FY 2022 PERFORMANCE PLAN

Nursing Case Management (NCM)	ADSD/CSCB	Fiona Elad x1715

Program Purpose	Improve and maintain the health status of adults with multiple chronic illnesses and/or disabilities, so they may successfully age in place at home.

Program Information	**Nursing Case Management (NCM)**
	• The NCM Program serves Arlington residents 60 years old or older with multiple chronic illnesses and adults aged 18 to 59 with a permanent disability; all of whom require assistance managing health care needs yet lack a sufficient support system.
	• Core services are provided primarily in client homes weekly to monthly and include:
	  ○ Initiating and updating care plans focused on individual needs
	  ○ Assessing and monitoring health status and care needs
	  ○ Educating clients about health and wellness
	  ○ Pre-pouring medications if pharmacy bubble-packing is not available
	  ○ Referring to and coordinating with other providers and services
	• Additional services include pre-admission screenings for nursing home level services to include placement or community-based care and assessing clients for in-home services.
	• The Nursing Case Management Program is the only program of its kind in Virginia. It is primarily locally funded. Revenue is generated from state reimbursements for Medicaid Waiver screenings for nursing home level services that are completed in collaboration with the Adult Service Program.
	
	Community Living Program (CLP)
	• The CLP provides personal care services, help with household tasks, and supportive services to eligible county residents who are aged 60 and over or adults aged 18 to 59 who live with physical or cognitive disabilities.
	• Two contracted vendors, both licensed home health agencies, provide the services in client's homes. The second vendor was introduced in February 2019.
	• To be eligible for CLP one must live in Arlington in an independent setting (i.e., home or apartment), have a physical or cognitive disability that makes it difficult to complete home and self-care tasks, are homebound or have great difficulty and require assistance to leave the home, and are willing to participate and follow program guidelines.
	• Program Revenues are 90% local funds and 10% state and federal funds.

Service Delivery Method	• In FY 2022 NCM continued to operate as an essential service, and prioritized home visits and appointments for clients with the most acute needs and limited supports. Nurses adjusted the frequency of home visits based on health metrics and CDC guidelines. • CLP utilized a hybrid model of in-person and virtual assessments for new clients, increasing in-person assessments as health metrics improved. Our contracted home care vendors continued to provide in-person services for clients in the community, unless the client requested to be placed on hold. • The goal is for a 100% in-person service delivery model in FY 2023.
PM1: How much did we do?	
Staff	Total 6.5 FTEs: NCM and CLP

- **NCM 5.0 FTEs**
  - 4.5 FTE Nurses
  - 0.50 FTE Manager
- **CLP 1.50 FTEs**
  - 0.50 FTE Nurse
  - 0.50 FTE Manager
  - 0.50 FTE Human Services Clinician II

Customers and Service Data

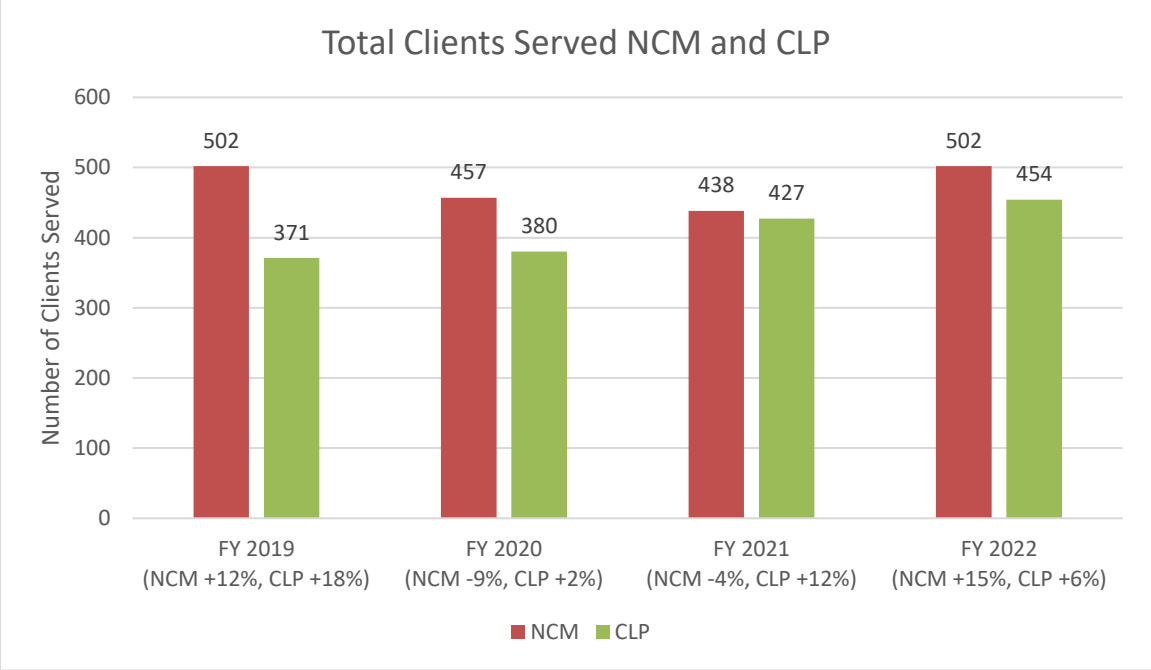
	FY 2019	FY 2020	FY 2021	FY 2022
Total NCM Clients Served	502	457	438	502
Ongoing Services Clients	79	77	94	92
Clients receiving NCM/CLP intake assessments or consultations	190	192	139	173
Clients screened for nursing home level care	233	188	211	237
All NCM Client Services Contacts	5,104	6,795	5,802	5,425
Total CLP Clients Served	371	380	427	454

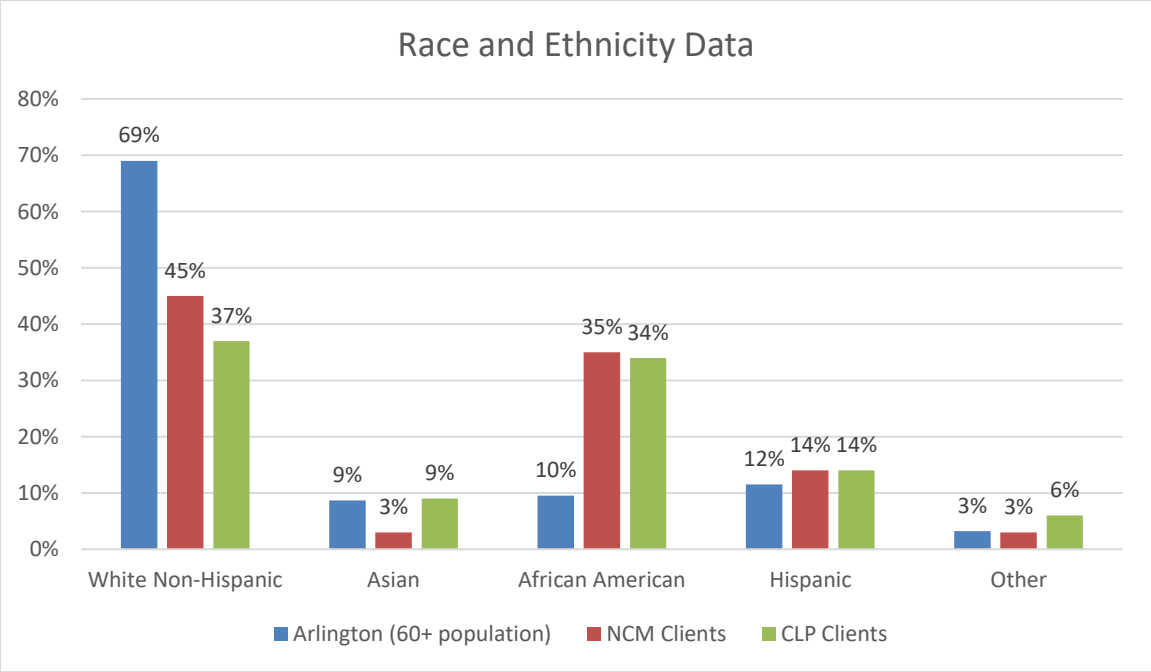
PM2: How well did we do it?	
2.1	NCM caseload Size
2.2	Customer Satisfaction with CLP vendor services
PM3: Is anyone better off?	
3.1	NCM clients who have improved or maintained their health status in the last year: (A) Blood Pressure (BP) for clients with high blood pressure diagnosis; and (B) Medication adherence for clients who have medication pre-poured
3.2	Clients maintained in the community

Nursing Case Management

Measure	1	Customers and Service Data

Data





Clients by Age	Under 60	60-69	70 and Over	Avg Age
NCM	18%	38%	44%	74
CLP	14%	18%	68%	78

Data Summary	• Both NCM and CLP saw an increase in the number of individuals served. There was a 15% increase in the number of individuals served by NCM, from 438 to 502. • CLP saw a 6% increase in the number of clients served, from 427 clients in FY 2021 to 454 in FY 2022. • Both NCM and CLP served higher rates of individuals of color compared to the total population of older adults age 60+ in Arlington. This is most prominent for older adults who identify as African American, where the proportion served is three times higher than the proportion of African Americans 60+ in Arlington. • Most of the clients served by NCM are individuals of color, at 52% of total clients served (the number of White non-Hispanic individuals served increased from 35% in FY 2021 to 45% in FY 2022). • Most clients served (57%) by CLP in FY 2022 were individuals of color with no significant changes in the rates seen in FY 2021. There was a slight decline in the percentage of Hispanic clients from 19% to 14%.

What is the story behind the data?

- Most (75% NCM, 74% CLP) clients live alone. The majority (65% NCM, 61% CLP) have incomes below the Federal Poverty Level. Fifty-eight percent of NCM clients are diagnosed with mental illness.
- For NCM: the program provided ongoing services to 92 unique clients and provided 5,425 contacts. There was a 6% drop in the number of contacts from the previous fiscal year, as NCM experienced an unfilled vacancy for much of the fiscal year. A new registered nurse (RN) started in February 2022, then another RN left the County at the end of March 2022. The program was only fully staffed for one month during the fiscal year.
- Total referrals to NCM continued to remain low throughout the fiscal year with a slight increase in new referrals noted in Q4. The increase in NCM clients served was the result of an increase in CLP referrals, for which NCM staff conducted the initial assessment.
- Both programs worked on updating informational materials for outreach. This was started in Q2 of FY 2022 with the update of NCM program brochure. The update of the CLP program brochure was pending a policy revision that was completed in Q4.
- CLP served 454 clients in total, providing 58,194 aide hours for FY 2022. Having a dedicated and highly skilled Assessment Coordinator helped to increase the number of clients that were assessed and served.
- Due to the current healthcare staffing shortage that is due in part to the pandemic, the CLP vendors experience significant difficulty staffing cases. In Q3, a contract amendment allowing for the use of Personal Care Attendants helped to shorten the time to staff cases and initiate services, but more clients could potentially be served with an increase in staffing.
- The number of screenings for the State Medicaid services increased significantly from the previous fiscal year with 237 completed screenings in this FY compared to 188 in FY 2021.

Recommendations	Target Dates
• Update informational and outreach materials for CLP and share with key community partners such as healthcare providers, physician offices, BHD and faith communities. • Continue to partner with ADSD outreach team to promote services at health fairs, wellness events and community engagements.	• FY 2023 Q2 • Ongoing

• Evaluate current program trends to determine creative solutions to support the CLP program and supplemental services provided by CLP vendors. • Incorporate planned CSCB Referral Tool to include aspects of the Physical Activity Vital Sign Mental Health Wellness screening tool, or Accountable Health Communities Screening tool to assess Social Determinants of Health across core domains. The Team began to explore the use of these tools in FY 2022 Q4.	• Q4 FY 2023 • Q2 FY 2023

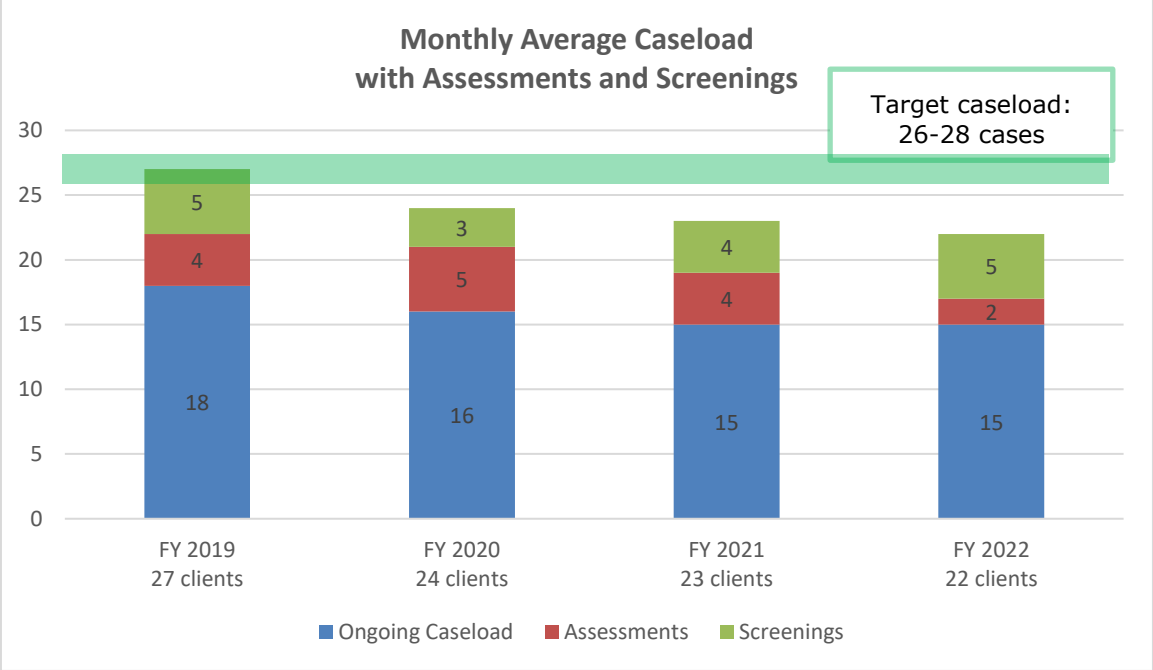
Forecast

- For FY 2023, NCM anticipates serving 500 unique individuals and CLP anticipates serving 500 unique individuals.

Nursing Case Management

Measure	2.1	NCM caseload size

Data



Data Summary

- The workload ratio for on-going clients, as well as assessments and pre-screenings, are presented. The average ongoing caseload in FY 2022 was 15 ongoing clients per month for each nurse.
- Total workload per RN for all clients served (including assessments, consultations, and pre-screenings) is 22, similar to FY 2021 (23). The average monthly workload per RN includes the average ongoing caseload of 15 plus an average of 2 NCM assessments and 5 Medicaid Waiver screenings each month per FTE. The program averages 20 Medicaid screenings per month.
- The average workloads are calculated by the end-of-month census.

What is the story behind the data?

- Monthly average on-going caseload per nurse was 15 with a slight increase in the number of clients open to NCM being noted in Q4. Caseloads varied due to staffing changes. While fewer clients may have been served on NCM case loads, client served continue to be high in acuity and NCM provided 5,425 contact units in FY 2022.
- Due to staffing changes and the acuity of client needs, increased contact frequency and duration was offered to the most acute clients enrolled in on-going services. NCM conducted 928 home visits, 104 medical escorts to physician appointments, and 235 trips to the pharmacy in FY 2022. The average time spent with each client during a home visit is not currently reflected in NCM metrics. Medical escorts average 4 hours total per client, yielding more than 400 hours in medical escorts.
- To address the increased demand for pre-admission screenings, the Team evaluated a pilot of having one dedicated NCM complete all Medicaid Waiver screenings, but this was not sustainable. Currently each NCM is assigned weekly slots on the screening calendar, along with the Adult Day program nurse to assist with screenings. For NCM and CLP, there is a NCM who serves as the dedicated Assessment Coordinator to accept and complete

assessments primarily for NCM and CLP. The Assessment Coordinator completes most of the screenings, allowing the other NCM to focus on delivery of ongoing case management services to clients.
- The program continued to have staffing challenges and was down one FTE for 11 months in the FY. One NCM position remained unfilled as one NCM resigned and another NCM transitioned to the role of Assessment Coordinator.

Recommendations	Target Dates
• Continue to monitor trends, while developing better tools to measure client acuity and increasing complexity.	• Ongoing
• Continue to use a model in which all NCMs participate in monthly screenings, with the Assessment Coordinator completing the majority of screenings.	• Ongoing
• Explore options in Peer Place and with existing reports to analyze time study data. Utilizing existing features in Peer Place, Nurses will document the amount of face-to-face time spent with clients, as well as the amount of time spent for each contact unit as a measure of client acuity.	• Q3 FY 2023

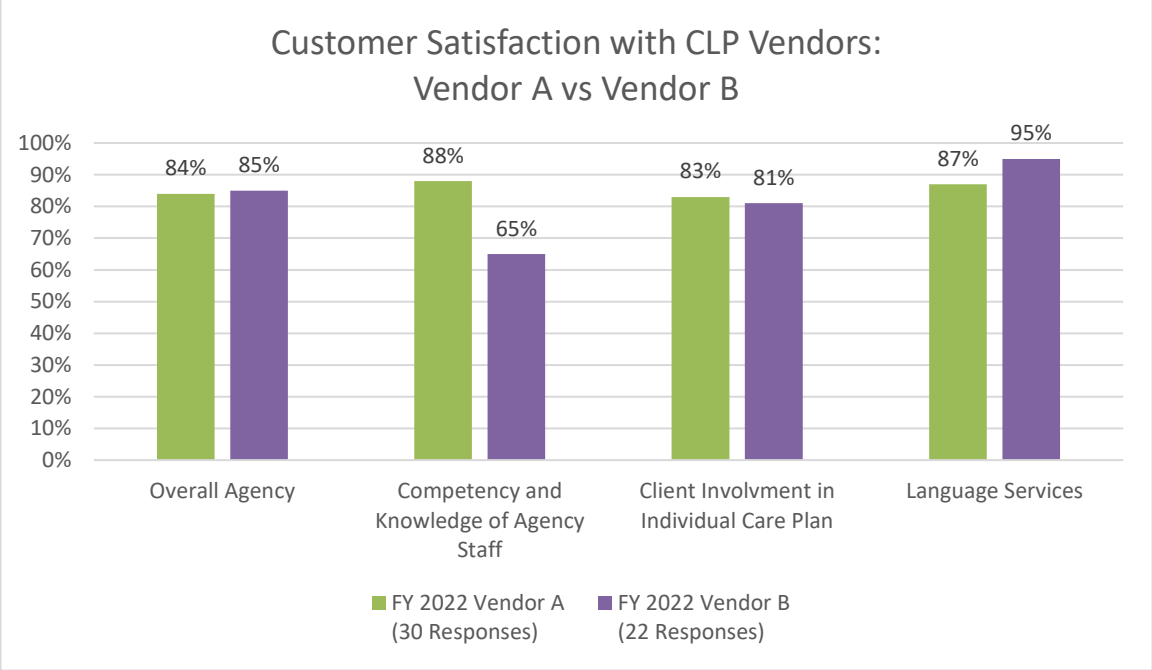
Forecast

- FY 2023: The monthly Workload per Nurse which includes ongoing caseload, assessments, and Medicaid screenings will average 26, so that NCM can continue to prioritize high acute needs.

Nursing Case Management

Measure	2.2	Customer Satisfaction with CLP vendor services

Data



Domain	FY 2021 Vendor A	FY 2022 Vendor A	FY 2021 Vendor B	FY 2022 Vendor B
Overall	96%	84%	81%	85%
Staff	90%	88%	67%	65%
Involvement	92%	83%	67%	81%
Language	88%	87%	88%	95%

Data Summary

- The Community Living Program (CLP) provides services that enable individuals to remain at home safely for as long as possible or to return home after hospitalization or rehabilitation. ADSD conducts the screening and assessments, then eligible individuals are referred to one of two participating vendors: Vendor A or Vendor B.
- In FY 2022, ADSD conducted a phone survey with 100 (50 per vendor) randomly selected participants in the program and received 52 completed responses (52% response rate). The survey response rate was 58% for vendor A and 42% for vendor B.
- Overall, an average of 84% of survey responses were satisfactory for both CLP vendors in providing services to help clients remain in their homes, improving their quality of life, and ensuring clients receive the services they need. This was a decline from a rate of 89% in FY 2021.
- Respondents range from age 42 to 93, with an average age of 72
- 56% (29) of respondents identified as female while 44% (23) identified as male.
- The largest racial groups of respondents were Black or African American and White non-Hispanic individuals. Among survey participants, 6% (3) are Asian,

	48% (25) are Black or African American, 35% (18) are White non-Hispanic, 10% (5) are White, Hispanic, 2% (1) declined to specify. The demographics of survey respondents were generally proportionate to those of program participants.

What is the story behind the data?

- In April 2021, ADSD staff conducted the first client satisfaction survey for CLP clients.
- Results for Vendor A: For FY 2022, 84% of survey responses were satisfied with Vendor A services in helping clients remain in their homes, improving their quality of life, and ensuring clients receive the services they need. This was a 13% decrease from FY 2021. 88% of respondents reported feeling satisfied with the skills and competence of staff. 83% of respondents reported satisfaction with their involvement in the development of their care plan. A high percentage of respondents provided "non-applicable" as a response.
- Results for Vendor B: 85% of clients who were satisfied with services in helping clients remain in their homes, improving their quality of life, and ensuring clients receive the services they need. 65% of respondents reported feeling satisfied with the skills and competence of their case managers – a 3% decrease compared to 2021 responses. 35% disagreed. Compared to 2021 responses, there was a 2% decrease in respondents reporting satisfaction of their involvement with their individual care plans. 81% were satisfied and 19% were dissatisfied.
- Both vendors experienced significant staffing challenges in FY 2022 due to factors related to the pandemic and the healthcare shortage. Staffing challenges were particularly pronounced for Vendor A. This likely had some impact on client satisfaction with both vendors. Clients who provided suggestions identified opportunities for improved communication with vendors. Some also requested more hours.

Recommendations	Target Dates
• ADSD staff a will continue conducting surveys in the Spring of each FY.	• Spring of each FY
• Staff will review and evaluate current survey questions to determine if adjustments are needed to better capture client satisfaction.	• Q3 FY 2023
• Continue to use client satisfaction data to improve services provided by our vendors. Use client satisfaction data to inform vendors of areas of training for staff.	• Ongoing
• Include feedback on annual monitoring visits with vendors.	• Q3 of each FY

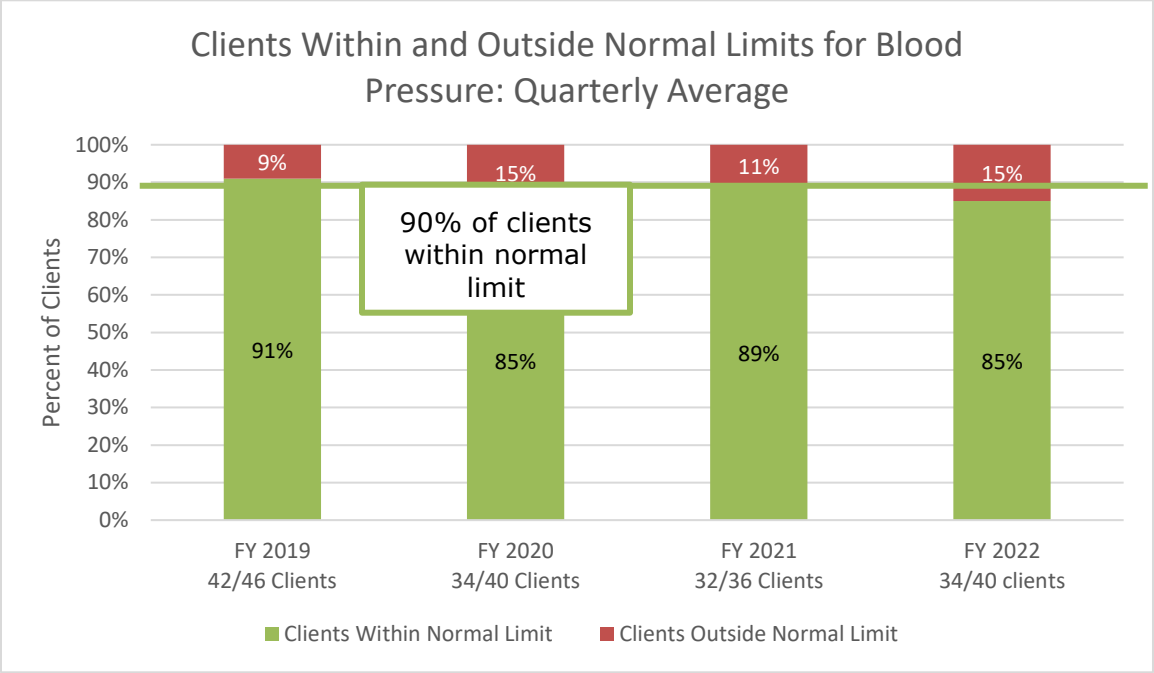
Forecast

- FY 2023: CLP satisfaction survey data will be reported with a goal of 90% satisfaction and more aligned responses across vendors.

Nursing Case Management

Measure	3.1a	NCM clients who have improved or maintained their health status in the last year: Blood Pressure (BP) for clients with high blood pressure diagnosis

Data



Data Summary

- In FY 2022, 60% (40/67) of NCM clients who received home visits recorded a diagnosis of high blood pressure during the reported timeframe. For these clients, data was collected at each visit and pulled into a report each quarter, using the electronic documentation system.
- 85% (34/40) of NCM clients with a diagnosis of hypertension recorded stable blood pressure and blood pressure recordings within normal limits.

What is the story behind the data?

- In FY 2022, 73% (67/92) of ongoing clients served received home visits, and by midyear all admitted clients were receiving home visits. The remaining clients received virtual or telephonic services. Of the clients receiving home visits, 60% reported a diagnosis of hypertension. Of these 40 clients, 85% had blood pressure within normal limits.
- NCM interventions are effective in helping people manage blood pressure.
- Percentage of NCM clients with blood pressure within normal limits is significantly higher than a national survey that indicated 50% of older adults with a high blood pressure diagnosis had blood pressure within normal limits (CDC Vital Signs).
- The national standard for normal blood pressure (JAMA Network | Hypertension and High Blood Pressure) is 80% of the time blood pressure is:
  - 150/90 or less for clients over 60
  - 140/90 or less for clients under 60
  - 140/90 or less for clients (all ages) with diabetes or chronic kidney disease
- Since diabetes is a risk factor for hypertension, the team considered measuring the A1C levels of clients during routine home visits but determined that no additional benefits would come from this as physicians routinely monitor A1Cs of diabetic clients. Nurses continue to monitor A1C based on numbers reported by physicians.

- The program explored referrals to the AAA Registered Dietician for ongoing nutrition education and counseling beginning in FY 2020, but there was limited success due to the fact that this service is telephonic in nature. Many clients served by NCM have hearing difficulties and are also difficult to engage over the phone. Nurses will continue to make referrals to the AAA Dietician on an as needed basis.

Recommendations	Target Dates
• Nurses will continue to monitor blood pressure at each visit for all clients with a diagnosis of hypertension and report findings. • Nurses will continue to educate clients on healthy activities and diets that can lead to improvements in blood pressure and make referrals to the AAA Dietician as needed. • Explore offering the Chronic Disease Self-Management program to deliver this group-level intervention in the community. This evidenced-based 6-week education program provides tools and information to assist people with chronic diseases to better manage their health.	• Ongoing • Ongoing • FY 2023 Q4 for implementation in FY 2024

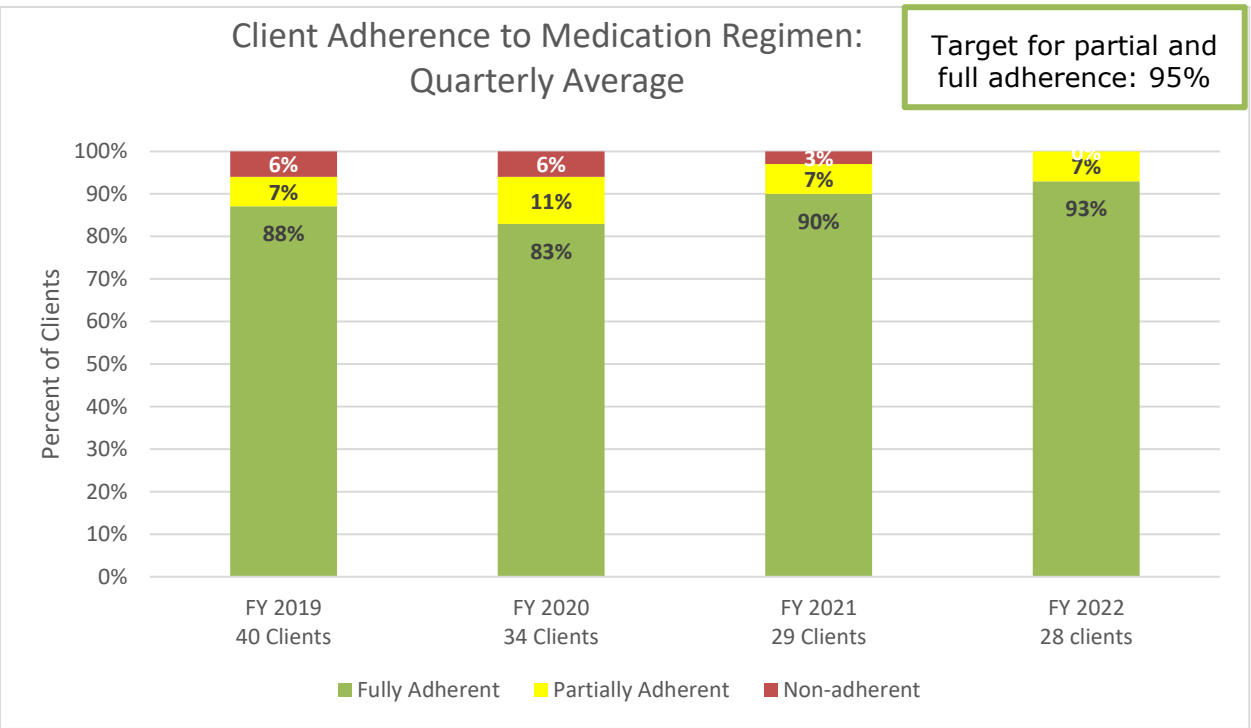
Forecast

- FY 2023: At least 90% of clients with high BP will maintain blood pressure within normal limits.

Nursing Case Management

Measure	3.1b	NCM Clients who have improved or maintained their health status in the last year: Medication adherence for clients who have medication adherence intervention in place

Data



Data Summary

- For FY 2022, there were 28 ongoing clients who had medications monitored or pre-poured by nurses who monitor pharmacy bubble-packed medications, pre-poured medications into a pill box, or pre-filled insulin syringes. 26 fully adhered to their medication regimen as prescribed. Most visits occurred weekly or every other week.
- The average number of medications for each client was 20.
- Nurses evaluate medication adherence based on a 2005 New England Journal of Medicine article: 80% to 100% of medications taken is adherent; 60% to 79% is partially adherent; below 60% is not adherent.
- Data was recorded at each visit and pulled into a report each quarter using the electronic documentation system. Nurses reported if clients were "adherent" "partially adherent" or "non-adherent" at each visit. Quarterly and annual averages were calculated.
- 93% (26/28) of clients receiving medications monitored or pre-pours were fully adherent while 7% (2/28) clients were partially adherent to their medication regimen.

What is the story behind the data?

- NCM intervention is effective in helping people manage adherence to medications.
- The percent of NCM clients fully or partially adherent to their medication treatment regimen exceeds a national study indicating 68% of adults fully or partially adhered to medication treatment regimens (2013 US National Report Card on Adherence).

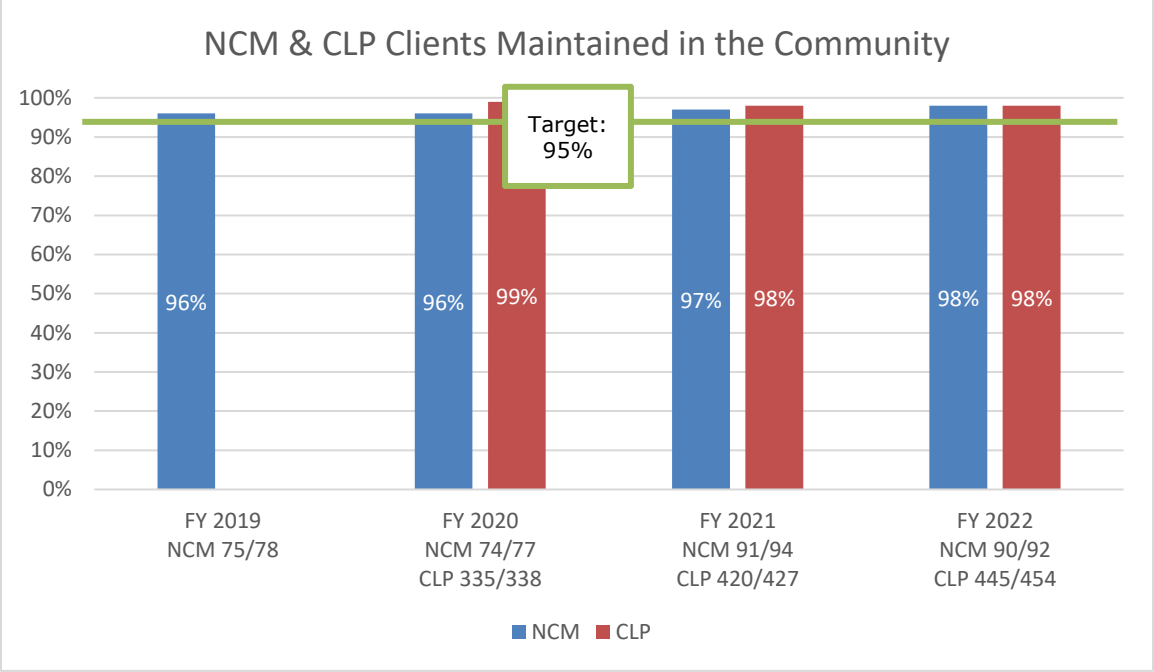
Recommendations	Target Dates
• Nurses will continue to use pharmacies that can bubble-pack medication, pre-pour if bubble-packing is not available, and monitor medication adherence, increasing the frequency of home visits as indicated for better monitoring. • Continue nursing interventions aimed at improving adherence whether the nurse is pre-pouring the medication or the pharmacy is bubble-packing medication.	• Ongoing • Ongoing

Forecast
• FY 2023: At least 95% of clients for whom the nurse monitors pharmacy bubble packs, pre-pours medication, or pre-fills insulin syringes will demonstrate full or partial adherence.

Nursing Case Management

Measure	3.2	Clients maintained in the community

Data



Data Summary

- Clients maintained in the community are those who continue to be open to on-going services or have been discharged from services but remain living in the community instead of transferring to a long-term care residence (LTCR i.e. nursing home or assisted living). If a closed client moved to a LTCR, the client was not considered to be maintained in the community
- 98% (90/92) of on-going NCM clients were maintained in the community.
- 98% (445/454) of CLP clients served in FY 2022 were maintained in the community.

What is the story behind the data?

- According to a 2021 study by the American Association of Retired People (AARP), 77% of adults age 50+ want to stay in their current home and community as they age. This number has been consistent for more than a decade.
- In a 2022 survey by the University of Michigan National Poll on Healthy Aging, 88% of adults age 50-88 felt it important to remain in their homes for as long as possible.
- Living independently with home and community-based services, at a cost of $55,209 per year in the D.C. metro region, results in cost savings compared to a nursing home, estimated at $140,708 per year for a semi-private room (2021 data).
- The NCM and CLP interventions are effective in helping people remain in the community.
- Only 2% of NCM clients (2) and 2% of CLP clients (9) were discharged from on-going NCM and CLP services to long-term care residences because their needs increased such that they could no longer safely live in the community. Of the 2 NCM clients discharged to LTC, one went to assisted living and the other to a nursing home. Of the 9 CLP clients discharged to LTC, 2 went to assisted living and 7 went to a nursing home.

Recommendations	Target Dates

• Nurses and the CLP vendors' staff will continue to help clients maintain their health and homes, making referrals aimed at helping clients continue to stay in their homes. • Continue tracking client disposition to measure the effectiveness of the program in helping to maintain clients in the community.	• Ongoing • Ongoing
Forecast	
• FY 2023: At least 95% of NCM and CLP clients will continue to be maintained in the community versus a more restrictive placement in a residential setting or LTCR.	