Approaches to Workforce Development to Support Care Management

A Guide to Resources, Promising Practices, and Tools

Prepared for:

Centers for Medicare & Medicaid

Submitted by:

The Lewin Group, Inc.
Institute for Healthcare Improvement

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The goal of the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) is to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high quality health care that includes the full range of covered services in both programs. To support these efforts, MMCO contracted with The Lewin Group, along with the Institute for Healthcare Improvement, to investigate provider-led practices that show promise in increasing provider capacity to deliver integrated care to Medicare-Medicaid enrollees. Based on its research, the Lewin team developed four guides that present resources, examples, and tools for providers interested in enhancing their ability to deliver integrated and coordinated care, including this one, *Approaches to Workforce Development to Support Care Management*.

MMCO directed the Lewin team to focus its investigation of promising practices on providers that serve individuals with physical disabilities, dementia or Alzheimer's disease, or serious mental illness. The team selected several provider-led practices through an iterative process based on an environmental scan and guidance from numerous experts. It also conducted site visits to selected practices to understand the core components that contributed to their success.

Based on the site visits and input from a Technical Evaluation Panel, the Lewin team identified four inter-dependent, high-level concepts that support the delivery of integrated, coordinated care:

- Integrating physical health services into behavioral health organizations
- Supporting self-management for adults with serious mental illness
- Workforce development to support care management
- Navigation services for individuals with severe mental illness

Approaches to Workforce Development to Support Care Management is based largely on information from the Visiting Nurse Service of New York CHOICE (VNSNY CHOICE) program, a managed care organization serving approximately 15,000 vulnerable and ethnically diverse members of the five boroughs of New York and surrounding counties. The concepts that were found to underpin the VNSNY CHOICE workforce development approach were supplemented with a thorough environmental scan and expert reviews, including in-depth conversations with representatives of other organizations that have developed robust workforce development and staff training programs, such as Care Oregon, Community Care of North Carolina, and On Lok Senior Health Services. This is one of four documents designed to support providers in integrating care for Medicare-Medicaid beneficiaries. All documents are available at www.lewin.com.

Supporting Self-Management for Individuals with Serious Mental Illness

Navigation Services for Individuals with Serious Mental Illness

Integrating Physical Health into Behavioral Health Organizations

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Introduction

To improve health care access and quality while containing costs for individuals with complex health needs, providers must adopt new expectations for and ways to develop the health care workforce. The number of individuals with complex health needs in the United States is rapidly increasing.[1] At the same time, there are expanding opportunities for providers to effectively integrate and coordinate care. Initiatives such as accountable care organizations and health homes, as well as broader use of managed care, particularly for populations with complex needs, allow providers to move beyond historical financial and institutional barriers to effective coordination. Workforce development to build and strengthen care management will be critical to maintaining and even accelerating this movement.

> Medicare and Medicaid enrollment in managed care is growing. Twenty-five percent of Medicare beneficiaries are currently enrolled in privately administered managed care plans,[a] a number that has more than doubled since 2004. Seventy-one percent of Medicaid enrollees receive most or all of their benefits through managed care.[b]
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> [a] Kaiser Family Foundation (2011 Sept). *Medicare Advantage Enrollment Market Update*. Retrieved from www.kff.org/medicare/upload/8228.pdf
> [b] The Center for Medicare and Medicaid Services (2010). *Medicaid Managed Care Enrollment Report*. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/2010July1.pdf

Projections indicate that without change, the current health care workforce will not include an appropriate mix of trained professionals — including care managers, pharmacists, and community health workers — to meet the needs of a population with complex needs.[2] To address this gap, the functions associated with care management must be developed and expanded such that providers have the capacity to deliver efficient and effective care for these individuals. With a more targeted application of care management workforce strategies, a robust "care management culture" can permeate an organizationor spread across occupational boundaries, inspiring new ways of performing those functions that support better health outcomes and at lower costs.

What is Workforce Development?

Workforce development with a specific focus on care management aims to build a human capital infrastructure to support care management functions. An effective strategy will weave practices and principles into an organizational vision that builds employee morale and effectiveness in carrying out the organization's mission. Organizational investment in staff who are responsible for care management directly supports the coordination and integration of medical care, community-based services, and long-term services and supports (LTSS) for individuals with complex care needs. This investment, in turn, expands provider capacity to effectively care for complex populations.

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[1] Robert Wood Johnson Foundation (2010 March). *Chronic Care: Making the Case for Ongoing Care*. Retrieved from http://www.rwjf.org/pr/product.jsp?id=56828

[2] Bodenheimer T, Chen E, Bennett HD (2009). Confronting the Growing Burden of Chronic Disease: Can the US Health Care Workforce Do the Job? *Health Affairs*: 28(1): 64-74. Retrieved from http://content.healthaffairs.org/content/28/1/64.full

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Workforce Development in the Management Literature

Management expert Peter Drucker has written that in the modern organization, "training and development must be built into all levels." However, organizational investment in workforce development has declined. A study of U.S. workers found that just 21 percent of the employees surveyed had received any formal training over the previous five years.

Workforce development is defined as "a relatively wide range of activities, policies and programs employed by geographies to create, sustain and retain a viable workforce that can support current and future business and industry."[3] The goals of care management are identified as (1) improving individuals' functional health status, (2) enhancing coordination of care, (3) eliminating duplication of services, and (4) reducing the need for expensive medical services.[4] The care management workforce typically includes health or social services professionals who are responsible for coordinating medical and social support services for individuals with disabilities or complex health needs. Individuals with complex health needs include those who require help with two or more activities of daily living or those with high health needs combined with serious mental illness or with multiple comorbid conditions. Care management functions vary across organization or settings, though it typically includes providing assessments, developing care plans, monitoring health status and health services received, providing education and advocacy, connecting individuals with community supports, and offering general social support (See Table 1).

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[3] Federal Reserve Bank of St. Louis (2011). *What Is Workforce Development?* Retrieved from
   http://www.stlouisfed.org/publications/br/articles/?id=1953
[4] Ibid

Table 1: Care Management Functions

Connecticut Care, Inc.	National Association of Professional Geriatric Care Managers	Florida Geriatric Care Managers Association
• Conduct in-depth assessments • Develop care plans and recommendations • Coordinate services • Act as liaisons to health care providers and insurers • Monitor services to ensure that the individual's unique needs are met • Direct patients to the wide array of available resources • Work closely with family caregivers to identify other community supports	• Assess and monitor patient • Plan and problem-solve • Provide patient education • Advocate for patient • Provide family caregiver coaching • Assist with housing, home care services, medical management, communications, social activities, legal issues, financial issues, safety and security at home • Have extensive knowledge about the costs, quality, and availability of resources in their communities	• Conduct care-planning assessments to identify problems, eligibility for assistance, and need for assistance • Screen, arrange, and monitor in-home help or other services • Review financial, legal, or medical issues and offer referrals to geriatric specialists to avoid future problems and conserve assets • Aid provider crisis intervention • Act as a liaison to families at a distance • Assist with moving an older person to or from a retirement complex, care home, or nursing home • Provide consumer education and advocacy • Offer counseling and support

Sources:

Connecticut Community Care, Inc. (2012). *What Is Care Management?* Retrieved from https://www.ctcommunitycare.org/Content/What_is_Care_Management_.asp; National Association of Professional Geriatric

Care Managers (2012). *What You Need to Know*. Retrieved from http://www.caremanager.org/why-care-management/what-you-should-know/; Florida Geriatric Care Managers Association (2012). *What Is a Care Manager?* Retrieved from http://www.fgcma.org/manager/

Workforce development to support care management will focus on continuous development of skills and competencies underlying these functions and may ultimately contribute to higher staff satisfaction, lower turnover, and better care management. A more knowledgeable and skilled care management workforce may provide exemplar organizations "with a service that can be marketed across the health care system,"[5] which may translate into stronger financials, better patient outcomes, and evidence of better coordinated care.

Why Adopt Workforce Development and Training Strategies?

There is a need for an expanded care management workforce that is capable of caring for individuals with complex care needs in a rapidly changing health care delivery system. The benefits of investing in workforce development include reduced staff turnover, better performance, and more efficient and effective care.

- **Recruiting and retaining a committed workforce:** Staff turnover may be a prevalent and expensive problem. Annual staff turnover among home care agencies can be 60 percent

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[5] National Council of Community Behavioral Healthcare (unknown). *Case Management to Care Management Training*. Retrieved from http://www.integration.samhsa.gov/workforce/Case_Management_to_Care_Management_Training.pdf

or higher.[6] The cost to replace one staff person for a long-term care provider is estimated to be approximately four months' salary.[7] In addition, staff turnover may affect the quality of patient care, especially for consumers who have developed relationships with their caregivers.

> According to James Buchan, staff turnover "may reduce individual and organizational performance through the loss of experienced staff, and by undermining teamwork."

The CHOICE program, offering several managed care plans for complex populations, including a Medicaid Managed Long-Term Care Plan (MLTC) and a Medicare Advantage Plan (MA), weaves care management and staff training into all aspects of the organization through a robust workforce development and training model. As a result of optimal identification of candidates and continuous education and support, staff turnover is low.

- **Improved health outcomes and reduced costs:** Several providers that support care management with training and other development opportunities for their workforce have demonstrated improved outcomes and reductions in health care costs. Although these positive results cannot be directly attributed to the workforce development for care management, the organizational commitment, emphasis on care management, and general culture implied by these investments may contribute to the outcomes.

The Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration at the Massachusetts General Hospital, which involves providing practice-based care management (PBCM) services to high-cost Medicare fee-for-service (FFS) beneficiaries, resulted in improved beneficiary satisfaction, reduced acute care hospitalizations and emergency room (ER) visits, a lower mortality rate, and cost savings due to the decreased hospitalizations and ER visits.[8]

The Guided Care intervention, organized by researchers at The Johns Hopkins School of Medicine, is a care model in which registered nurses (RNs) are trained in care management of individuals with complex care needs. A pilot study of this program found that it "reduced the number of hospital days by 24 percent and insurers' net health care costs by 11 percent for the intervention group, though the differences were not yet statistically significant," during the early stages of the study.[9]

The CHOICE program has reported positive outcomes across several dimensions. A cohort of 573 members enrolled in the CHOICE Special Needs Plan (SNP) for 24 months experienced a 54 percent decrease in hospital admissions, a 24 percent decrease in readmissions within 30 days, and a 27 percent decrease in emergency room visits. Among all CHOICE Medicare Advantage members, the 30-day readmission rate declined by 27 percent from January 2009 through March 2011. Moreover, 96 percent of Medicare Advantage members had an annual primary care visit in 2010, and 95 percent of VNSNY CHOICE managed long-term care members report they are satisfied with the care management, compared to 88 percent of members in all managed long-term care plans in New York State.

[6] Dill J, Cagle J. 2010. Caregiving in a patients' place of residence: Turnover of direct care workers in home care and hospice agencies. *Journal of Health and Aging* 22:713-733.

[7] Even W, Macpherson D. (2007). Employee turnover in the long-term care industry. Retrieved from www.academyhealth.org/files/2007/tuesday/.../MacphersonD.ppt

[8] RTI International on behalf of The Center for Medicare and Medicaid Services (2010 Sept.). *Evaluation of Medicare Care Management High Cost Beneficiaries Demonstration: Massachusetts General Hospital and Massachusetts General Physicians Organization (MGH) – Final Report*. Retrieved from http://www.massgeneral.org/News/assets/pdf/FullFTIreport.pdf

[9] Robert Wood Johnson Foundation (2009 December). *Care Management of Patients with Complex Health Care Needs*. Retrieved from http://www.rwjf.org/files/research/52372caremgt.rpt.revised.pdf

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Context and Considerations

The first step in implementing an appropriate workforce development strategy is to ensure leaders have a shared vision. When considering how to adopt or modify the strategies presented in the Components Section, organizations may find their answers to the following questions helpful:

1. What are we contracted to accomplish for our consumers? (What is our aim?)

   Example: Understand our consumers' unmet needs that may contribute to ineffective or inefficient use of the health care system; work closely with primary care providers to fulfill those needs by extending support into the community and home.

2. What specific population are we serving?

   Example: Nursing home eligible frail elderly in the state of Oregon.

3. What specific outcomes are we hoping to accomplish for our population?

   Example: Lower rates of institutionalization.

4. What is our role in achieving those outcomes for this population?
   Example: To provide care management support that improves consumers' health and quality of life and keeps them in their homes.

5. How do we know that what we are changing will help to achieve those outcomes?

   Example: Track consumer visits, self-reported health status, and utilization of health care services, particularly hospitalizations and ED visits.

6. Who would be the best team members to meet our organization's goals and provide the best outcomes?

   Example: Individuals from the community with skills in patient engagement and an understanding of social services, combined with an ability to communicate with health care professionals.

7. What care management skills and competencies are necessary across all occupational areas?

   Example: Motivational interviewing, cultural sensitivity, care management training, ability to communicate with physicians and care team members.

8. What "soft" skills or competencies are necessary for the staff being hired and retained?

   Example: Emotional intelligence, intellectual approach to understanding others, engagement strategies, critical thinking, problem-solving skills.

9. What are the requirements for accreditation bodies (National Committee for Quality Assurance (NCQA), etc.) and how do they relate to staff recruitment and training?

   Example: NCQA requires verification of licensure for relevant staff.

Components of Workforce Development

Interviews with experts and leaders identified the following components of workforce development that will support care management. Any organization that wants to pursue this strategy, however, will need to consider which ideas to pursue and the way to implement them in the context of its own mission, leadership, vision and culture; business model; organizational structure, skills and processes; and consumer needs. Further, organizations will have different levels of experience with this strategy. Therefore, some of the ideas presented below may already have been explored or implemented. In the following section, potential adoption ideas that require the least infrastructure, resources, and experience to implement are marked with an asterisk (*). Organizations with relatively few resources to invest in workforce development or those just beginning this work may want to focus on the ideas with an asterisk. Organizations looking to advance existing workforce development strategies may want to focus on the unmarked ideas.

Recruitment and Hiring

Developing a system for recruiting and hiring ensures that staff fit with the culture and mission of the organization. It also supports recruiting staff that have the desired traits to meet the needs of the population being served.

Ideas to consider

- **Identify the "soft" skills needed by employees.*** The strongest, highest performing employees are those with a combination of "soft" skill traits and occupational skills and competencies (the ability to perform a task). Essential traits for those working in care management include: adaptability, flexibility, analytical ability, critical thinking, conflict resolution, time management, compassion, problem solving, curiosity, and self-directed learning.

  Community Care of North Carolina (CCNC), a public-private care management organization, looks for care managers who are inherently motivated and take initiative over all aspects of their lives. At CCNC, staff are geographically dispersed and spend much of their time in local communities. To account for this organizational structure, CCNC leaders look for individuals who will be able to thrive without continuous, direct supervision.

- **Implement targeted interview selection techniques (behavioral-based interviewing).*** These techniques can capture candidate characteristics that are inherent in the person and are not necessarily taught.

  CareOregon, a non-profit health plan serving Medicaid and Medicare enrollees, seeks home care workers who have high emotional maturity, good engagement skills, and diverse backgrounds through its behavioral-based targeted selection interviewing techniques.[10]

  VNSNY CHOICE allows job candidates to demonstrate their critical thinking skills and other desired competencies by describing how they would respond to a hypothetical situation.

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[10] The Qualitative Report Volume 14 Number 3 September 2009 454-465. Retrieved from: http://www.nova.edu/ssss/QR/QR14-3/noy.pdf

- **Focus on characteristics and traits in addition to academic training and skills.*** When hiring, it is important that the values and personal traits of a candidate match those of the organization.

  VNSNY CHOICE believes that while many skills can be taught and learned on the job, certain core competencies and traits cannot and these are often more important than clinical skills or credentials when recruiting nurse consultants and clinical evaluation managers.

  At CCNC, care managers play a crucial role in coordinating services for the consumer and facilitating communication and collaboration between members of the care team. Therefore, CCNC needs care managers who are able to critically think about all the factors that may affect a consumer's care and ultimately the outcomes of care. The ideal care manager at CCNC is able to evaluate social, psychosocial, environmental, and economic factors that may affect health care status, and is then able to use this information to initiate an effective plan of care consistent with consumer-centric goals. The care manager also possesses the skills to develop collaborative working relationships with community providers that assist consumers in accessing the care they need.

- **Offer job previewing opportunities.** Job previewing, which is intended to communicate the realities of a job prior to acceptance of an offer, promotes a better match between prospective employees and employers.

  VNSNY CHOICE uses job previewing and offers a "care management 101" open house to prospective employees. It has found that individuals who are attracted to the position through job previewing are often a better fit.

- **Partner with local health professions schools and programs to start an internship program to help recruit and vet potential candidates.**

  VNSNY CHOICE has an established internship program with local nursing schools, in which students are placed at VNSNY CHOICE for one year to gain experience in home care and care management. This internship opportunity also allows for job previewing, thus enabling interns to determine if the job is a good fit.

- **Identify individuals with professional job training who have been out of the job market and want to return.** Many universities, government organizations, and health care organizations have developed programs for nurses wishing to re-enter the workforce. These are offered through a combination of experiential and didactic curriculum over a period of several weeks to several months. These programs could develop potential employees with care management skills.

Orientation

Providing orientation to new staff is an investment that can result in a more productive workforce if conducted in a strategic way that promotes the employee, the consumer and the business goals of the organization. Benefits of effective orientation include faster adoption of workload, lower anxiety and more positive impressions of the organization among employees, fewer burdens on supervisors, and lower staff turnover.

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Ideas to consider

- **Design an orientation program in care management for new employees.***

  VNSNY CHOICE holds a two-week, intensive orientation for all new care management staff. The orientation covers topics such as: telephonic care management, communication with primary care physicians, data systems, care team management, performance improvement, critical thinking, cultural competency, and the VNSNY CHOICE philosophy of care management.

  CCNC sponsors a three-day orientation at its central office for staff hired by the fourteen networks across the state. The orientation includes an entire day devoted to motivational interviewing (MI) — a "collaborative, person-centered form of guiding to elicit and strengthen motivation for change."[11,12] They have found that MI skills are invaluable for those involved in care management to be able to find the balance between being focused on medical issues and being able to "meet people where they are" and speak candidly about cultural, social, spiritual, financial, and other issues that may be affecting an individual's quality of life. The orientation also includes a session on learning to teach principles of chronic disease self-management. Together, these topics are aimed at providing care managers with knowledge and skills to provide effective patient education targeted to the individual needs and goals of each patient. Each network also conducts an orientation focused on local resources and processes.

- **Develop a checklist of critical skills to help employees assess their progress toward mastering these skills.*** Use the checklist as an ongoing way to help trainees see advancement and to identify areas for further training.

  VNSNY CHOICE uses a "checklist of care management experiences" to help the care manager and regional staff development specialist track learning of staff.

- **Develop an "apprenticeship" period that gradually increases autonomy, so that employees continue to progress without feeling overwhelmed.**

  At VNSNY CHOICE, trainees' caseloads are gradually increased after the two-week orientation, and the knowledge obtained during the orientation is reinforced throughout an initial six-month probationary period.

- **Implement a probationary period that allows employers to assess a candidate's fit and aptitude in a job.** The employee and the employer need to have a realistic discussion about whether the employee is likely to have long-term success in a given position. *At the end of an initial three-month and six-month period, new staff are assessed on their fit with VNSNY CHOICE and their progress. VNSNY CHOICE reserves the right to let staff go at multiple points during orientation and training. The staff reporst that when new employees are terminated, the decision is often mutual.*

Training and Continuous Development

Providing opportunities for ongoing training and professional development is integral to developing a strong care management culture. In a rapidly changing health care environment, it is increasingly important to support and cultivate employees. Creating a culture of continuous learning that may include face-to-face and e-learning opportunities, will contribute to consistency

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[11] Rubak S, Sandbæk A, Lauritzen T, Christensen B. Motivational interviewing: a systematic review and meta-analysis. The British journal of general practice 2005;55:305.

[12] Substance Abuse and Mental Health Services Administration (2012). Motivational Interviewing. Retrieved from http://www.samhsa.gov/co-occurring/topics/training/motivational.aspx

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in learning and information for staff, lower staff turnover, and higher staff satisfaction and performance. It is important to distinguish training that is imperative for all staff from optional training. There are many ways to accomplish this, several of which are described below.

Ideas to consider

- **Provide opportunities for employees to gain the skills and competencies necessary to perform in a job or career.*** The first principle for implementing a care management training strategy is to identify the competencies needed by employees across a variety of occupations. Second, use a training program that effectively conveys those skills and competencies to employees and demonstrates knowledge acquisition through a test or demonstration of proficiency.

- **Create interdisciplinary learning groups to build relationships and knowledge among care team members.***

- **Implement case scenario discussions during team meetings or in learning groups.*** Case scenarios are an effective adult learning methodology.

- **Conduct care management "grand rounds" or lunch conferences.***

  VNSNY CHOICE offers formal "clinical education training rounds" every other month for care managers and nurse practitioners at which staff across all regions convenes to learn from one other. There are also weekly interdisciplinary team meetings for learning via member case-based scenarios.

- **Incorporate multiple approaches to training and development to meet staff needs and to engage staff.** Convene all-staff meetings for new programs when everyone needs to learn the same content. Create e-learning resources for less time-sensitive or more established information.

  At Hebrew Senior Life, an elder care provider in Boston, Massachusetts, new programs and training models are introduced as pilots, to allow staff the opportunity to provide feedback and shape the course of the training. Additionally, most training is first disseminated through in-person venues, but later, when the materials and formats are more established, training may be developed into modules available electronically and asynchronously.

  For some topics, CCNC subscribes to The Johns Hopkins University chronic care module, which are available to staff. For other competencies, it hosts its own webinars and trainings on various aspects of chronic disease management. CCNC has found it beneficial to include both well-reputed vendor modules as well as more organic, personalized training modules, where staff can hear from their peers about how to handle complex issues. All CCNC networks recently installed videoconferencing equipment so that educational offerings and workgroup meetings can be conducted via live videoconference, allowing for audience and speaker interaction without requiring participants to travel to the central office. This ultimately enables networks to stay connected with CCNC goals and directives with minimal disruption to staff.

- **Create customized training approaches for staff when possible.**

  At VNSNY CHOICE, staff who require more training in certain competencies or skills are provided with additional opportunities for education in those areas through online modules and supplemental hands-on experience (e.g., shadowing experienced care managers when they are providing in-home care to members).

- **Encourage advanced education through tuition reimbursement or flexible schedules.** It is valuable to identify future knowledge gaps of the current workforce and target staff for further education. This may include partnering with other providers, such as home health agencies or skilled nursing facilities, to help staff obtain a broader skill set.

    At VNSNY, home health aides are supported to complete nursing degrees and transition to care managers.

Mentoring and Modeling

Mentoring is one way to provide more personalized development resources to staff. If mentoring relationships are structured with specific goals and expectations, the benefits of mentor programs may include access to a support system during critical stages of career development; exposure to diverse perspectives and experiences; more direct access to resources within and outside the organization; identification of skill gaps; greater knowledge of career success factors; and a foundation of a lasting professional network. Even loosely structured or informal programs can provide many of these benefits.

Ideas to consider

- **Allow care managers to observe all processes before performing them ("see one, do one"); this includes home-based procedures and assessments.*** For example, new care managers observe an in-home comprehensive assessment or a telephone follow-up before conducting one.

- **Allow frequent opportunities for problem solving with mentors through one-on-one support or team meetings.***

    After completing the orientation at VNSNY CHOICE, staff are assigned to a team and receive partnered one-on-one supervision with a regional staff development specialist. These teams may meet on an as-needed basis to discuss individuals whose conditions have changed or to practice difficult conversations with individuals or family members.

- **Create a mentoring model.** Mentoring does not have to be formal; most employees simply need to know to whom they can go when they have a problem or need support. However, a more formal mentoring program may be beneficial in that it provides recognition and leadership opportunities to high-potential individuals.

Structures and Leadership to Support Care Management Culture

Leadership can establish an organizational structure that supports workforce development for care management. With a consistent approach to training, organizations may see higher efficiency and productivity, staff who are able to perform their job functions more effectively, and behaviors that will contribute to a culture of continuous learning.

Ideas to consider

- **Identify which workforce development and training functions can be centralized versus which must be kept within interdisciplinary teams.***

> *At CCNC, for all new training initiatives, the central office develops a workgroup that includes representatives from each of its 14 networks and then provides resources to develop toolkits, vet and evaluate the new programs, and educate each region locally.*

- **Organize staff into interdisciplinary teams, with a designated manager for each team.** Interdisciplinary teams may include nurses, social workers, rehabilitation specialists, personal care attendants, home health aides, transportation workers, physicians, and others. A care manager may coordinate the services provided by this team.

> *At VNSNY CHOICE, care managers supervise home health aides, which requires knowing their scope of practice, managing the home health aide's plan of care, and ensuring that the plan is carried out successfully. The structure of these teams helps develop and retain talented staff by exposing them to different disciplines and giving them increased responsibility.*

- **Designate certain staff members as "development specialists" or "education managers."**

> *CCNC identifies "champions" in each network for priority projects such as motivational interviewing, telehealth, and behavioral health to foster and facilitate a smooth staff education and implementation process. These champions receive continuous training on the specific topic as well as resources that are needed from the central office to introduce new training initiatives.*

- **Encourage both formal and ad-hoc (as needed) care team meetings to build team capacity, problem solve, and offer support to care managers. Understand the population served and their needs. Build an environment that supports a flexible team structure.** Use the questions in the previous Considerations section to think through the needs of the population served and the best structures to meet those needs.

> *At VNSNY CHOICE, CCNC, CareOregon, and PACE programs, care management is a team function that involves accessing and leveraging other disciplines (i.e., social workers, rehabilitation specialists) and arranging team case conferences as needed with additional staff, family members, and physicians.*

> *CCNC networks employ multidisciplinary teams that may include nurse care managers, social workers, pharmacists, medical directors, psychiatrists, behavioral health coordinators, disease management champions, palliative care coordinators, data experts, and support staff. These interdisciplinary teams collaborate with community agencies to facilitate coordinated care without duplication of services. The networks have developed a process for interdisciplinary case conferencing on their highest need clients.*

Leadership and Culture

Upon examining exemplar organizations and seeking best practices for care management workforce development, "culture" emerged repeatedly as a critical factor for success. Indeed, culture — defined as the norms, attitudes, and beliefs held among a group of people — is vital, but it is often difficult to describe In the case of workforce development, leaders can identify, model, and sustain vital behaviors. Additionally, leaders can link the vision of an ideal culture to a strategic assessment. For example, in preparing proactively for the changing demographic and workforce needs, new business models, additional paraprofessional roles, and creative ways to integrate with the needs of the community they serve may emerge.

Ideas to consider

- **Create focus and discipline around a strategy for workforce development.*** Scan the internal and external environment to keep strategies up-to-date.

  At VNSNY CHOICE, leadership regularly communicates strategic goals and objectives with staff at all levels and make staff aware of the opportunities to develop and move up the career ladder.

- **Strive to reflect the diversity of the community in the employee population across all levels of the organization.***

  Leaders at VNSNY CHOICE strive for their care management staff to reflect the diversity of the community they serve. Having staff represent the community helps to promote cultural sensitivity.

- **Role-model clear values.*** Model those behaviors that ensure a culture of respect for care managers and respect for consumers. In successful organizations, everyone knows from first-hand experience (e.g., via coaching) what leaders believe, how they behave individually and collectively, and what they expect in terms of organizational cultural norms.

- **Develop and share the business case for staff development.** Calculate the cost of staff turnover and staff training for your organization to understand and allocate resources to staff retention.

- **Determine the "vital behaviors" needed to achieve a culture of continuous learning.** Culture can take time to evolve, but identifying key behaviors that all employees are held to and then enforcing those behaviors can be the first step toward changing the culture. Examples of vital behaviors to reflect culture might include the following: leaders attend interdisciplinary team meetings once a week; leaders accompany a care manager on a home visit once a month; or the CEO always attends orientation sessions for new staff to personally welcome them to the organization. Vital behaviors often center on the important principle that leaders should retain close ties to the delivery of care or the core services that the organization provides.

Tools and Resources

This section of the document compiles tools and resources that may be valuable to organizations implementing this strategy. These include recruiting and hiring tools, orientation and training tools for care management staff, continuous training and development tools for care management staff, mentoring and modeling tools, and culture change tools.

Recruiting and Hiring Tools

Provided below are examples of care management recruiting and hiring tools. These include job descriptions, targeted interview guides, and sample advertisements. For instance, organizations looking to recruit and hire new care management staff may use the job descriptions and advertisements as a resource in developing their own job descriptions and advertisements. The job descriptions may also capture the many variations in job titles and responsibilities.

Job Listing: Case Manager

This Case Manager listing from CareMore, which includes the job description, job responsibilities, and required education and experience, can be used by managed care organizations and other organizations with care management functions as a resource in developing their own job descriptions, including skill and education requirements.

Appendix

Job Listing: Nurse Consultant

This Nurse Consultant job listing from Visiting Nurse Service of New York, which includes the purpose of position, responsibilities, competencies, and qualifications (licensure, education, and experience), can be used by managed care organizations and other organizations with care management functions as a resource in developing their own job descriptions, including skill and education requirements.

Appendix

Job Listing: Vocational Field Case Manager

This Vocational Field Case Manager job listing from Integrated Care Management, which includes the goal of position, job description, required experience and knowledge (including specific problem solving skills), and job responsibilities, can be used by managed care organizations and other organizations with care management functions as a resource in developing their own job descriptions, including skill and education requirements.

Appendix

Realistic Job Preview Tool Kit: A How-To Guide for Developing a Realistic Job Preview

This Realistic Job Review Tool Kit, developed by CPS Human Resource Services, helps organizations address problems of early turnover through job previewing. It can be used by any organization or human resources group looking to reduce early turnover, though in the context of workforce development for care management, it may be used by managed care organizations and

other organizations with care management functions when designing and implementing their own job previewing programs.

www.cps.ca.gov/workforceplanning/documents/ToolKitRJP.pdf

Targeted Selection Guide

This Targeted Selection Guide, developed by Pacific University Oregon, can be used by managed care organizations or other organizations with care management functions to best capture candidate characteristics that are inherent in the person and are not necessarily taught, when interviewing and selecting the "best" job candidates.

http://www.pacificu.edu/offices/hr/training/interview/pdfs/TargetedSelection.pdf

Orientation and Training Tools

Provided below are examples of care management training curricula, modules, and agendas, in addition to general tips, to be used as resources when designing the schedule and content of a structured, organizational care management training program. These are not intended to be recommended curricula or suggested best practices, but rather, may serve to inform the development of an organization's orientation and training content.

Care Transitions Program - Training Options

This Care Transitions Program Training Options resource, developed by the Care Transitions Program, offers a menu of training options through a web-based portal, in addition to a one-day intensive, interactive, case-based training session. It can be used by managed care organizations and organizations with care management staff looking for external training options for employees, or as a model in designing their own care transitions training programs.

http://www.caretransitions.org/training.asp

Complex Care Manager Recruiting and Training Tips

This Complex Care Manager Recruiting and Training Tips document, developed by the California Quality Collaborative, can be used by managed care organizations and organizations with care management staff when designing the schedule and content of a structured, organizational care management training program. This is not intended to be recommended curriculums or suggested best practices, but rather, may serve to inform the development of an organization's orientation and training content.

http://www.calquality.org/programs/clinicalcare/meteor/documents/3.2.1CareManagerRecruitingTrainingTips.pdf

Guided Care Models

This Guided Care Models resource, developed by Johns Hopkins University, provides a wealth of resources regarding a care model in which RNs are trained in care management of individuals with complex care need; this model has yielded successes in reducing unnecessary health care utilization, accordingly to a pilot study. This model and the associated materials may be used by managed care organizations and organizations with care management staff to develop and implement a new model of care management training.

http://www.guidedcare.org/

Integrated Case Management Training Curriculum

This Integrated Case Management Training Curriculum, developed by the Case Management Society of America, can be used by managed care organizations and other organizations with care management staff when designing the schedule and content of a structured, organizational care management training program. This is not intended to be recommended curriculums or suggested best practices, but rather, may serve to inform the development of an organization's orientation and training content.

http://www.cmsa.org/Individual/IntegratedCMTraining/tabid/380/Default.aspx

Mary Naylor Transitional Care Model

This Mary Naylor Transitional Care Model, developed by Transitional Care Model, can be used by managed care organizations and other organizations with care management staff when designing care coordination training programs and processes for their care management staff.

http://www.transitionalcare.info/

Provider Network Education Recommendations (Education and Training Program for Integrated Care Management)

This Provider Network Education Recommendation source (an education and training program for integrated care management), developed by the Aging and Independence Services of the County of San Diego, can be used by managed care organizations and organizations with care management staff when designing the schedule and content of a structured, organizational care management training program. This is not intended to be recommended curriculums or suggested best practices, but rather, may serve to inform the development of an organization's orientation and training content.

Link

Two-Day Care Manager Training Program

This Two-Day Care Manager Training Program, developed by Alzheimer's Coordinated Care for San Diego Seniors (ACCESS), can be used by managed care organizations or organizations with care management staff as a resource when designing the schedule and content of a structured, organizational care management training program. This is not intended to be recommended curriculums or suggested best practices, but rather, may serve to inform the development of an organization's orientation and training content.

http://www.adc.ucla.edu/access/cmtools/Care_Mgr_Educ_and_Training_Prgm.pdf

Continuous Training and Development Tools

As noted in this guide, providing opportunities for ongoing training and professional development is integral to developing strong management culture. While organizations may wish to encourage their care management staff to pursue educational certificates in care management, the content of the courses and programs noted in below may also be useful to organizations that are developing their own internal programs and courses.

Boston University School of Social Work: Care Management Certificate

This Care Management Certificate Program, developed by Boston University, provides participants with an understanding of the core functions and responsibilities of care management and care coordination, an introduction to care transitions, and a review of the resources available to support care in the community. Some care management organizations may wish to encourage their care management staff to pursue such educational certificates in care management, while other organizations may draw upon the content of this course to develop their own internal programs and courses.

http://www.bu.edu/igsw/online-training-programs/certificate-programs/care-management/

Building the Bottom Line by Developing the Frontline: Career Development for Service Employees

This case study on Career Development for Service Employees, developed by Donald Jackson and Nancy Sirianni and published within the Harvard Business Review, is intended to serve as a conceptual model for care management organizations and managers in evaluating their own career development efforts. It also provides a framework for connecting often compartmentalized areas of career development, from which organizations can re-frame their own organizational approaches to career development.

http://hbr.org/product/building-the-bottom-line-by-developing-the-frontli/an/BH331-PDF-ENG?N=4294841677

Developing Employees: Harvard ManageMentor Online Module

This Online Module for Developing Employees, developed by Harvard ManageMentor, may be used by managed care organizations looking for strategies to address employees' developmental needs, including "strategies for maximizing return on management, growing competent employees, and keeping star performers motivated."

http://hbr.org/product/developing-employees-harvard-managementor-online-m/an/6789K-HTM-ENG?Ntt=employee%2520development

Employee Development: Survey Report

This Employee Development Survey Report, a study by the Society for Human Resource Management and Catalyst, may be used by care management organizations and their human resources department to better understand "employee development methods and their effectiveness in grooming future leaders and strengthening workforce talent." Organizations may also use this report to improve the diversity of their workforce leadership, including improved development for women and racial/ethnic minorities.

http://www.shrm.org/research/surveyfindings/documents/employee%20development%20survey%20report%20-%20%20a%20study%20by%20shrm%20and%20catalyst.pdf

University of Massachusetts Medical School: Training Program for Care Managers and Navigators

This Training Program for Care Managers and Navigators resource, developed by the University of Massachusetts Medical School, includes an overview of the certificate program, an outline of training session topics, and the curriculum by module. Some care management organizations may wish to encourage their care management staff to participate in the training program, while other organizations may draw upon the content of this program to develop their own internal programs and courses.

http://www.umassmed.edu/Content.aspx?id=144780&linkidentifier=id&itemid=144780

http://www.umassmed.edu/uploadedFiles/fmch/CIPC/Care%20Managers_Navigators%20and%20application%5b1%5d.pdf

Visiting Nurse Service of New York: Continuing Education Courses

This list of Continuing Education Courses, which have been developed by the Visiting Nurse Service of New York, includes a list of upcoming and past continuing education courses provided by the VNSNY, such as "Care Management: Transitioning from Clinical Nurse to Case Manager." Some care management organizations may wish to encourage their care management staff to enroll in the courses, while other organizations may draw upon the content of this program to develop their own internal programs and courses.

http://www.vnsny.org/careers/continuing-education-courses/

Mentoring and Modeling Tools

Mentoring is one way to provide additional, more personalized development benefits and resources to staff that are not typically offered in a formal orientation and training program. This section outlines tools and resources that may prove helpful to organizations implementing a mentor program.

Best Practices: Mentoring

This Mentoring Best Practices guide, developed by the US Office of Personnel Management, may be used by managed care organizations, or any workplace, to develop a workplace mentoring program. Developing structured mentoring relationships with specific goals and expectations can aid organizations in providing their workforce with: access to a support system during critical stages of career development; exposure to diverse perspectives and experiences; more direct access to resources within and outside the organization; identification of skill gaps; greater knowledge of career success factors; and a foundation of a lasting professional network.

http://www.opm.gov/hrd/lead/BestPractices-Mentoring.pdf

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Culture Development Tools

Instilling a culture of continuous learning and support for care management staff is central to successfully developing a care management workforce. This involves changing attitudes, norms, and beliefs. Approaches and strategies for doing so, however, may be difficult to develop and are not successful over night. While this document provides discussion on how to implement this piece of the adoption strategy, the list below provides some specific resources for developing organizational culture. For instance, one strategy is to develop and share the business case for staff development, which may include calculating the cost of staff turnover. Thus, Turnover Calculators are provided.

Assessing the Direct Costs of RN Turnover

This report discussing the Direct Costs of RN Turnover, developed by The Lewin Group on behalf of the RWJF, can be used by care management organizations and other organizations with care management staff as a resource when determining the various components that contribute to the cost of staff turnover, particularly for nursing staff.

http://www.rwjf.org/files/research/revlewinevalrnturnover.pdf

Turnover Calculator: Achieving Excellence in America's Nursing Home

This Turnover Calculator, developed by Achieving Excellence in America's Nursing Home, can be used as a model by managed care organizations and other organizations with nursing and/or care management staff to monitor staff turnover and in turn, develop action plans to improve staff retention.

Appendix

Turnover Calculator: Fazzi Associates

This Turnover Calculator, developed by Fazzi Associates, can be used by managed care organizations and other organizations with nursing and/or care management staff to calculate the specific costs of staff turnover.

http://www.fazzi.com/tl_files/pages/research-and-resources/QWL08.pdf

Workforce Development Return on Investment Framework and Tool

This Workforce Development Return on Investment Framework and Tool, developed by Corporate Voices for Working Families within its Why Companies Invest in "Grow Your Own" Talent Development Models, can be used by care management organizations to calculate the return of investment (ROI) regarding organizational hiring, training, and workforce investment practices.

http://www.corporatevoices.org/system/files/CVWF-ROI-Report-revisedNov28.pdf

Acknowledgements

The Lewin Group is a premier national health and human services consulting firm with more than 40 years of experience delivering objective analyses and strategic counsel to public agencies, non-profit organizations, and private companies across the US. We support our clients with policy research and data analysis on Medicare, Medicaid and CHIP, health care financing, strategic workforce planning, health program evaluation, comparative effectiveness research and other important areas of the public health policy arena.

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization that works with health care providers and leaders throughout the world to achieve safe and effective health care. IHI focuses on motivating and building the will for change, identifying and testing new models of care in partnership with both patients and health care professionals, and ensuring the broadest possible adoption of best practices and effective innovations. Based in Cambridge, Massachusetts, IHI mobilizes teams, organizations, and increasingly nations, through its staff of more than 100 people and partnerships with hundreds of faculty around the world.

Reviewer(s):

- Adam Burrows, MD, Medical Director, Upham's Elder Service Plan

Contributors:

- Claudia Beck, NP, Director, Clinical Services, Visiting Nurse Service of New York (VNSNY) CHOICE Health Plans
- Richard Bernstein, MD, Medical Director, VNSNY CHOICE Health Plans
- Mason Bishop, MPA, PhD, Principal, WorkED Consulting
- Jennie Chin Hansen, MS, Chief Executive Officer, American Geriatrics Society
- Mary Ann Christopher, MSN, RN, FAAN, Chief Executive Officer, VNSNY
- Jane Clay, Quality Improvement Specialist, Community Care of North Carolina
- Jennifer Cockerham, RN, BSN, CDE, Chronic Care Coordinator, Community Care of North Carolina
- Regina Hawkey, RN, Senior Vice President, Clinical Operations, VNSNY CHOICE Health Plans
- Amelia Mahan, Behavioral Health State Coordinator, Community Care of North Carolina
- David Labby, MD, Medical Director, CareOregon
- Denise Levis Hewson, RN, BSN, MSPH, Director of Clinical Programs and Quality Improvement, Community Care of North Carolina
- Jay Luxenberg, MD, Chief Medical Officer, On Lok Senior Health Services
- Mary Jane Koren, MD, MPH, Vice President, The Commonwealth Fund
- Christopher Palmieri, MHSA, President, VNSNY CHOICE Health Plans
- Warren Wong, MD, FACP, Physician Lead for Medicare Strategy, Kaiser Permanente

Appendix

- CareMore Job Listing: Case Manager
- Integrated Care Management Job Listing
- VNSNY Job Listing
- Achieving Excellence in America's Nursing Homes: Turnover Calculator

CareMore Job Listing: Case Manager

Job Description:

The Case Manager collaborates in a patient care process to assess, plan, implement, coordinate, monitor, and evaluate options and services to meet member's health needs. The goal of the Case Manager is to utilize available resources to provide quality, cost effective care using selective benefits and alternative services best suited for the member while ensuring optimal outcomes.

Responsibilities Include:

- Develops and implements a comprehensive clinical case management plan for each patient.
  - Obtains input from all providers, including the Primary Care Physician (PCP), the patient and the family as appropriate.
  - The plan is periodically evaluated by RN staff and revised as needed.
- Analyzes patient variances from the plan and initiates the appropriate steps to resolve those variances.
- Performs admission and concurrent stay reviews daily on assigned hospitalized patients.
  - Uses established criteria to ensure placement at the appropriate level of care.
- Develops and implements discharge planning for patients in conjunction with Hospitalists and hospital-based Case Managers.
  - Facilitates the transfer or discharge from the acute care setting to a lower level of care.
  - Obtains appropriate "Notice of Non-Coverage."
- Performs telephonic, fax and/or on-site reviews with skilled nursing facilities, home health agencies, or other contracted service agencies as appropriate to determine need for continued care.
- Uses effective negotiation skills to obtain the resources necessary to achieve preferred outcomes.
- Provides communication and leadership to the care team in order to facilitate maximum patient outcomes.
- In conjunction with the physician and Case Management Nurse Extender, the Case Manager applies financial information in planning cost-effective care without compromising the quality of patient care.
- Advises the Medical Director promptly of level of care and patient needs.
- Identifies and monitors patients utilizing the following services: SNF, HH, DME, IV Therapy, and communicates information to the Physician.
- Maintains accurate database of patient activity.
- Collects and inputs data to support claims review process.
- Accurately reports bed days, home health hospice, and DME.
- Keeps accurate accounts of all institutionalized patients.

CareMore Job Listing: Case Manager (Continued)

Education and Experience:

- Current Registered Nurse or LVN license in the state for which you are applying.

- Must have at least two years of experience in acute hospital care, preferably in the discharge planning or medical review areas.

- Utilization Review/Case Management experience in a hospital and/or medical group setting is desirable.

- Knowledge of managed care (HMO, PPO, POS, etc.) is preferred.

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Integrated Care Management Job Listing: Vocational Field Case Manager

Goal of Position:

Provide a collaborative process to assess, plan, implement, coordinate, monitor, and evaluate options and services to meet the individual medical and vocational needs through communication with the patient, their medical providers, employer, and carrier as needed to promote quality, cost-effective outcomes.

Job Description:

- Provide Case Management services to various individuals, in various settings. These services include ensuring communications and coordinating benefits at the onset of injury/illness. The Case Manager must ensure that patients will receive adequate and timely support to ensure quality diagnoses and treatment plans; patient conformance with treatment plans; satisfactory rate of recovery; and, when applicable, return to work on undefined or accommodated duty as therapeutically indicated.

- Interject objectivity and information where it may be lacking to maximize efficiency in utilization of available resources.

- Promote cooperation between multi-disciplinarians in various settings to work collaboratively during different phases of the person's illness.

Knowledge:

- Experience communicating with patients, employers, medical professionals, carriers, legal professionals, and supervisors.

- Ability to form and maintain working relationships with accounts, employers, patients, health care professionals, vendors, legal professionals, and community medical team.

- Working knowledge of SSDI, rehabilitation, disability (STD & LTD), medical and workers' compensation benefits.

- Formal knowledge of medical/rehabilitation case management as manifested by a degree (or acceptable equivalent) as a Rehabilitation Counselor with a CRC and/or Registered Nurse, with a CCM (the following may be considered COHN, CRRN, or CDMS), as well as two years of experience in Field Case Management.

- Aptitude to create and follow administration, communication, and information systems.

- Solid computer literacy.

Integrated Care Management Job Listing: Vocational Field Case Manager (Continued)

Problem Solving:

- Ability to formulate clinical decisions within limits of training and experience.

- Ability to involve and correctly use clinical judgments outside limits of training and experience.

- Recognize deviations from adequate clinical quality and utilize resources to develop adequate plan for correcting quality.

Job Responsibilities:

Use case management skills to help coordinate the patient's individual treatment plan while maximizing cost containment.

- Educate the patient on his/her injury/disability and the treatment plan established by Physician. Explain Physician's and Therapist's instructions and answer additional questions the patient may have to facilitate his/her return to work.

- Work with Physicians and other treatment providers to coordinate an overall treatment plan to ensure cost containment and best medical care while meeting state and other regulatory guidelines.

- Research and assess alternative treatment programs such as pain clinics, home health care, work hardening as well as coordinate with possible Wellness Program.

- Work with employer to identify and develop transitional/modified duty based on medical limitations and patient's functional abilities as outlined by treating Physician. Assist in development of transitional work programs, where able, in effort to return patient to work per Physician direction.

- Provide expert testimony on litigated cases as needed.

- Coordinate patient's appointments and arranges services to assist with compliance (i.e., Transportation/Translation) when directed by account.

- In the event that the patient is unable to return to work with modifications, Case Manager will coordinate the patient's vocational rehabilitation to prepare him/her for suitable reentry into the workplace based on independent, professional decision making skills.

- Additional duties as assigned.

Visiting Nurse Service of New York (VNSNY)
Job Listing: Nurse Consultant

Purpose of Position:

Provides care management through a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's health needs through communication and available resources, while promoting quality cost-effective outcomes. Maintains members in the most independent living situation possible; ensures consistent care along entire health care continuum by assessing and closely monitoring members' needs and status. Provides nursing services and authorizes/coordinates services within a capitated managed care system. Closely communicates and collaborates with primary care practitioners, interdisciplinary team, and family members. Works under general supervision.

Responsibilities:

- Assesses, plans, and provides intensive and continuous care management across acute, home, and long-term care settings. Develops and negotiates care plans with members, families, and physicians.
- Assesses a person's living condition/situation, cultural influences, and functioning to identify an individual's needs; develops a comprehensive care plan that addresses those needs.
- Assesses an enrollee's eligibility for Program services based on his/her health, medical, financial, legal and psychosocial status, initially and on an ongoing basis.
- Plans specific objectives, goals and actions designed to meet the member's needs as identified in the assessment process that are action-oriented, time-specific, and cost effective.
- Implements specific care management activities and or interventions that lead to accomplishing the goals set forth in the plan of care.
- Consults with and educates members and their families on the disease process, self-care techniques and prevention strategies.
- Coordinates, facilitates, and arranges for long-term care services in the home and community-based sites, such as adult day care, nursing homes, rehab facilities, etc. Provides or arranges for ongoing nursing care, service authorization, and periodic assessment.
- Collaborates and negotiates with interdisciplinary teams, other health care providers, family members, and third party payors, as applicable, across all health settings to ensure optimum delivery and coordination of services to members.
- Monitors care management activities, services, and members' responses to interventions, to determine the effectiveness of the plan of care and the utilization of services.
- Evaluates the effectiveness of the plan of care in reaching desired outcomes and goals; makes modifications or changes in the plan of care as needed.
- Identifies trends and needs of groups in the community and plans interventions based on these identified needs.
- Provides care management services across sites and collaborates with appropriate facility discharge planner and/or HCC when members are transitioned between settings.
- Manages expenditures to ensure effective use of covered services within a capitated rate. Fiscally responsible in providing services based on members' needs.
- Assists patients with activities of daily living, which may require positioning, moving, transferring and lifting patients of varying weights and physical conditions, with and without assistance and as appropriate, from family members and/or paraprofessionals.

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Visiting Nurse Service of New York (VNSNY)
Job Listing: Nurse Consultant (continued)

Responsibilities (continued):

- Travels to patients' homes and/or other facilities with varying environments (e.g., elevated buildings, walk-ups, care facilities, single/multiple family homes, presence of pets, etc.) using approved transportation options to deliver direct care to the patient.
- Transports and utilizes required medical equipment and supplies using VNSNY designated/supplied carrying case (weighing approximately 25 to 30 lbs.) to and from patient homes/care facilities, VNSNY offices, and other locations.
- Provides nursing care in accordance with Agency policies, practices, procedures and Standards of Nursing Practice, which may require standing, stooping, sitting, crouching, bending, and stretching to deliver patient care.
- Participates in outreach activities to promote knowledge of the Program and its services and to coordinate Program activities with outside community agencies and health care providers (e.g., community health screening, In Services).
- Participates in the development of programs to meet the specialized needs of this selected patient population.
- Documents services in accordance with VNSNY CHOICE Community Care standards and Managed Long Term Care (MLTC) and Licensed Home Care Services Agency (LHCSA) regulations.
- Participates in special projects and performs other duties as requested.

Competencies:

- Accountable/Results-Oriented
- Adaptability/Flexibility
- Business Acumen
- Communications (written and oral)
- Customer Focus
- Initiative/Innovation
- Interpersonal Effectiveness
- Problem Solving
- Teamwork and Collaboration

Qualifications:

- *Licensure:* License and current registration to practice as a registered professional nurse in New York State required. Valid driver's license may be required, as determined by operational/regional needs.
- *Education:* Associates Degree in Nursing from an approved program, OR, Nursing diploma from a registered/licensed program by New York State Education Department (Department), or approved by another States' licensing authority, OR, Graduate of two year nursing program approved by the licensing department of another country and acceptable to the Department required. Bachelor's Degree in nursing or equivalent experience in geriatric care or care of the elderly preferred. Case Management Certification preferred.
- *Experience:* Minimum of one year RN experience required. Clinical expertise in geriatrics preferred. Long-term care experience preferred. Managed care experience preferred. Bilingual skills may be required, as determined by operational needs required.

Achieving Excellence in America's Nursing Homes

Monitoring Nursing Staff (RN, LPN/LVN, CNA) Turnover

CAMPAIGN GOAL #7: Measure staff turnover and develop action plans to improve staff retention.

NOTE: Campaign Goal #7 requires that annual turnover numerators and denominators be entered on campaign website for years 2007 & 2008.

www.NHQualityCampaign.org

Facility Name: **Provider Number (6-digit):**

Month & Year [A]	Number of Nursing Staff Employed on the First Day of Each Month [B]	Number of Nursing Staff Terminated by the Last Day of Each Month [C]	Turnover Rate Per Month	Cumulative Terminations Year-to-Date	Average Number of Nursing Staff Employed Year-to-Date	Annualized Turnover Rate Year-to-Date

Total # of Data Collection Months [MONTHS to be entered on website]
Total # of Nursing Staff Terminations During the Months [NUMERATOR to be entered on website]
Average # of Nursing Staff During the Months [DENOMINATOR to be entered on website]
Annualized Turnover Rate

Year 1 [Click to go to website for data entry.]

Month & Year [A]	Number of Nursing Staff Employed on the First Day of Each Month [B]	Number of Nursing Staff Terminated by the Last Day of Each Month [C]	Turnover Rate Per Month	Cumulative Terminations Year-to-Date	Average Number of Nursing Staff Employed Year-to-Date	Annualized Turnover Rate Year-to-Date

Total # of Data Collection Months [MONTHS to be entered on website]
Total # of Nursing Staff Terminations During the Months [NUMERATOR to be entered on website]
Average # of Nursing Staff During the Months [DENOMINATOR to be entered on website]
Annualized Turnover Rate

Year 2 [Click to go to website for data entry.]

Month & Year [A]	Number of Nursing Staff Employed on the First Day of Each Month [B]	Number of Nursing Staff Terminated by the Last Day of Each Month [C]	Turnover Rate Per Month	Cumulative Terminations Year-to-Date	Average Number of Nursing Staff Employed Year-to-Date	Annualized Turnover Rate Year-to-Date

Total # of Data Collection Months [MONTHS to be entered on website]
Total # of Nursing Staff Terminations During the Months [NUMERATOR to be entered on website]
Average # of Nursing Staff During the Months [DENOMINATOR to be entered on website]
Annualized Turnover Rate

Year 3

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