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Connecticut Office of Health Care Advocate
Hartford, Connecticut
Attention: Victoria Veltri, Healthcare Advocate
sim@ct.gov

Re: Draft 1.1 Connecticut Healthcare Innovation Plan Public Comment

Dear Ms. Veltri:

The National Association of Social Workers is a membership organization representing over 3000 social workers throughout Connecticut. Approximately two-thirds of our membership practice within the health and mental health systems. These members include those in agency settings, both public and private, plus members who are in independent practice in a solo or group practice that provides behavioral health services. Nationally and statewide social workers provide approximately two-thirds of all mental health services and social workers are part of the provider team for many physical health services.

Social workers have been involved in the health care field since the turn of the 20th century. The profession's earliest concerns were with making health care services available to the poor and with improvement of social conditions. As the role of social work expanded over the years social workers joined with other health professions in the delivery of high quality health care services. Today social workers are an integral part of the Connecticut's and the nation's health care systems.

The draft SIM proposal offers numerous opportunities to engage and involve social workers within the health care delivery system. The draft however does not adequately include social work services across all appropriate aspects of the plan and rarely mentions the profession as a specific practice field. The comments that follow will point out where we see our profession playing a key role. Following those comments we will offer non-social work specific comments for your consideration.

Whole-Person centered care: The draft appropriately has a focus on the person's health care needs as a whole person rather than the silo-care model that is too often the approach in our present health care system. This whole-person approach directly correlates to the training of social workers where our profession uses a "person in environment" model that accesses the biopsychosocial needs of the person in the context of their of environment and the systems the person relates to and is impacted by. This professional training is particularly suitable to the approaches of the Advanced Medical Homes (AMH), population health management, care coordination and community based care. We recommend that social work be mentioned as one of the professions in the provision of whole-person centered care. Specifically, social work should be included in the list of "core providers" of the care team for the AMH model (page 45).

Team-based coordinated care: The SIM proposal rightfully puts an emphasis on multi-disciplinary team based care. We especially appreciate that behavioral health care is combined with physical health care and that mental health care is seen as an equal part of the equation. Here again, social workers bring to the table experience in multi-disciplinary

care within a health care model. The *NASW Standards for Social Work Practice in Health Care Settings* specifically states that “*Social workers shall participate in care teams, and collaborate with other professionals, volunteers, and groups in and outside of their practice setting to enhance all aspects of the client and family system’s care*”. As the multidisciplinary teams are built it is imperative that social workers are included. This is especially important as approximately two-thirds of all mental health services in Connecticut are delivered by clinical social workers, plus supportive services for physical care is often coordinated and delivered by medical social workers.

Care coordination: Throughout the proposal is the stated need for care coordination. This is particularly needed when working with lower income individuals & families, and culturally diverse populations (especially where English is not the first language). One approach within the proposal to address this need is to have Community Health Workers (CHW). **It is our recommendation that the state’s six baccalaureate programs in social work be engaged in the planning for care coordinators, including the CHWs.** Baccalaureate Social Workers (BSW) are well prepared for case management functions. While social workers are generally thought of as part of behavioral health providers, in fact our profession is more than just behavioral health, with case management a key function that social workers are trained in. If the SIM only perceives social work within the behavioral health provider framework than SIM will not be successful in fully utilizing the skills of the social work profession.

Healthcare Workforce Development: The concern of the aging out of the healthcare workforce is a significant concern. We do want to note however that in the field of social work in 2012 approximately 400 Master level graduates (MSW) and 200 baccalaureate level (BSW) students graduated from schools in CT and the three immediately surrounding states. Furthermore, enrollment in social work education is on the increase in all of the schools of social work. We feel that if the SIM fully incorporates social work into its model that many of these graduates can be recruited into health and mental health services. In addition, our schools, especially at the BSW level are very diverse with many students of color. In a review of two of the three MSW programs in CT and five of the six BSW programs we found that the 2012-13 class had a range amongst the schools of 9.6%-25% of African American students and 4.9%-14.6% Latino students. The report correctly notes that persons of color have a harder time climbing the career ladder, in the field of social work that ladder begins with BSWs attaining the MSW degree. **We recommend that a state loan forgiveness program that includes social workers be implemented (CT did have a loan forgiveness program administered through DPH that did not include social workers and to the best of our knowledge is currently not funded).** Such a program should include an emphasis on practitioners of color.

We must make note that on page 84 where license data is listed in reference the title “psychiatric social worker” is used. This is actually very outdated terminology. The correct title is “clinical social worker” as clinical social work functions come under social work licensure in Connecticut. **We recommend that “clinical social worker” be used instead of psychiatric social worker.**

Cultural Competence: There remains a strong need for increased healthcare services that are culturally and linguistically competent to meet the diverse population of Connecticut. The SIM proposal recognizes this need and addresses it, though perhaps not as strongly as required. One area that can be improved is in provider training and continuing education on cultural competence. Physicians are required to have at least one hour per license renew period in cultural competence. As of October 1, 2013 licensed individuals in social work, marital & family therapy, professional counseling and alcohol & drug counseling will need to also get an hour in cultural competence continuing education starting when they renew their license. However the remainder of health care providers has no such requirement. **We recommend expansion of the cultural competence training requirement to all licensed health care providers.** This will be a good starting point to building a more culturally competent healthcare workforce. Such training can be inter-professional so as to best reach providers and allow for cross training amongst professions.

Value-Based Insurance Design (VBID): The draft speaks of VBID in regards to Health Enhancement Program (HEP) and notes that the Office of Comptroller will organize a task force to review VBID. We support such a move as HEP programs can be a win-win for employers and employees. We do wonder however if any consideration has been given to the small employer market and if there is a way to incorporate HEP into small employer group insurance plans? The draft proposal appears to limit this initiative to medium and large employers. Small employers face the highest insurance premiums (in the group market) and often have high cost shifting to employees through co-pays, co-

insurance and high deductibles. HEP designs within the small group market could have a positive impact on premium and out-of-pocket costs.

Rewards for Nutritional Purchasing: Having a rewards system for better nutritional choices is a positive approach. We do however note that for lower income populations, especially those residing in urban centers, access to healthier food choices are often limited by the lack of large grocers. This is an issue that needs to be addressed within the larger context of access to health related services. The draft does indicate that DSS will explore a pilot program within SNAP however the cutbacks in SNAP funding and the number of eligible households not receiving SNAP limits this approach. Additional approaches to nutritional purchasing are needed as SIM moves forward. **We recommend outreach to anti-hunger advocates to better address this concern.**

Health Information Technology: SIM has a strong focus on health information technology, including electronic medical records (EMR). This direction makes sense in terms of easier measurement of care factors and ease of sharing information between practitioners. It will however be a resources challenge for small practices, which constitutes much of the state's mental health provision in non-agency independent practices, be it solo practitioners or group practice. Cost alone for initial medical records technology and upgrading of technology is prohibitive for many small practices. **We recommend that financial assistance with EMR technology costs and technical assistance be available to small practitioners in solo or small group practices.**

Provider Performance Measures: Designing a "report card" on provider performance that can be reviewed by consumers does assist in empowering consumers choices of providers. We support tools that will enhance the knowledge available to consumers as to health care options. The challenge here is how one designs a system of performance measures that addresses the range of services a provider offers and more importantly takes into account the severity of health issues within a provider's patient population. In designing of this system special care must be attended to factoring in of patient health issues. Otherwise providers may choose to not accept for treatment certain patients in order to avoid being "penalized" for outcomes that are not deemed as successful as their colleagues who have a more balanced patient load.

Supportive Services: The draft proposal is lacking of clear definition and role delineation of support services that are needed for a complete approach to health care delivery. How will SIM incorporate supportive services such as care coordination, transitional care from institutional to community setting, patient & family support, referral, social supports and patient advocacy? The proposal does address case management to a degree though even on this service it is not sufficiently spelled out. In looking at the person as a whole a more complete description is needed on how collateral services will come into play, who will provide the services and how will they be covered.

Payment Strategy: One major concern we have is that the payment model may lead to denied or restricted access to care to maximize revenue. **We recommend that providers found to have denied care or restricted access to care be prohibited from receiving shared savings or other financial rewards.** Furthermore, we are concerned that low Medicaid payments are already a deterrent to providers accepting Medicaid patients and because of this we **recommend that downside risk payment models exclude Medicaid.**

Consumer Involvement: Many advocates, including NASW/CT have expressed concern as to the degree of direct involvement by consumer representatives in the work groups that developed this SIM proposal. We appreciate the recent appointment of two additional advocates as consumer representatives and **recommend that going forward that consumer advocates are represented in sufficient levels on all work groups, committees and governance bodies of SIM.**

Patient Involvement: At the end of the day the full success of the SIM system will depend on consumers of health care having buy-in to the SIM plan by being active participants in their own care. This is easier said than done for a variety of reasons that include consumers not feeling adequately knowledgeable, not having easy access to information they need, being use to a system where they are not decision makers, lacking an understanding of health care matters, language barriers, poor comprehension of personal health issues, lack of necessary time, and being in the midst of a health problem where they lack the fortitude to participate in care decisions. The SIM needs to take all of this into

account and to offer both meaningful incentives to consumers for participation and systems to assist consumers in the engagement with the health care system.

NASW/CT appreciates the opportunity to provide these comments for consideration and is willing to further engage with SIM as the planning moves forward.

On behalf of NASW/CT,

Stephen A. Karp, MSW
Executive Director