Consideration of Public Health Nurse vs. Social Worker

- Requirement of a Multi-disciplinary Team approach to MNChoices and Assessments/Case Management
  - Currently the only PHN that works with HCBS programs is the PH Supervisor
  - Currently there are 5 Social Workers working with HCBS programs/waivers, they have trained and are currently conducting MNChoices assessments.
- Cases are medically fragile and complex
  - Consistent and ongoing discussion and consultation between SW and nursing staff re: medical needs, devices, prescriptions, co-morbidity, etc.
  - CADI, CAC, BI--all are medical waiver programs
- Ongoing/Back-up/Additional nursing support for PH Team
  - Immunizations/flu shots/outbreaks, etc.
  - Emergency Preparedness
  - When other staff are out--retirement, vacations, medical/family leave, etc.

Consideration of Public Health Nurse vs. Registered Nurse

- Public Health Nurse Credentialing Requirements
  - A Registered Nurse must be licensed and currently registered in MN
  - Have a Baccalaureate or higher degree with a major in nursing
  - Have completed course work which includes theory and clinical practice in public health nursing as outlined in MN statute (not all schools offer this coursework nor do all nursing students choose to complete this option)
  - Submit application and fee and be approved
- The additional education and experiential learning equips and prepares a PHN for the PH philosophy, policy, system and environmental work. PHN's have the educational background to work with groups, community engagement, politics, family and group dynamics, epidemiology and population assessments.
- Staff hired with a PHN certificate will likely undergo less PH orientation due to their ability to better understand basic PH concepts (RN's that have been hired for positions in the past have undergone a significant learning curve)
- PHN's receive education and training to work collaboratively with agencies/departments that RNs trained to work 1-1 with patients are not always likely to collaborate with, i.e. social services, court system, mental health, child protection, etc.
- In HCBS/MNChoices, if we hired an entry level RN, it would take a minimum of 2 years experience before they can be trained and certified as a MNChoices assessor....this is a reimbursable position...with ½ their position doing MNChoices assessment work. A significant portion of the staff's position will be reimbursed with revenue producing work.
- With this particular position, even an entry level PHN is required to have at least 1 year experience before moving on with MNChoices training/assessing capabilities.
- We have already run into issues with PCA assessments, as they MUST be completed by a PHN. Our current HCBS nursing staff is not a PHN. There are cases in which legacy documents must continue to

be completed...we have no HCBS PHN staff other than the PH Supervisor to complete or approve these documents.

- TANF has some language that targeted home visiting requires that a PHN complete an initial family assessment in order to accept TANF FHV funds for those services. If a PHN is not performing those services, MDH wants to know why, the nurse's background, credentials, experience and additional training that qualify them to perform in such a capacity.
- The Minnesota Board of Nursing examination tests the minimum qualifications to conduct Registered Nursing safely in the State of MN. However, that said, it does not account for additional training and experiential learning included and provided by BSN/PHN programs.

Offering a higher wage to candidates

- There have been 5 offers made to date. 2 of those offers were to the same individual. 3 individuals were already making above our current experienced staff and supervisor. To my knowledge, the counter offers were all above current PH staff with the most seniority.
- Offers were made at a level taking into consideration the candidate's education, experience, HCBS experience, ability to be MNChoices Assessor trained and in comparison to where current PH staff are on the wage scale. We did not feel it was justified to offer less experienced staff the same wage as our experienced staff.
- It is a disservice and disrespect to bring new PH staff (yes, many years of nursing experience, however, few to no years of PH experience) in at a wage just under, at or over current PH staff. We have staff that have dedicated their careers to this agency and have gotten no recognition of that or market rate when placed on the new pay scale.
- This practice creates morale issues, distrust, team unrest, agency turmoil and retention issues.

Consideration of Part-Time vs. Full-Time

- We have a caseload supporting full-time
- Reassessments and Managed Care are both set to roll-out and be in full production by the first of the year
- Assessments take on average 10 hours to complete--geography is an issue in Aitkin County, travel time is significant
- Supporting other PH activities by working more than part-time hours is unlikely due to the salaried position.

Shifting Present Staff

- 1 PHN option
    - Considered shifting caseloads/focus area and shadowed Case Manager prior to resignation
    - Has training and background in family health and early intervention
    - Has received specialized cohort infant/child mental health training at U of M
    - Would need to backfill position to manage programs that require additional training, i.e. WIC

- 2 Social Workers
    - Coordinating new initiative and nationally recognized program
    - Obtained credentialing, training and certifications to perform CD assessments and manage MI clients
- Work satisfaction and retention concerns

Additional Eligibility Requirements for Staff (MNChoices Certified Assessors)

Qualified candidates must complete required training and have at least one of the following:

- Bachelor's degree in social work plus at least one year of home and community-based experience
- Bachelor's degree in nursing with current licensure as a registered nurse along with public health certification and at least one year of home and community-based experience
- Bachelor's degree in a closely related field plus at least one year of home and community-based experience
- Current license as a registered nurse with at least two years of home and community-based experience.

Additional MNChoices Training Requirements

- The MnCAT training consists of four steps. Steps 1, 2 and 3 require you to pass tests with an 80% proficiency or higher before moving to the next course.

- **Steps 1 and 2**
- These MnCAT steps are available in DHS TrainLink. Anyone may take Steps 1 and 2 if they have a TrainLink unique ID (PDF).
    - **Step 1. Foundations = 4 to 5 hours**
        - **Overview**: Online course providing a basic understanding about MnCHOICES
        - **Basics**: Series of open book tests about fundamental information certified assessors need to know that links to online resources

    - **Step 2. Principles = 10 to 12 hours**
        - Consists of seven eLearning program courses
        - Includes key principles about MnCHOICES and attributes of a certified assessor
- **Step 3**
    - This step is also available in TrainLink. DHS will send this link to lead agencies when they are preparing to launch or have launched MnCHOICES. Step 3 requires access to the MnCHOICES Training Zone (MTZ), which is available through a lead agency MnCHOICES Mentor.
    - **Step 3. Application = 7 to 8 hours plus an actual Assessment which = another 10 hours**
        - Access and navigate MnCHOICES and instructed activities in MnCAT Training Zone
        - Increase familiarity with assessment content/functions and instructed activities in MTZ
        - Complete an assessment based on given scenario and participating in a multi-disciplinary learning lab.
- **Step 4**
        - This is continuing education and professional development to support certified assessors to enhance their knowledge and skills.
        - **Recertification**
        - Every three years
        - Professional development that deepens knowledge, skills and abilities of a certified assessor.

Per MACSSA Policy Statement dated July 2015:

What is County Case Management?

At a basic level, case management services assist an individual in identifying the individual's goals, strengths and needs; involve planning with the individual what services and community resources might help the individual to accomplish the individual's goals; provide referrals (and often accompany) the individual to obtain services and resources; and monitor and coordinate with those services and resources to assure that the individual is getting the help needed to accomplish the individual's goal and to address the individual needs[1].

In concert with current Legislation and Rules, Minnesota counties invest significant amounts of local levy dollars into programmatic, fiscal, legal, and other administrative aspects of case management services. Given that context, counties consider case management to be at the center of our community-based service system. These services directly impact individuals who are critical to the identity of our communities. County boards have responsibility, under statute, for the development of an affordable system of care serving children, families, and adults that are uninsured or underinsured.

Counties in our combined roles as "payer/purchasers", "developer of integrated services", and "direct care providers", are well positioned to partner with the State and local vendors to continue case management service delivery into the future. Our practice philosophies reflect a holistic framework to promote a consumer-driven, community-based, and recovery-focused system of care.

Developer of Integrated Services

Adults and children in need of case management services typically have complex needs that may include food, clothing, shelter, and access to health care coverage. Counties are in a key position to address the holistic needs of consumers by integrating Social Services, Financial Assistance, and Public Health, with the consumer being the focal point. Consumers seeking case management often have multiple needs that are best served through a county-delivered system that can integrate all public services and internally coordinate the needs of each consumer. Effectiveness of county case management increases as access to all appropriate public services are streamlined.

Because of local contacts and familiarity, counties are well positioned to avoid duplication, navigate jurisdictional nuance, and address issues of diversity. Counties bring passion, commitment, and expertise to the development of an array of embedded services that specifically respond to community needs. Counties, especially in rural Minnesota, are often the sole provider of direct care services which usually require additional efforts (and additional levy resources) to ensure the basic needs of each community member are appropriately met.

Provider (Coordinating with the External Service Network)

Counties offer specialized expertise in serving public consumers. Because of long-standing local reference points, counties are best positioned to link individual citizens with unique local supports (both formal and informal). Counties claim expertise in intensive person-to-person and community-based service delivery. By understanding the integration of funding (Private, County, State, and Federal funding) *and* the available community resources (County, Non-Profit, Private), Counties are uniquely afforded the perspective to provide case management services in a manner that are customized to the individual. Addressing the needs of consumers in this dual manner mitigates the limitations of a model that is based more solely on "funding" as the primary driver of service delivery. Funding defined tasks naturally creates an incentive for "task completion" for all eligible clients, regardless for the individual's need for the specified services. Counties believe it is critical that individualized care plans are customized to match personal needs with community services. The funding needs to be packaged in a manner that supports customized care plans.

Care Coordination Requirements for Managed Care

- The Care Coordinator will work with the member with support from IHM-GP staff and/or Government Programs staff to assure that the member has access to the following services as needed:
    - 1) Rehabilitative Services. These are services that promote the rehabilitation of members following acute events and for ensuring the smooth transition and coordination of information between acute, sub-acute, rehabilitation, nursing home and community settings.
    - 2) Range of Choices. The care coordinator is key in ensuring access to an adequate range of choices for members by helping the member identify formal as well as informal supports and services, ensuring that the services are culturally sensitive. Interpreter services are available for all BluePlus members.
    - 3) Coordination with Social Services. The Care Coordinator will collaborate with the local Social Service Agency when the member may require any of the following services:
        - Pre-petition Screening
        - OBRA Level II Screening
        - Spousal Impoverishment Assessments
        - Adult Foster Care
        - Group Residential Housing and Board Payments; or
        - Extended Care or Halfway House Services covered by the Consolidated Chemical Dependency Treatment Fund
        - Targeted Mental Health Case Management
        - Adult Protection
    - 4) Coordination with Veteran's Administration (VA). The Care Coordinator shall coordinate services and supports with those provided by the VA if known and available to the member.
    - 5) If the Care Coordinator receives notification of a member's hospital admission, contact will be made with the hospital social worker/ discharge planner, to assist with discharge planning. The Care Coordinator can work with the discharge planner, member or home care nurse (if appropriate) to complete the following:
        - Assess the member's medical condition;
        - Identify any significant health changes;
        - Reassess and revise the CSP for the member to meet their new health needs, if required; and
        - Schedule an interdisciplinary team conference, if needed at this time.

- 6) Identification of Special Needs and Referrals to Specialists. The Care Coordinator should have the ability to identify special needs that are common geriatric medical conditions and functional problems such as poly pharmacy issues, lack of supports, high risk health conditions, cognitive problems, etc. and assist the member in obtaining specialized services to meet identified needs.

Care Plan Service and Guidelines

Delegate staff use professional judgment interpreting the following guidelines to make decisions related to the care and treatment of their Blue Advantage (MSC+) members:

- MN rules and statutes,
- DHS policies and training,
- County program training and guidelines,
- Provider training and guidelines,
- Medicare coverage criteria,
- Long Term Care Screening Document,
- Disease Management protocols,
- Case mix caps/budget, and
- Blue Advantage (MSC+) Certificate of Coverage

Additional MCO Requirements

- Completion of additional forms customized to Managed Care programs
- Adherence to specific guidelines and timelines set forth by Managed Care organizations
- Documented compliance, reviewed during annual audits by Managed Care organizations

HCBS Nurse WORKER SALARY CHART W/BENEFITS

2015		Start	1	2	3	4	6
2015 Wage Scale		**A**	**B**	**C**	**D**	**E**	**F**
GRADE 10		$ 25.30	$ 26.05	$ 26.82	$ 27.62	$ 28.44	$ 29.28
FICA		$ 1.94	$ 1.99	$ 2.05	$ 2.11	$ 2.18	$ 2.24
PERA		$ 1.83	$ 1.89	$ 1.94	$ 2.00	$ 2.06	$ 2.12
Health/Life Single		$ 4.41	$ 4.41	$ 4.41	$ 4.41	$ 4.41	$ 4.41
Total Hourly	**$ -**	**$ 33.48**	**$ 34.34**	**$ 35.23**	**$ 36.14**	**$ 37.08**	**$ 38.05**
Total Salary	**$ -**	**$ 69,637.78**	**$ 71,430.22**	**$ 73,276.43**	**$ 75,178.03**	**$ 77,136.68**	**$ 79,154.08**

CADI Case Manage	$ 24.47	15 min units/Fed and State Share
	$ 240.00	units per month
Monthly CM	$ 5,872.80	
Yearly CM	$ 70,473.60	

**Worker will also bring in SSTS Admin revenue

**ALL MNChoice Assessments are reimbursed by SSTS Admin.

2015						
2015 Wage Scale		**K**	**L**	**M**	**N**	**Maximum/O**
GRADE 10		$ 33.90	$ 34.91	$ 35.94	$ 37.01	$ 37.80
FICA		$ 2.59	$ 2.67	$ 2.75	$ 2.83	$ 2.89
PERA		$ 2.46	$ 2.53	$ 2.61	$ 2.68	$ 2.74
Health/Life Single		$ 4.41	$ 4.41	$ 4.41	$ 4.41	$ 4.41
Total Hourly	**$ -**	**$ 43.36**	**$ 44.52**	**$ 45.71**	**$ 46.94**	**$ 47.84**
Total Salary	**$ -**	**$ 90,186.09**	**$ 92,594.98**	**$ 95,076.14**	**$ 97,631.73**	**$ 99,511.78**