center (PRC) is one of the “hubs” as a Centers of Excellence. This site and others like it in Pennsylvania serve as a resource to connect and provide warm handoffs to



other specialty services. The PRC is one of six sites designed to accommodate the needs of pregnant and postpartum women. Through these centers, families dealing with NAS can access gender-specific treatment and obstetrics services.<sup>43,44</sup> Facilitating these connections can reduce the risk of care transitions and keep families engaged in treatment.

## Considerations For Rhode Island

In considering the impact of NAS of children and families, the current resources available in Rhode Island, the barriers that exist, and what we have learned from other state models, Neighborhood Health Plan of Rhode Island and Rhode Island Health Centers Association (RIHCA) recommend Rhode Island stakeholders consider the following opportunities for new solutions to address NAS.

### › Improve Accuracy of NAS Impact in Rhode Island

The road to improving care for these families in Rhode Island requires a greater understanding of the magnitude and impact of the issue. Rhode Island has the opportunity to divert resources to develop a complete picture of NAS beyond incidence rates and to examine the greater picture of the cost for all payers and the demographics of the families impacted. This information will help to further guide and target additional interventions.

### › Focus on Prevention and Education

The Nationwide Children's Hospital model provides prevention and education efforts far in advance of pregnancy. Increasing access to treatment, lengthening detox times, and building communities to support mothers will help improve their recovery from OUD. Rhode Island can continue to expand its efforts to ensure access to MAT for all individuals along with securing access to contraceptives for all individuals suffering from OUD. Access to these resources could assist in reducing the incidence rate overall and reduce

harm to infants by promoting the safest possible treatment guidelines during pregnancy.

### › Add Structure to Improve Care Coordination

Rhode Island could continue its work to create plans of care and link existing resources in a manner specific to families impacted by NAS. Lessons from Magee-Women's Hospital in Pennsylvania show us the value of establishing the right resources for a specific family's needs along with help navigating these resources. Rhode Island could work to establish single entities that have a more leadership role in coordinating care across the various resources with this population. Likely candidates include health plans or community health centers. By expanding the current infrastructure, Rhode Island can reduce the number of families that feel saturated by the number of supports available.

### › Create a Comprehensive Campaign to Destigmatize Opioid Abuse

Rhode Island stakeholders could continue to think about the best ways to combat stigma of OUD to address the shame associated with being pregnant and seeking treatment. Specifically, stakeholders could examine current training for how medical staff interacts with these families to facilitate support for pursuing treatment and engagement with the pregnancy.

### › Engage Payers

Insurers can use their role to explore new financial arrangements with providers to incentivize and support changes in clinical pathways. This could include models that bundle payments for a set of services tied to this work, or include key quality indicators tied to NAS as part of existing larger financial arrangements. The establishment of these payment provisions will support sustaining new models of care, especially those that may be currently supported by federal grants.

## Conclusion

Rhode Island has done remarkable work to combat the opioid overdose crisis. Through raising the profile of NAS, and its associated issues, we hope to foster a dialog to explore the opportunities available through existing resources and potential federal resources that could spur additional innovation. Neighborhood and the RIHCA look forward to engaging others to work towards reducing stigma, enhancing collaboration and finding ways to engage beyond simply medical needs. Working together we can reduce incidence of NAS, save state resources, and change the lives of impacted Rhode Island families.

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## ISSUE BRIEF

# Addressing Hidden Wounds: Trauma-Informed Care

## Introduction

Over half of Americans report exposure to at least one traumatic event within their lifetime. Among individuals in behavioral health settings, the number climbs to 90 percent.<sup>1,2</sup> Ignoring these statistics, as studies have demonstrated, can negatively impact health outcomes and increase health care expenditure.<sup>1</sup> Traditionally, managing trauma has been directed to behavioral health treatment facilities and targeted towards children and adolescents who have reported psychologically harmful experiences. However, as we move towards a health care system increasingly focused on value and proactively managing the care of high utilization patients, opportunities are developing to diagnose and treat trauma in adults in other areas of the health system. Patients labeled as difficult, untrusting, or non-compliant are often individuals who have been impacted by trauma and have the most to gain from better rapport and engagement from their care team.<sup>1</sup> To address this need, some health care providers are developing unique strategies for integrating new health screening practices and trauma-sensitive treatment for their clientele, often called Trauma-Informed Care (TIC).

This brief examines the current understanding of the impact of trauma on individuals and provides examples within the health care system to change culture and behaviors to support a more TIC environment. Neighborhood Health Plan of Rhode

Island (Neighborhood) and the Rhode Island Health Center Association (RIHCA) believe now is a critical time to address trauma within our health system as Rhode Island and the country contend with a plethora of potentially traumatic circumstances. Most notably, the impact of COVID-19 pandemic and the longstanding adverse treatment of populations of color. Preparing our primary care infrastructure to take these and other factors into account is maximizing our ability to support our patients, members and neighbors. We look forward to collaborating with other community stakeholders for a robust dialog on how to help place Rhode Island at the forefront of delivering holistic, restorative care for all populations.

## Defining Trauma

Trauma is often defined as an emotional response to an event, experience or set of circumstances that adversely affect an individual's mental and physical wellbeing.<sup>1</sup> Traumatic events may be acute, such as a natural disaster, or chronic, as in the case of domestic abuse. Following a traumatic event, individuals may experience any number of physical, cognitive, behavioral, or psychological symptoms. The onset, range and duration of trauma symptoms are highly individual.<sup>3</sup> Infrastructure is often in place to address and

support high-profile traumatic events, while other forms of trauma are often overlooked. Examples of trauma that are often unaddressed in the health care setting include the death of a close family member, a significant life transition or receiving a life-changing health care diagnosis. All forms of trauma have the potential to limit the ability of someone to access or receive appropriate and necessary health care services.

The impact of trauma can cause very real physical and mental effects that are debilitating factors in someone's life. Studies support the connection between trauma and increased risk of depression, anxiety, smoking, substance abuse, heart disease, and premature mortality with some consistency across race and socioeconomic status.<sup>4</sup> We also know that individual responses to real or perceived adversities are unique and do not always result in poor physical or mental health. In some cases, individuals are influenced by trauma in ways that make it difficult for them to be compliant with their treatment plans.

How someone responds to trauma may be influenced by a wide range of factors, including social support, socioeconomic status, previous adverse events, perceived danger, mental health status, and extent of exposure.<sup>4</sup> Individuals with strong support structures, including social and financial, may be better positioned to avoid or overcome many of the impacts of traumatic experiences. While a lack of supporting variables can place individuals at additional risk for responding negatively to trauma.<sup>4</sup> For many, the effects of trauma clear relatively quickly. However, it is estimated that one in eleven people in the United States will suffer Post-Traumatic Stress Disorder (PTSD) in their lifetime, with the risk being greater for women.<sup>4</sup>

Health care providers who treat patients with trauma can be at risk for experiencing secondary trauma. Chronic exposure to trauma-impacted individuals, coupled with a stressful work environment, can contribute to increased burnout and staff turnover. Further complicating the issue, much like those directly impacted

by trauma, it is not easy to determine which providers are at risk as a variety of factors can contribute to the issue.

[ CARLOS ]

### **Carlos is 46 years old, has diabetes, and his sporadic employment makes him eligible to be insured through the Medicaid program.**

Previously, Carlos was an established patient with a primary care provider (PCP), but the recent death of his father due to complications associated with heart disease caused Carlos to have a significant aversion toward the medical system. Since then, he has had several visits to the emergency room each year and avoids any preventive health care visits with his PCP. However, Carlos recently visited his local health center or CHC for treatment of a serious cold. Health center staffs, who practice trauma-informed care, worked to understand Carlos's hesitancy to seek care without blaming him; his assigned case manager held conversations in an office setting, not an examining room, and his health care provider worked with him to develop a care plan tailored to his needs. As a result, over time, Carlos has come to trust the health center staff, stabilize his diabetes, and reduce his emergency room visits.

## **What is Trauma-Informed Care?**

TIC is an organizational structure and treatment framework built on understanding, recognizing and responding to all kinds of trauma. Healthcare organizations delivering TIC take universal precautions with patients, even when trauma hasn't been identified. TIC requires

acknowledging that even well-intentioned medical care can re-traumatize already impacted individuals and damage rapport between provider and patient.

As a result of increased awareness of trauma's impact on health and wellbeing, a variety of TIC models have emerged with a few common themes. Implementation of the care models varies dramatically based on the organizations, but common strategies change organizational and clinical policies and practices with intent towards changing the culture. These strategies are often governed by elements that include safety, trustworthiness, choice, collaboration, and empowerment for patients, staff and health care providers alike.<sup>5</sup> Senior leadership plays a critical role when implementing a TIC approach—their ability to dedicate financial resources, lead plan development and communicate new procedures and policies.<sup>6</sup>

Community stakeholders and patient feedback can also help inform and tailor the model of care. Many trauma-informed healthcare organizations have adapted similar strategies to make their environment feel safer, enhance patient engagement and improve health outcomes.

## Trauma-Informed Care in Health Centers and Managed Care Organizations





The experience of the community health centers (CHCs) and managed care organizations (MCOs) make them rational institutions to advance TIC in the primary care setting. CHCs and MCOs are the primary point of access for a large portion of diverse and often marginalized patient populations. Many of their shared patients may have continued exposure to a variety of social deterrents, such as poverty, homelessness, and unsafe neighborhoods. Such conditions can exacerbate patients affected by trauma and contribute to missed medical appointments and poor medication adherence. While not all individuals cared for by CHCs are survivors of trauma, those experiencing its effects might mistrust the medical system, frustrate easily, and act out. Many may also be at risk or have a chronic disease, a substance use disorder or other mental health conditions. Studies also indicate such patients may use high-cost, often-fragmented medical care as compared to those without traumatic episodes.<sup>4,8</sup>

Health centers are also ideally situated among other providers to adopt TIC due to a history of interventions focused on delivering care focused on the patient and adopting new best practices. The level of behavioral health integration within treatment plans, the attributes of the populations they serve, and even the physical space of their facilities can all make health centers ideal for the delivery of TIC. The investment in adopting a TIC model can pay off with improved patient outcomes,

[ THE ROBERT WOOD JOHNSON  
FOUNDATION TRAUMA-INFORMED CARE PILOT ]

### The Robert Wood Johnson Foundation's Advancing Trauma-Informed Care (ATC) pilot,

a national initiative to embed trauma-informed practices in the health care sector, recommends starting with an organizational level approach before widespread implementation. They have provided four foundational steps health centers might consider,<sup>7</sup>

-  Building awareness and generating buy-in for a trauma-informed approach;
-  Supporting a culture of staff wellness;
-  Hiring a workforce that embodies the values of trauma-informed care; and
-  Creating a safe physical, social, and emotional environment.

medication adherence, lower no show rates, and reduction in provider and staff burnout.

In consideration of the elements of TIC and the health centers' relationship with the most at-risk populations for trauma, community health centers should evaluate their unique qualities in creating a system of TIC.

[ MARY ]

**Mary is 72 years old, lives alone in an apartment, and recently underwent leg amputation surgery due to medical complications.**

Despite a successful surgery, Mary has been depressed and her health has declined since the procedure. She is still having difficulty walking and has missed follow-up appointments. If she continues on this path, she knows she will need to move into a nursing home, and after two trips to the emergency room in one week, her health plan's care managers called Mary. The care manager, trained in TIC, engaged Mary to develop clear goals and connect her with new resources. Her health plan's care management team sent providers to her home, including a nurse practitioner, community health worker and social worker, who were careful to ask Mary's permission before providing care and help connect her with behavioral health supports. The new rapport with her team has helped Mary improve steadily since the initial engagement.

Likewise, MCOs can directly engage in trauma-informed care through education and screening delivered through care managers, customer service representatives and other front-line staff. Care managers or coordinators are common roles employed by health plans that may not often be involved in the direct provision of care. However,

their role in coordinating or coaching individuals could be enhanced through an understanding of trauma-informed care principles.

For example, Neighborhood specifically employs teams of nurse practitioners, social workers, community health workers and pharmacists who operate in the community through the Health@Home program. Providing this training could help them better manage complex cases in which trauma is a strong influencing factor. Customer service staff could, through understanding key questions to ask or how to discuss trauma, serve as a first line of defense or source of rapport with patients. While improving the knowledge of health plan staff can be impactful, also important is the access managed care can provide through its financial resources to the adoption of these principles within the provider network.

Health plans can use health outcomes measurement tied to financial incentives to support providers adopting TIC practices. Currently, fee-for-service is the primary system of payment, compensating providers for each medical service they provide. This model offers a limited financial opportunity to support the adoption of TIC outside of grants and narrow initiatives. However, as more experimentation occurs with providers owning more risk under a grouped, consistent payment model, providers will increasingly be incentivized to focus on variables, like trauma, impacting patient outcomes.

These new models of care are often referred to as: Accountable Care Organizations, Accountable Entities, Pay for Success, or Bundled Payment. The common features of these models are payment tied to quality performance rather than quantity of services.<sup>9</sup> Providers' success with these models is based upon what metrics payers select to determine high-quality performance. For TIC, potential measures may be related to screening for trauma or structural modifications to create an environment that feels safer. There is ample opportunity to leverage the work of existing behavioral health integration and team-based care models as a platform for creating more trauma-sensitive care.



## Innovators in Trauma-Informed Care

### **Montefiore Medical Group**

Montefiore Medical Group is located in the Bronx, a borough of New York City, and has focused on improving trauma-informed care in 22 of its primary care practice sites. The physician's group has built on existing structures of transformation efforts, such as patient-centered medical home and behavioral health integration. Montefiore leveraged training staff already responsible for practice transformation to help push the TIC information and training. Also, Montefiore leveraged specialized training for behavioral health staff, increased the use of a screening questionnaire, and created a critical incident management team.<sup>10</sup> This model of leveraging existing mechanisms for transformation is an ideal model for advanced practices looking to integrate trauma sensitivity into their care model.

### **San Francisco Department of Public Health –**

In California, the San Francisco Department of Public Health model focused on transitioning to a “healing organization” that creates wellness and resilience rather than a system that induces trauma to those it serves. The department’s Trauma-Informed Systems Initiative identified “champions” as well as other staff throughout the organization to help orchestrate the change. While all employees received foundational training, champions received specialized training not just on TIC, but on organizational change, project implementation, evaluation, racially focused cultural humility, and participatory decision making. The department continually surveyed the organization and came together to discuss progress.<sup>10</sup>

### **Stephen and Sandra Sheller 11th Street Family Health Services**

Stephen and Sandra Sheller 11th Street Health Center in Philadelphia, PA, embarked on its journey to become a trauma-informed center. The model is a set of interactive tools for moving a whole organization toward being trauma-informed and trauma-responsive.<sup>11</sup> 11th Street

began with a small core planning team and over time, expanded trainings to the larger staff. In addition, the health center developed several unique elements including forming an Undoing Racism committee, enabling primary care providers to make warm handoffs to in-house support staff, and providing services like creative art therapy, mindfulness classes, cooking classes and an on-site fitness center.<sup>10</sup>

## Rhode Island Policies to Consider

The following policy options are recommended pathways to the creation of a trauma-informed primary care system in Rhode Island.

### › Support TIC training for the workforce serving the adult population in primary care and health plan settings

Increase the number of practice staff who complete Mental Health First Aid training or other evidenced-based programs that teach strategies for how to help someone in both crisis and non-crisis situations. Organizations can commit to leveraging initial trainings and having those individuals train others within their organizations. In parallel, identify and disseminate resources designed to address provider burnout.

### › Include TIC in the evolving Accountable Entity (AE) discussions

Executive Office of Health and Human Services (EOHHS) and collaborative AEs are engaged in the shift toward a more value-based payment option for delivering care to the Medicaid population. The inclusion of TIC in dialog, with potential investments in such areas as social determinants of health, will increase the likelihood TIC is considered as part of the transition to quality performance measures for payment incentives.

### › Host a Health Care Leadership Forum

Bring together leaders across Rhode Island’s health care system to promote organizational culture and practice for implementing TIC in medical care setting modeled after “SAMHSA’s Concept of Trauma and Framework for a Trauma-Informed Approach” and Center for Health Care Strategies (CHCS) tools.

### › Assess screening tools

In current screening tools, seek opportunities for improvement to questions asked to determine if individuals have been impacted by trauma.

## Conclusion

Addressing trauma in the adult population has quickly become a significant concern for the health system to contemplate as we work to integrate behavioral health, address influencing factors outside of the traditional medical system, and move towards more value-based payment models. Neighborhood and RIHCA believe in exploring policies in Rhode Island that can foster the growth of TIC care models in our state. We look forward to engaging partners to overcome the barriers of trauma and deliver better outcomes for the communities we serve.

## Endnotes

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