COMMUNITY BASED HEALTH HOME (CBHH)

Corinne Jan, RN, PHN
Chief Executive Officer
Family Bridges, Inc.

A Project of Alliance for Leadership & Education
Funded by the SCAN Health Plan Community Giving Program

Who*What*When*Why*Where

- WHO: Chronically ill elderly, ‘dual eligibles’
- WHAT: Community Based Adult Services (CBAS) as Health Home
- WHEN: Before exacerbation; before institutionalization
- WHY: Alternative to SNF, prevention of premature ED visits, acute hospitalizations, tenets of CCI and ACA
- WHERE: In the community, in your own home

Person Centered Care

"Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs and preferences and that patients have the education and support they need to make decisions and participate in their own care."

Institute of Medicine (IOM)

Hallmarks of Effective Coordination

- ❑ Targeting those at substantial risk
- ❑ Far higher levels of in-person contacts.
- ❑ Access to timely information on hospital and emergency dept. admissions.
- ❑ Close interaction between care coordinators and primary care physicians.
- ❑ Interventions focused on assessing, care planning educating, monitoring, and coaching on self management, as well as social supports such as transportation, help with ADLs, or overcoming isolation.

Source: “Promising Models for Care Coordination” 2009. National Quality Forum

Family Bridges

Hong Fook CBAS Centers

What is Community Based Adult Services (CBAS)?

- Began in 1970s as Adult Day Healthcare (ADHC) in response to increasing incidence of nursing home abuse
- Eliminated in 2011, Darling vs Douglas settlement agreement created CBAS
- Community based, multidisciplinary healthcare services in congregate setting
- Vigilant monitoring by multidisciplinary team
- Prevention
- Cost effective
- Dignity

CBAS "E – Factor"

CBAS as Health Home

Wave of the future

What is CBHH

- A comprehensive person-centered care model that allies adult day health care/CBAS to managed care and the PCP to provide improved outcomes for older adults with complex bio-psychosocial needs.

- A 2 year project to provide intervention, support and care coordination through the intensive hands-on effort of an RN Navigator, who can work outside of the ADHC/CBAS center walls.

California's Community-Based Health Home Pilot Sites

Generously funded by SCAN Health Plan ~ Long Beach CA
A project of the Alliance for Leadership & Education in collaboration with California Association for Adult Day Services

Target population

Dual eligibles in 6 counties who are 65 years or older and:

- Authorized by MC Plan as eligible for CBAS at one of the 7 project sites.

- Identified by the CBAS MDT as high risk using project criteria and team judgment

- Red flags are:
  - Living alone with cognitive impairment or psych condition
  - Abrupt changes in health, mental or cognitive condition
  - Changes in caregiver or living status
  - Absences from the CBAS Center
  - Care Transitions

Patient Profiles

- Multiple chronic conditions
- Polypharmacy/Medication mismanagement
- Clinical depression/Mental Health
- Self-neglect
- Poor judgment/risky decision-making
- Living alone/isolation
- History of falls
- Challenging behaviors
- Family / caregiver conflict

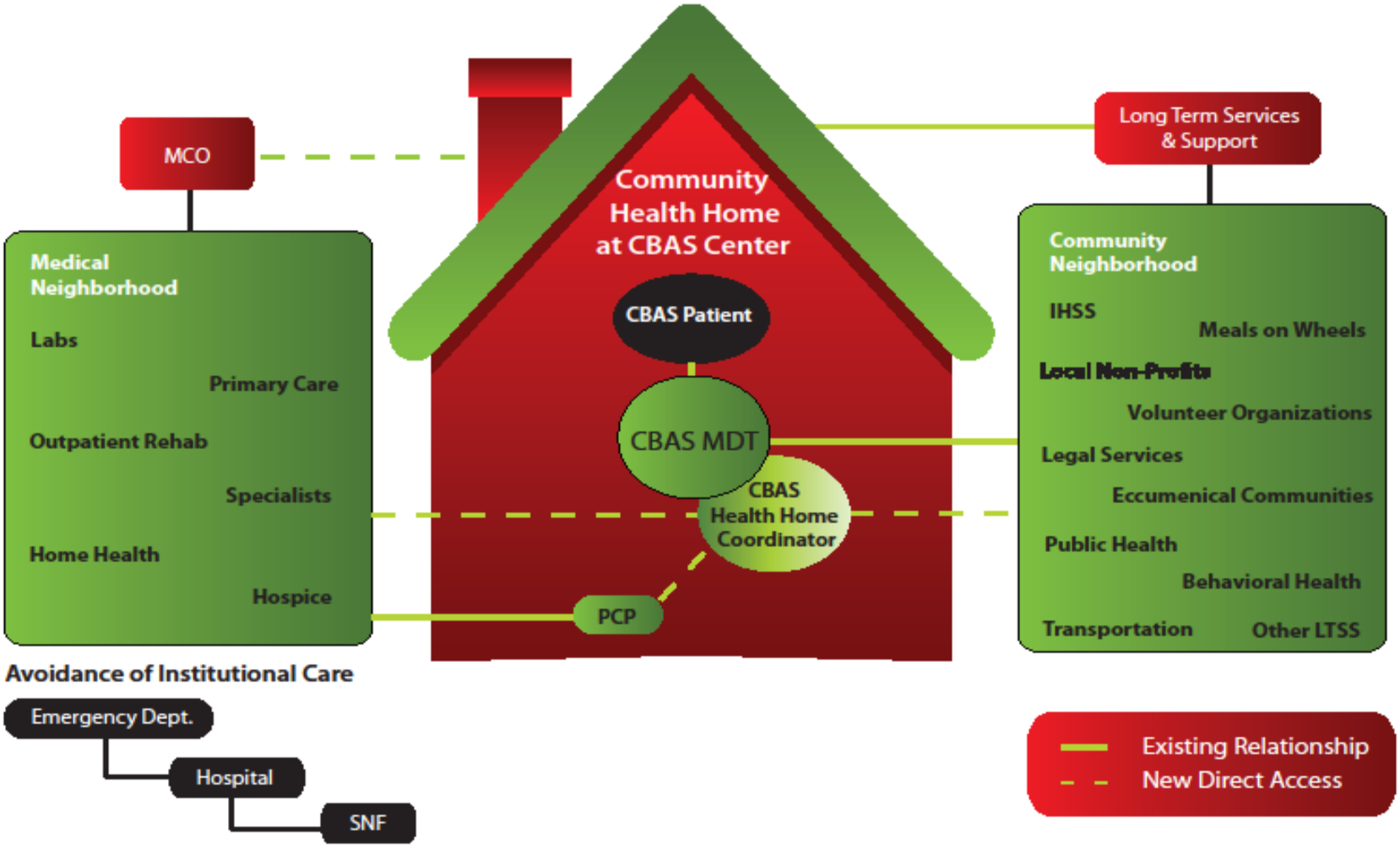
Patient Profiles (con't)

- High Risk and high cost - multiple physicians, multiple services and supports, complex unstable conditions
- Requires "high touch"
- Over-utilizes 911, (super-utilizer) avoidable hospital admissions, avoidable NF admissions
- Complex multiple chronic conditions

Nurse Navigator (NN)

- Focus on care transitions, changes in patient status (bio-psycho-social), close monitoring and close collaboration with ADHC IDT and MCMC Plan.
- Navigate Medi-Cal, Medicare, community resources, CBAS IDT and caregiver on behalf of patient, especially those without Plan CM.
- Facilitate unified decision-making for person-centered care for those in CM as well as those without Plan CM.
- Hands-on “high touch” care - extension of CBAS IDT, including PCP orders
  - Liaison with Plan
  - Home visits
  - Accompany patient to PCP visit
  - Work with discharge planner at NF or hospital
  - Ad hoc RN assessment, as needed (home or center)
- Application of uniform assessment tools, protocols and best practices

Community Based Adult Services (CBAS) as a Managed Care Health Home



Advantages of NN

CBAS

- Unable to leave center
- Reliance on self reports of incidents (after the fact)
- No involvement in DC planning from acute or NF
- Reactive

CBHH

- Home visits – assessment, intervention, prevention
- Face to Face with providers
- Point person
- Hospital visits, ER visits
- Face to Face with hospital discharge planners
- Enhanced support to CBAS MDT
- Provide or arrange for 24/7 infor and emergency consult
- Bi-directional notification of admission/DC
- Smoother ‘hand off’ back to community
- Use of TOPS data collection

Minimal transitional contact

Enhanced Transitional Care

TOPS

TRACKING OUTCOMES FOR PROGRAM SUCCESS

The patient centered outcome system for community-based adult day services

- TOPS, Tracking Outcomes for Program Success, is an outcome measurement system developed by CAADS under a grant from the California Community Foundation in 2009-2010 and piloted among 8 adult day programs and Adult Day Health Centers in Los Angeles County.

- It has been recently adapted as the basis for measuring outcomes in the Community-Based Health Home.

- Gwen Uman, RN, Ph.D, of Vital Research, is the developer and project consultant.

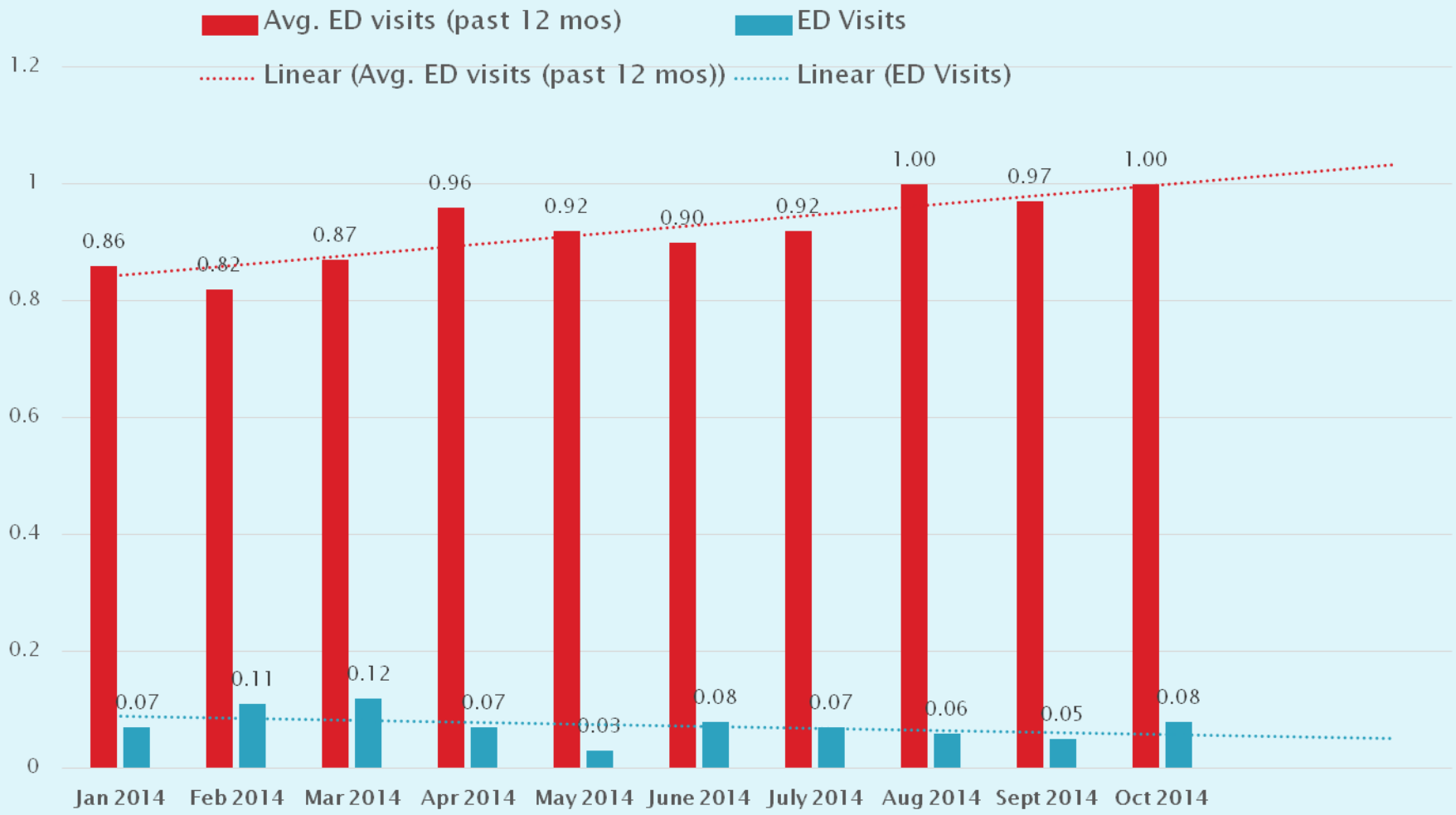
Opportunities

- Track CBHH patients and share claims data/encounters:
  - ID & examine gaps/mismatches in data
- Refer comparable Plan members to CBHH site.
  - During 18 month pilot phase, enhanced CBHH services are provided to identified Members at no cost to the plan, with funding from the SCAN Health Plan.
- Provide a primary care coordinator contact for RN-N.
- Give RN-N priority access to care coordinator for authorizations, problem-solving, etc.
- Share patient level data & collaborate re: analysis of claims / encounter data for studying outcome/cost results.

Data Sharing Opportunities

- Data sharing and metrics at patient level.
- Analysis of cost/utilization outcomes pre-and post- CBHH intervention (usual care v. CBHH).
- Comparison of claims data from Medi-Cal and Medicare to actual data/records collected by CBHH Project.
- TOPS patient/outcome data available to CM on line.

Emergency Department Visits Prior to CBHH Admission Compared to CBHH Intervention



At Project's End

- As of January 2015, when the pilot funding ends, we expect to be able to offer CBHH services to health plans as a service option for identified dual eligible high-risk Members.
- Rate development, admission criteria aligned with the Plan's needs and coordination details, all under development now under the pilot project, will be finalized by that time.
- We welcome the opportunity to work with health plans now to ensure that the CBHH is designed and tailored to the unique goals and guidelines of each Plan to serve its Members.

Challenges

- Hospital discharge planners unfamiliar
- Need “buy-in” from MDs (may be resistant)
- Cannot duplicate other services (may be necessary overlap, however)
- Difference for pts who are in or out of Duals Demo?
- Need “buy-in” from MCMC or Medicare HMO
- Need access to patient data from outside sources
- Potential resistance from others positioning for Health Home payment

Funding Update

- Thomas J. Long Foundation has funded Alliance for Leadership (ALE) and Education a grant for $750,000 over three years for replication of the CBHH model at Alzheimers Services of the East Bay, and at Rehabilitation Services of Northern California (to start January 2015)
- ALE will take the lead to continue to provide technical assistance and content expertise in replication efforts
- Family Bridges will receive funding to continue its current nurse navigation position for through 2015