

## HUMAN SERVICE SPECIALIST ROLE

The purpose of the Social Worker and Human Service Specialist (HSS) positions on CHNCT's clinical team is to contribute to the organizations mission of improving the health of underserved and vulnerable populations by providing access to high quality and comprehensive health care resources. These roles are about helping people; encouraging enrolled members to become independent, healthy, and safe. The HSS team strives to address the needs of members in a culturally, linguistically and economically appropriate manner. Services provided by Social Workers and the Human Service Specialists are delivered in the least restrictive setting and in partnership with existing community resources. All interactions with members/their families, providers, and established resource programs are confidential and any exchange of information is strictly follows national HIPAA regulations.

CHNCT's population will be supported across five (5) regional areas of Connecticut. These geographic areas will be supported by clinical teams that include Intensive Care Managers, Specialized Intensive Care Managers, Social Workers and Human Service Specialists. Social Workers and Human Service Specialists are key to supporting member service care delivery as they function as experts on community-based resources.

The Social Worker and Human Service Specialist (HSS) roles are designed to assist and support all Community Health Network of Connecticut (CHNCT) members in the Medicaid family/children (HUSKY), Charter Oak, Aged, Blind, and Disabled (ABD), and Medicaid Low Income Adult (MLIA) programs that demonstrate social services needs. These member populations represent a wide variety of demographic backgrounds with socioeconomic and psychosocial challenges. The primary focus of CHNCT's social service team is to link members and providers with community based social support. Referrals are received through multiple data resources as well as sources that are internal and external to the organization.

- The children and family membership predominantly consist of pregnant members and children with special health care needs such as asthma, diabetes, and/or other complex disabilities and behavioral health conditions (Husky A, Husky B)
- The ABD and MLIA populations typically have complex chronic medical and/or behavioral health conditions and disabilities, (including blindness, substance abuse, etc) (Husky C, Husky D)
- Charter Oak is a mix of members with chronic health issues and social service needs

The Human Service Specialist team contact members by phone and/or meet face to face in their homes and/or at community sites to identify and evaluate social service needs. Members are then referred to appropriate ASO and community-based resources with the goal of connecting members and their providers to social supports that address specific existing social service issues. Social workers provide psychosocial support across regional teams; also working in member's homes and providers offices to establish linkages to community based specialists and support entry into waiver programs.

The HSS role also provides a targeted outbound intervention for pregnant members who are at high risk of adverse birth events. Data resources proactively identify members with risk factors that are associated with poor neonatal outcomes. These data resources include but are not exclusively restricted to:

- Member Welcome/HRA calls
- UM Referrals

- Emergency Department (ED) visits
- Prenatal Care Registration Form (PCRF)
  - Submitted by Providers
- Referrals from the Behavioral Health Partnership
- Prenatal Identification Reports
  - DSS daily eligibility files listing members with Medicaid Eligibility Groups, P01, P02, P05, P95 indicating pregnant.
- Predictive Modeling
- Post Partum Identification Reports
  - DSS daily eligibility files listing members with Medicaid Eligibility Groups, M01, M02 indicating postpartum.
  - DSS daily eligibility files listing newborns whose date of birth is the same as the eligibility month to identify postpartum mothers.
- Claims

Once pregnant members are identified as high risk they receive screening and outreach initiatives as well as the opportunity to enroll in CHNCT's peri-natal SICM program, Healthy Beginnings. Home visits are available and arranged for by a HSS team member if necessary during the pregnancy and post-partum period. These visits provide resource allocation that supports the best outcomes for both mother and infant. A comprehensive assessment and coordination of referrals is completed by the health service specialist to drive an organized systemic approach that includes proactive involvement by the member, provider and other healthcare team members.

Human Service Specialist develop strong relationships with provider practices and community based agencies; linking them together on specific cases and, at a programmatic level.

- ASO members with concomitant behavioral needs that are identified during the HSS evaluation demand prompt coordination of care with the behavioral health team.
- When dental needs are evaluated the HSS will facilitate collaboration and communication between the member's PCP, and dental providers.

The provision of community-based services will be incorporated in CHNCT's training regimen that is lead by the Transformational nursing team as part of medical home training. Community resource toolkits will be made available and continuously updated for those practices that achieve medical and health home status in an effort to provide the robust support providers need to achieve and maintain independence.

For small medical practices that could not otherwise evolve into a medical home and for members who do not wish to participate in a medical home CHNCT's social workers and Human Service Specialists will remain available to provide ongoing support to stabilize member health.