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 services in client's homes.
	• 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 funds are 90% local funds and 10% state and federal funds.

Service Delivery Method	• In FY 2024 NCM continued to provide community-based services to clients in need of ongoing medical case management. The nursing team spent the majority of their time providing face to face services, prioritizing home visits and appointments for clients with the most acute needs and limited supports. Nurses adjusted the frequency of home visits, ensuring each client was seen in the home at least once a month unless the client was in the hospital or rehab. • CLP staff continued to provide home-based assessments for new clients. 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 model is anticipated to continue in FY 2025.

PM1: How much did we do?

<table>
<tr><td>Staff</td><td>Total 7.0 FTEs: NCM and CLP
NCM 5.0 FTEs
4.50 FTE Nurses
0.50 FTE Manager
CLP 2.0 FTEs
0.50 FTE Nurse
0.50 FTE Manager
0.50 FTE Human Services Clinician II
0.50 FTE Human Services Aide (grant funded)</td></tr>
<tr><td>Customers and Service Data</td><td>
<table>
<tr><th></th><th>FY 2021</th><th>FY 2022</th><th>FY 2023</th><th>FY 2024</th></tr>
<tr><td>Total NCM Clients Served</td><td>438</td><td>502</td><td>610</td><td>505</td></tr>
<tr><td>Individuals Receiving any Type of NCM Service</td><td>94</td><td>92</td><td>100</td><td>123</td></tr>
<tr><td>Ongoing Services Clients</td><td>NA</td><td>NA</td><td>NA</td><td>*74</td></tr>
<tr><td>Clients receiving NCM/CLP intake assessments or consultations</td><td>139</td><td>173</td><td>207</td><td>126</td></tr>
<tr><td>Clients screened for nursing home level care</td><td>211</td><td>237</td><td>303</td><td>305</td></tr>
<tr><td>All NCM Client Services Contacts</td><td>5,802</td><td>5,425</td><td>7,067</td><td>7,745</td></tr>
<tr><td>Total CLP Clients Served</td><td>427</td><td>454</td><td>411</td><td>300</td></tr>
</table>
*Prior to FY 2024, clients were included in the Ongoing Services Clients count if they were assessed for ongoing services, regardless of whether they actually moved on to ongoing services. For FY 2024 and beyond, this measure only counts clients who actively received ongoing services.
</td></tr>
<tr><td colspan="2">PM2: How well did we do it?</td></tr>
<tr><td>2.1</td><td>NCM caseload Size</td></tr>
<tr><td>2.2</td><td>Customer Satisfaction with CLP vendor services</td></tr>
<tr><td colspan="2">PM3: Is anyone better off?</td></tr>
<tr><td>3.1</td><td>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</td></tr>
<tr><td>3.2</td><td>Clients maintained in the community</td></tr>
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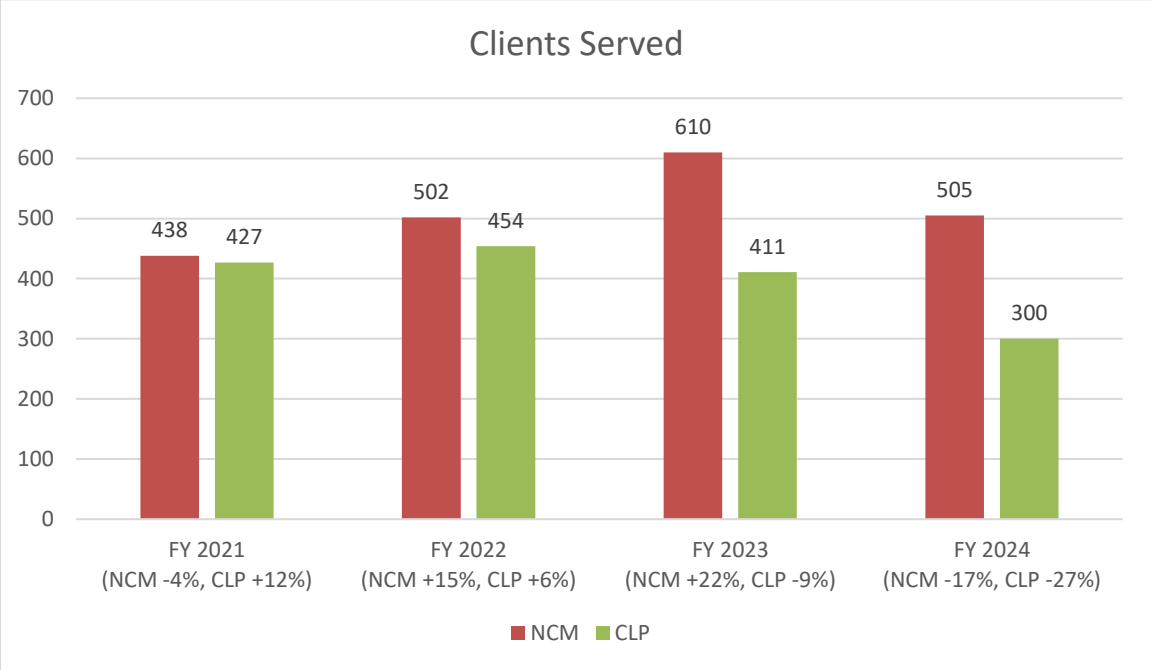
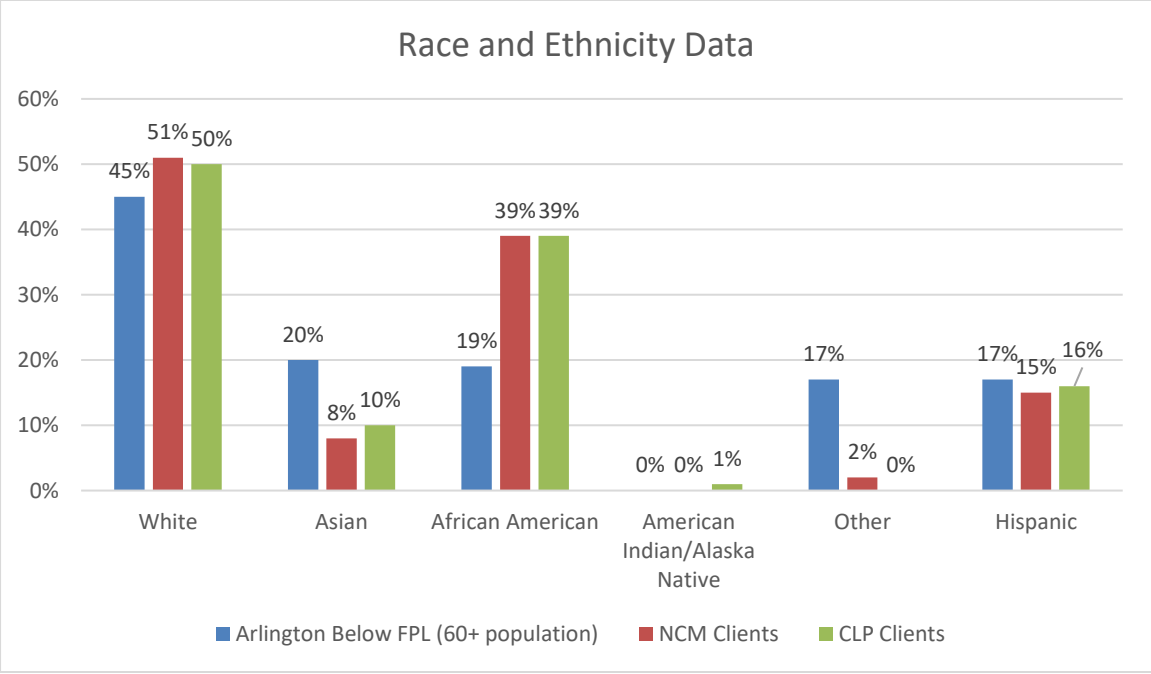
Nursing Case Management

Measure	1	Customers and Service Data

Data





Clients by Age	Under 60	60-69	70 and over	Avg Age
NCM	15%	25%	60%	72
CLP	12%	17%	72%	75

Data Summary	• NCM saw a decrease in the number of individuals served. There was a 17% decrease in the number of individuals served by NCM, from 610 to 505. • CLP saw a 27% decrease in the number of clients served, from 411 clients in FY 2023 to 300 in FY 2024. • Both NCM and CLP served higher rates of individuals identifying as Black or African American compared to the total 60+ population of older adults living below the Federal Poverty Level (FPL). In both cases, the rate of older adults served who identify as African American, is nearly two times higher than the Arlington population below the FPL.

What is the story behind the data?

- Most (76% NCM, 75% CLP) clients live alone. The majority (59% NCM, 61% CLP) have incomes below the Federal Poverty Level.
- More than 50% of clients served by both NCM and CLP identified as White. Although African Americans make up about 19% of the 60+ population below the Federal Poverty Line in Arlington, the rate of African Americans served was twice the rate seen in the comparison population. This highlights the health disparities and higher rates of chronic diseases seen in the African American population.
- For NCM: the program provided ongoing services to 74 unique clients and provided 7,745 contacts. There was a 10% increase in the number of contacts from the previous fiscal year. This increase in the number of client contacts also speaks to increasing needs and acuity of the population served.
- The number of total NCM clients served decreased by 17% in FY 2024. This can be attributed to a staffing shortage and the way in which data was tracked this year. The NCM team was down 1 FTE for 4.5 months in FY 2024, starting February of 2024. The program had to slow down the rate of referrals and admissions as the rest of the team absorbed the caseload for the departing staff member.
- This FY the data was collected in a manner that eliminated duplication in data.
- The team completed a similar number of Medicaid Waiver screenings this year (305 in FY 2024 compared to 303 in FY 2023) The demand for screenings outpaced the Team's ability to complete requested assessments.
- CLP resumed referrals to our contracted vendors in July 2023 after putting referrals on hold in Q3 of FY 2023. The program served 300 clients in total, a 27% drop from 411 clients served in FY 2023. The program provided 42,380 aide hours for FY 2024 compared to 56, 771 aide hours in FY 2023. Clients receiving the most hours are the most frail and vulnerable and not eligible for other services such as the Medicaid Waiver. The actual CLP census was 395, however not all data has been recorded in Peer Place.
- The team started the fiscal year with 46 clients pending assessments. The team processed over 250 referrals this fiscal year, assessing and referring those who met eligibility criteria.
- Staff provided short-term case management for clients on the referral list until the clients could be assessed and referred to the vendors. The part-time Human Services Clinician provided more ongoing case management services and caregiver supports.
- The program policies and procedures were updated to reflect current eligibility criteria to include the requirement that a client be homebound to meet eligibility. During the COVID Public Health Emergency, clients that did not meet the definition of homebound but requested services were served by CLP. This practice was stopped with the end of the Public Health Emergency and accounts for the fewer number clients served.
- A few CLP clients that were discharged due to not meeting the homebound criteria continued to receive limited services from a part-time contracted vendor using grant funds. This part-

time contractor provided limited assistance with Instrumental Activities of Daily Living (IADLS) and provided safety checks to clients that were discharged from the CLP program.
- The Program Manager and Assessment Coordinator increased outreach efforts to collaborators and service partners to provide education on the program and updated eligibility criteria. These outreach efforts occurred in the form of presentations at team meetings, as well as 1:1 consultations with staff. This helped to reduce the number of inappropriate referrals to the program.

Recommendations	Target Dates
• Continue to partner with ADSD outreach team to promote services at health fairs, wellness events and community engagements.	• Ongoing
• Continue to evaluate current program trends and monitor the CLP budget to serve the greatest number of clients in need of services with the allotted budget.	• Ongoing
• Evaluate staffing needs and roles to meet the increasing demand for both NCM and CLP services.	• Ongoing
• Consider increasing staffing from 0.5 FTE Human Services Clinician to 1 FTE Human Services Clinician to help meet the case management needs of clients enrolled in the program.	• Q3, FY 2025
• Evaluate impact of using a management intern to assist with improvement in service delivery and coordination with community providers.	• Q3 FY 2025
• Translate the program brochure into the most common languages spoken by program participants to meet client needs.	• Q4 FY 2025

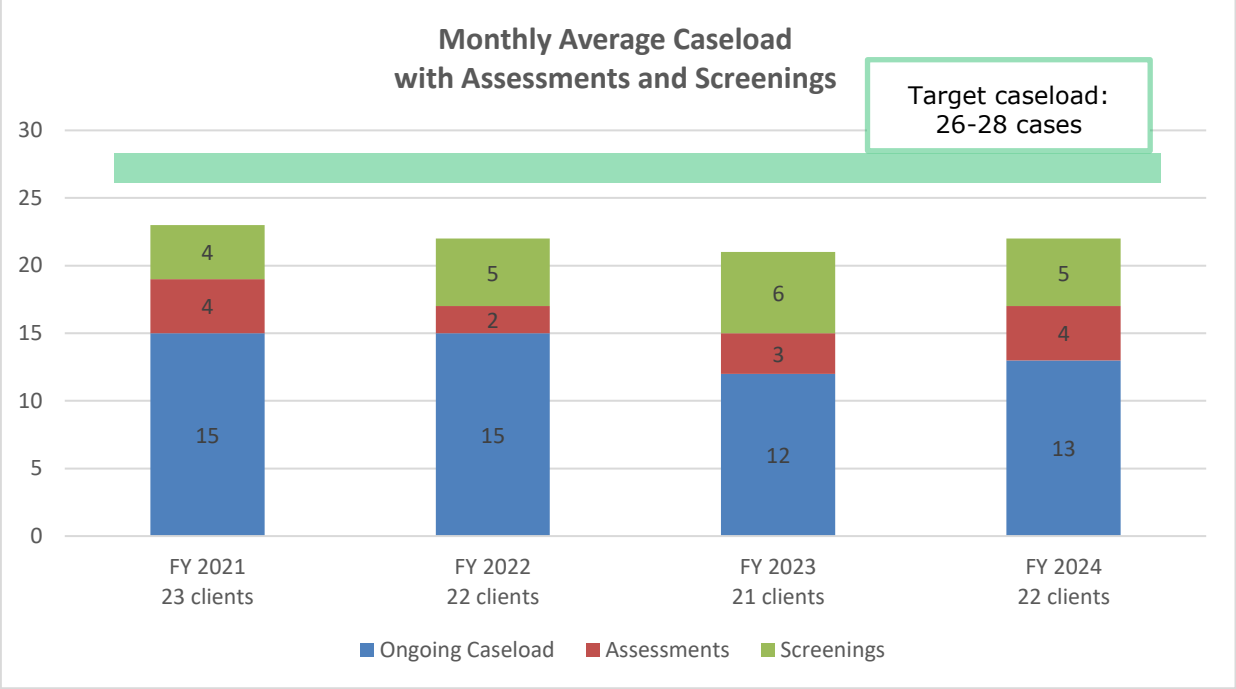
Forecast

- For FY 2025, NCM anticipates serving 550 unique individuals and CLP anticipates serving 440 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 2024 was 13 ongoing clients per month for each nurse. This is a slight increase from the previous year because the team was down 1 FTE position for a portion of the year and the workload was adjusted to accommodate staffing levels.
- Total workload per RN for all clients served (including assessments, consultations, and pre-screenings) is 22, similar to prior years. The average monthly workload per RN includes the average ongoing caseload of 13 plus an average of 4 NCM assessments and 5 Medicaid Waiver screenings each month per FTE. The program averages 25 Medicaid screenings per month.
- The average workload is calculated by the end-of-month census.

What is the story behind the data?

- The monthly average for on-going caseload per nurse was 13, similar to the caseload size of 12 last FY. While NCM caseloads remained steady, more client service units were recorded. Clients continued to be high in acuity and NCM provided 7,745 service units, an increase from the 7,067 recorded in in FY 2023.
- NCM conducted 1,144 home visits, 252 medical escorts to physician appointments, and 261 trips to the pharmacy in FY 2024. The average time spent with each client during a home visit is not currently reflected in NCM metrics. The team attempted to track the amount of face-to-face time spent with clients but found that this was not always accurate. Currently, the team uses the number of service units as a measure of acuity.
- Medical escorts exceeded 1,000 hours spent by the nurses to provide medical escorts. This is more than a 100% increase in the number of escort hours provide by the NCMs in previous FY. This is likely due to more clients having regular in-person physician appointments post-

pandemic. The program has a high number of clients with complex needs including behavioral health needs (38% of ongoing clients), cognitive issues, and higher medical acuity requiring multiple visits to medical specialists. The number of hours recorded for medical escorts is underreported as it does not include the 24 medical escorts (average of 96 hours) completed by our part-time grant-funded aide.

- The number of client home visits recorded is underreported as it does not include joint consultation home visits with our partner programs such Adult Services and Adult Protective services.
- The NCM team continued to see an increased demand for pre-admission Medicaid Waiver screenings, however the demand for services outpaced the team's capacity to complete the assessments. Currently each NCM is assigned weekly slots on the screening calendar. In addition to helping to coordinate CLP, the NCM/CLP Assessment Coordinator completes most of the screenings, allowing the other NCMs to focus on delivery of ongoing case management services to clients. This is an area of cost savings and program efficiency to have a Coordinator who is skilled at handling assessments for both the NCM and CLP programs as clients can be assessed for more than one service at a time which reduces delay in assessments.
- Staffing shortages contributed to a lesser number of completed prescreening as the team was down 1 FTE NCM for 4.5 months in the year.

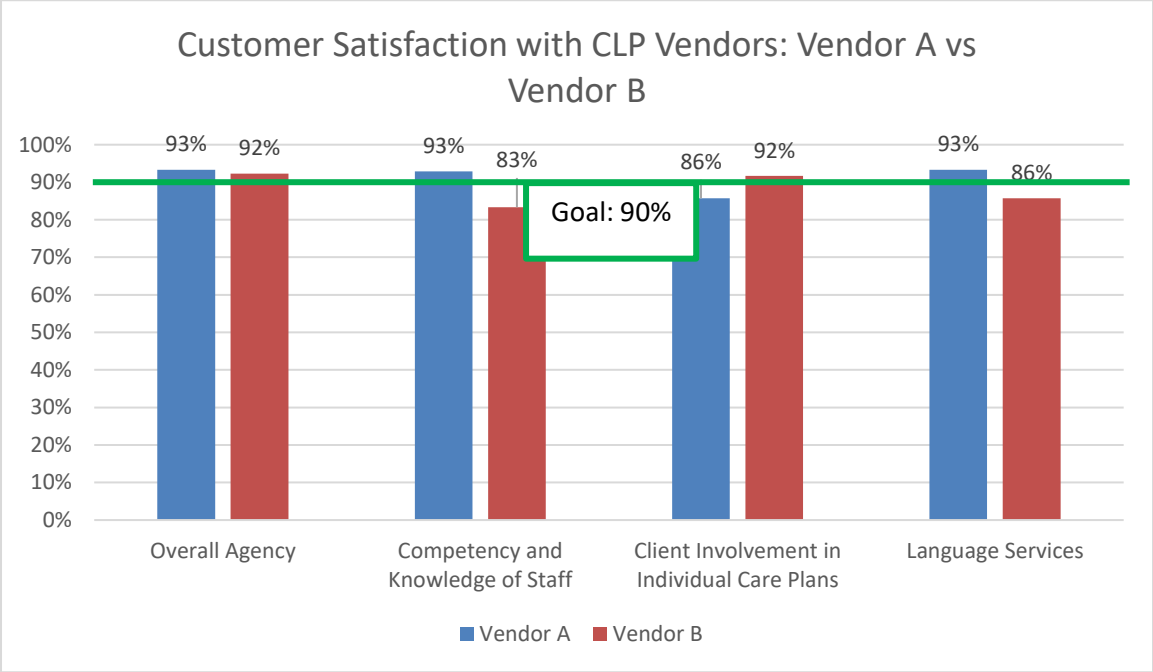
Recommendations	Target Dates
• Continue to monitor trends, while developing better tools to measure client acuity and increasing complexity.	• Ongoing
• Evaluate current staffing and consider increasing staffing to include a FTE NCM dedicated to completing the State-mandated Medicaid Waiver assessments.	• Q3 FY 2025
• Evaluate staffing and need for a full-time Human Services Aide to help meet increasing client needs, including the need for medical escorts.	• Q3 FY 2025
• Add Medical Escort hours to PM 1 data points	• Q3 FY 2025
• Explore ways to better capture Face-to-Face hours and consider the development of a performance metric around face-to-face contacts.	• Q2 FY 2025

Forecast

- FY 2025: The monthly Workload per Nurse which includes ongoing caseload, assessments, and Medicaid screenings will average 26, based on current trends in service demand.

Nursing Case Management		
Measure	2.2	Customer Satisfaction with CLP vendor services

Data



Domain	FY 2023 Vendor A	FY 2024 Vendor A	FY 2023 Vendor B	FY 2024 Vendor B
Overall	100%	93%	76%	92%
Staff	84%	93%	88%	83%
Involvement	100%	86%	86%	92%
Language	94%	93%	95%	86%

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 2024, ADSD conducted a phone survey using a sample size of 84 (about 28% of total clients served) randomly selected participants in the program and received a total of 29 completed responses. 35% of randomly selected clients responded, which represented 11% of total clients at the time. The survey response rate was 38% for vendor A and 32% for vendor B.
- Overall, an average of 93% of survey responses were satisfactory for services provided by both CLP vendors. This was an increase from the 88% satisfactory rate in FY 2023.
- Respondents range from age 53 to 89, with an average age of 69
- 59% (17) of respondents identified as female while 41% (12) identified as male.

- The largest racial groups of respondents were Black or African American (40% for vendor A and 14% for vendor B) and White (27% for vendor A and 78% for vendor B).

What is the story behind the data?

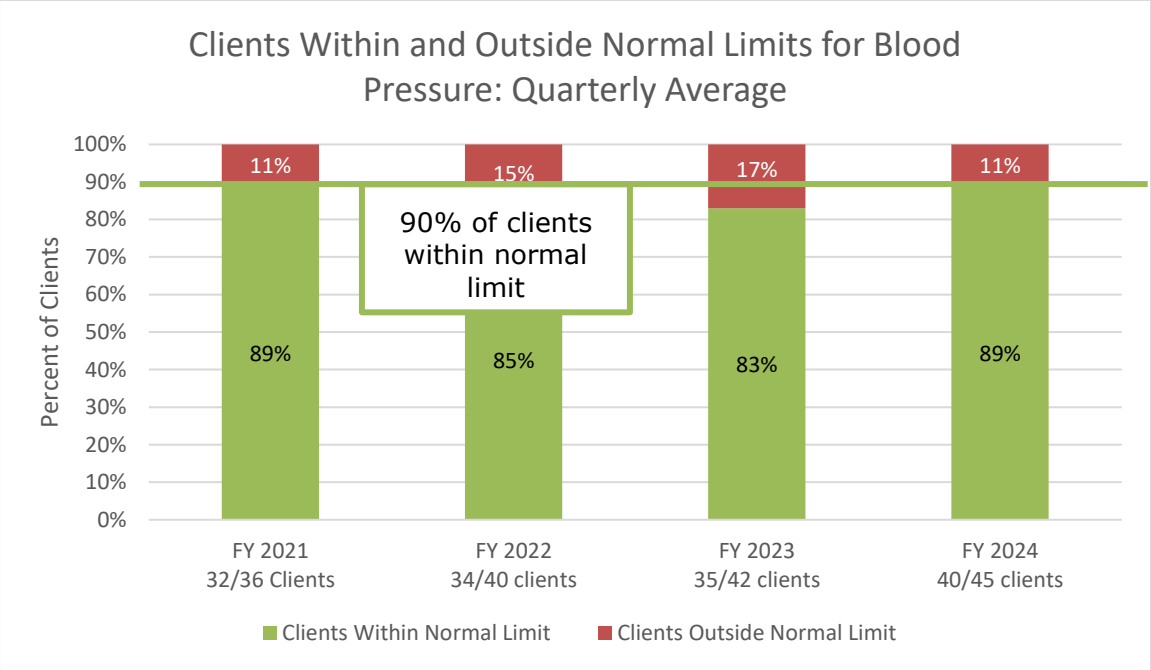
- Results for Vendor A: For FY 2024, 93% of survey responses were satisfied overall with Vendor A's services. This was a 7% decrease from FY 2023. 84% of respondents reported feeling satisfied with the skills and competence of staff. 86 % of respondents reported satisfaction with their involvement in the development of their care plan. 93% of Vendor A clients reported they were able to receive services in the client's primary language
- Results for Vendor B: 92% of clients were satisfied overall with Vendor B's services. This was a significant increase from the 76% reported in the previous year. 83% of respondents reported feeling satisfied with the skills and competence of their case managers – a decrease from the 88% reported in FY 2023. Compared to the previous year responses, there was a 6% increase in respondents reporting satisfaction of their involvement with their individual care plans. 92% were satisfied with their level of involvement with their plan of care.
- Both vendors had the authorized number of hours per client cut by almost 50% in April 2023 due to factors related to the budgetary constraints. Both vendors worked closely with the Arlington clinical team to assess clients' current needs and adjust services levels based on needs. In FY 2024, some clients who had their hours cut in the previous fiscal year, had a portion or all of their hours restored. Some clients did not have their FY 2023 hours of service restored because it was not clinically indicated. This may have contributed to the significant drop in satisfaction levels for client involvement in care plan for Vendor A.
- In FY 2024, Vendor A received over a 90% rating for providing services in the client's primary language while Vendor B dropped from 95% to 86% satisfaction for services in a client's language. Vendor B serves a larger population of Amharic speaking clients and while the staffing coordinator for vendor B is a native Amharic speaker who could understand the needs of clients, staffing with Amharic speaking aides who provide services in the home was particularly challenging this year for Vendor B. Plans are underway to recruit more Amharic speaking aides.
- Results of CLP Satisfaction Survey are shared with each vendor to improve service provision.

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.	• Ongoing
• 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
• Explore racial and ethnic identities of clients assigned to each vendor to determine if there are any trends.	• Q3 FY 2025
• Explore the possibility of sharing access to the language line with vendors or connecting the vendors to other interpretation services.	• Q3 FY 2025
• Explore the possibility of a mail survey or electronic outreach to increase the number of clients reached and decrease staff burden.	• Q3 FY 2025

Forecast
• FY 2025: 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 2024 61% (45/74) of NCM ongoing clients served had a recorded diagnosis of high blood pressure during the reported period. For these clients, data was collected at each visit and pulled into a report each quarter, using the electronic documentation system.
- 89% (40/45) 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?

- NCM interventions are effective in helping people manage blood pressure.
- The 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
- The program explored referrals to the Chronic Disease Self-Management program for clients with uncontrolled hypertension. However due to the limited uptake of this group program , the program was not widely implemented. Several NCM clients considered the program for implementation this year, but ultimately decide not to participate.
- The NCM team explored the use of wearable technology to measure blood pressure in the home over time, as this would provide a better measure of blood pressure control instead of relying on a few BP readings recorded at each home visit After factoring in some of the

financial considerations, ability to use technology, and cognitive status of many NCM clients, the team decided to explore having clients self-monitor and record weekly blood pressure readings on a log provided by NCM. The NCM factors these BP readings into the analysis for overall BP control. This has been met with limited success and most clients require calls to remind them to check and record their blood pressure.

- Data was analyzed by race and ethnicity to determine if there were inequities. Analysis indicated similar results across racial and ethnic identity groups.

Recommendations	Target Dates
• Continue to have clients self-monitor and maintain a blood pressure log that can be used to determine client blood pressure range and level of blood pressure control.	• Ongoing
• Nurses will continue to educate clients on healthy activities and diets that can lead to improvements in blood pressure and make appropriate referrals as needed.	• Ongoing
• Continue to explore offering the Chronic Disease Self-Management program to deliver this group-level intervention in the community. This evidence-based 6-week education program provides tools and information to assist people with chronic diseases to better manage their health.	• Ongoing
• Consider additional health outcome measures for Nursing Case Management clients that may apply to a broader portion of the client population.	• Q3 FY2025

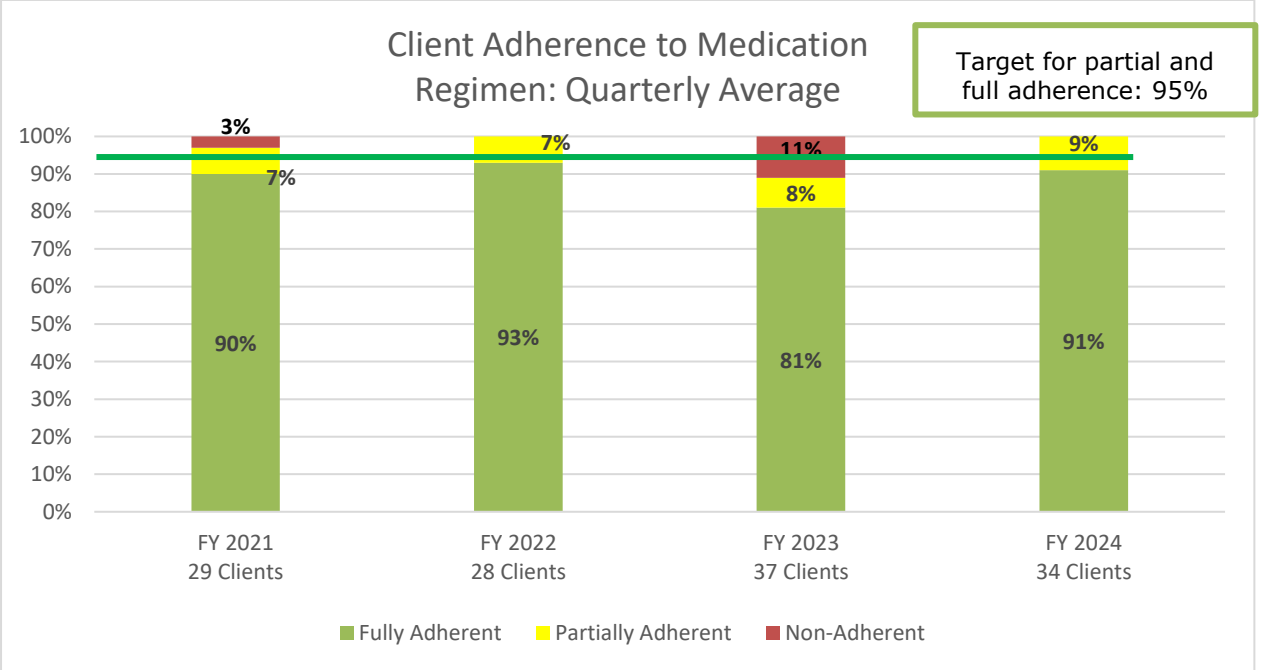
Forecast

- FY 2025: 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 2024, there were 34 ongoing clients who had medications either pre-poured into pill boxes by nurses, bubble-packed medications by the pharmacy, or pre-filled insulin syringes filled by the nurse case manager. Nurses monitored adherence levels during home visits. Most visits occurred weekly or every other week. 31/34 clients monitored were fully adherent to their medication regimen as prescribed.
- 91% (31/34) of clients receiving medications monitored or pre-pours were fully adherent while 9% (3/34) clients were partially adherent to their medication regimen. 0% (0/34) were not adherent.
- The average number of medications for each client was 17 over the fiscal year.
- 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.

What is the story behind the data?

- NCM intervention is effective in helping people manage adherence to medications.
- Most of the challenges the Team experienced around medication adherence were related to clients with mental health issues who at times refused interventions such as having an aide in the home to provide medication reminders. 78% (7/9) clients with variable medication adherence had mental health needs, 56% (5/9) were connected to mental health services.

- 100% of clients demonstrated full or partial medication adherence.
- The percentage 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.	• Ongoing
• Continue nursing interventions aimed at improving adherence whether the nurse is pre-pouring the medication or the pharmacy is bubble-packing medication.	• Ongoing
• Continue to connect clients with mental health challenges to BHD and SAMH for mental health services.	• Ongoing

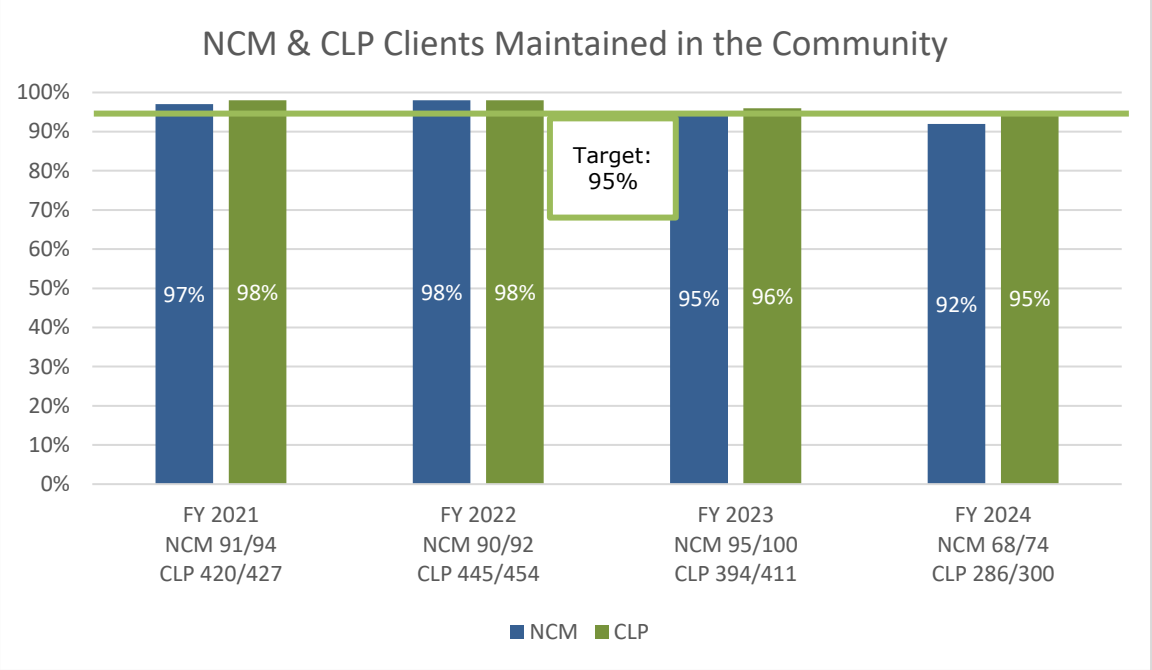
Forecast

- FY 2025: 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.
- Only clients receiving ongoing services are considered in this measure.
- 92% (68/74 of on-going NCM clients were maintained in the community. 95% (286/300) of CLP clients served in FY 2024 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 aged 50-88 felt it important to remain in their homes for as long as possible.
- Living independently with home and community-based services provides a significant cost savings. In 2023 the estimated cost of in-home services was $70,928 per year in the D.C. metro region, compared to $151,475 for a semi-private room in a nursing home (Cost of Care Survey).
- The NCM and CLP interventions are effective in helping people remain in the community. Most clients served by NCM received NCM services for more than 3 years. NCM served 3 Centenarians this past year and successfully maintained each of them in their homes for at least five years. The oldest client aged 106 has been successfully maintained in the community since 2015.

- NCM successfully maintained 68/74 clients in the community. One client was discharged to Assisted Living and five clients were discharged to a Nursing Home because their needs increased such that they could no longer safely live in the community.
- CLP successfully maintained 286/300 clients in the community. Of the 14 CLP clients that were discharged to Long-term care, 8 went Assisted Living and 6 went to a Nursing Home.

Recommendations	Target Dates
• Nurses and the CLP vendor staff will continue to help clients maintain their health and homes, making referrals aimed at helping clients continue to stay in their homes.	• Ongoing
• Continue tracking client disposition to measure the program's effectiveness in helping maintain clients in the community.	• Ongoing
• Explore tracking length of service in NCM for discharged clients to track how long clients are successfully maintained in the community.	• Q3 FY 2025
• Disaggregate this measure by race and ethnicity for the FY 2025 PMP.	• Q3 FY 2025

Forecast

- FY 2025: 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.