The Community Based Health Home

The role of the Nurse Navigator

A National Model
Developed by Alliance for Leadership and Education

FAMILY BRIDGES, INC.
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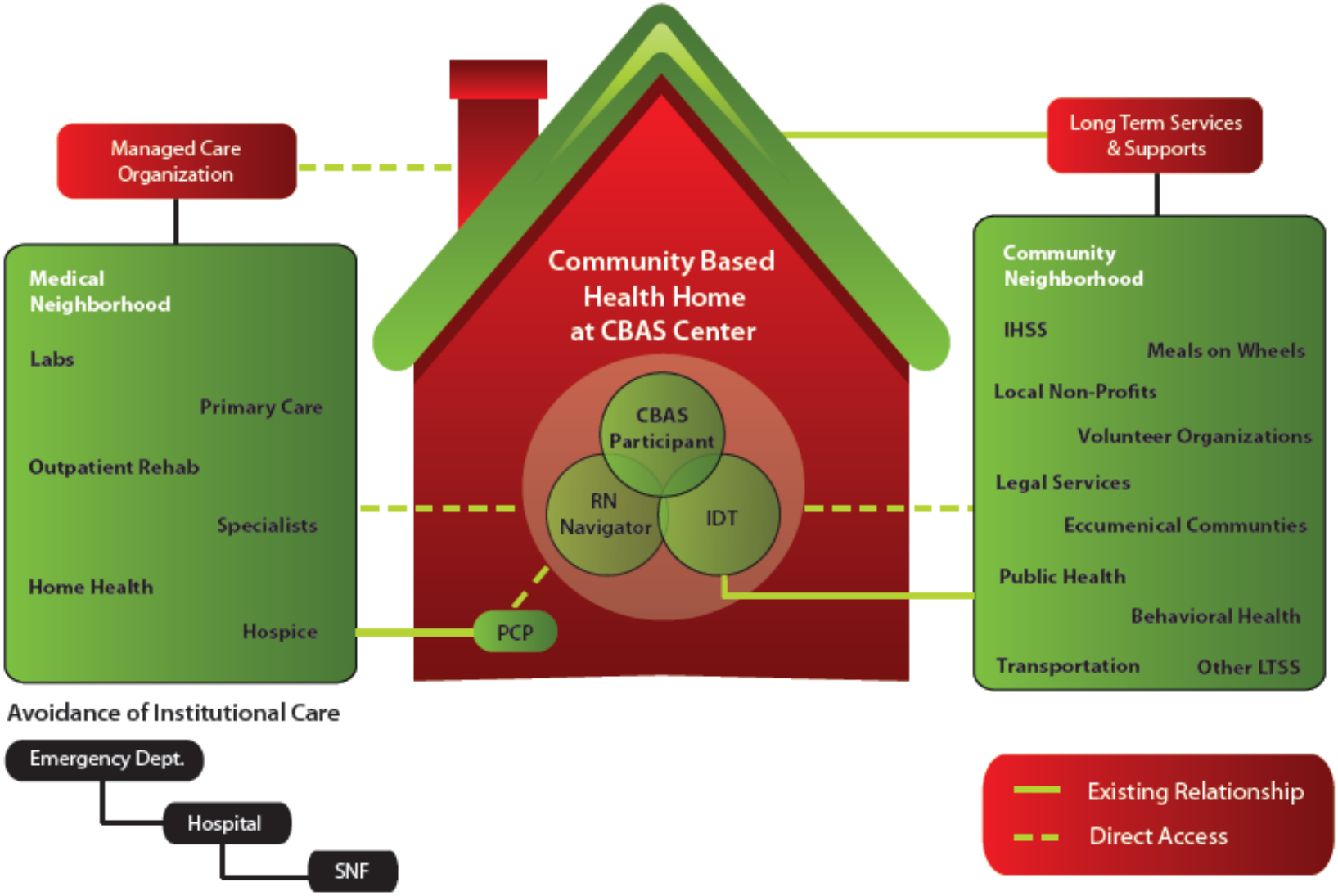
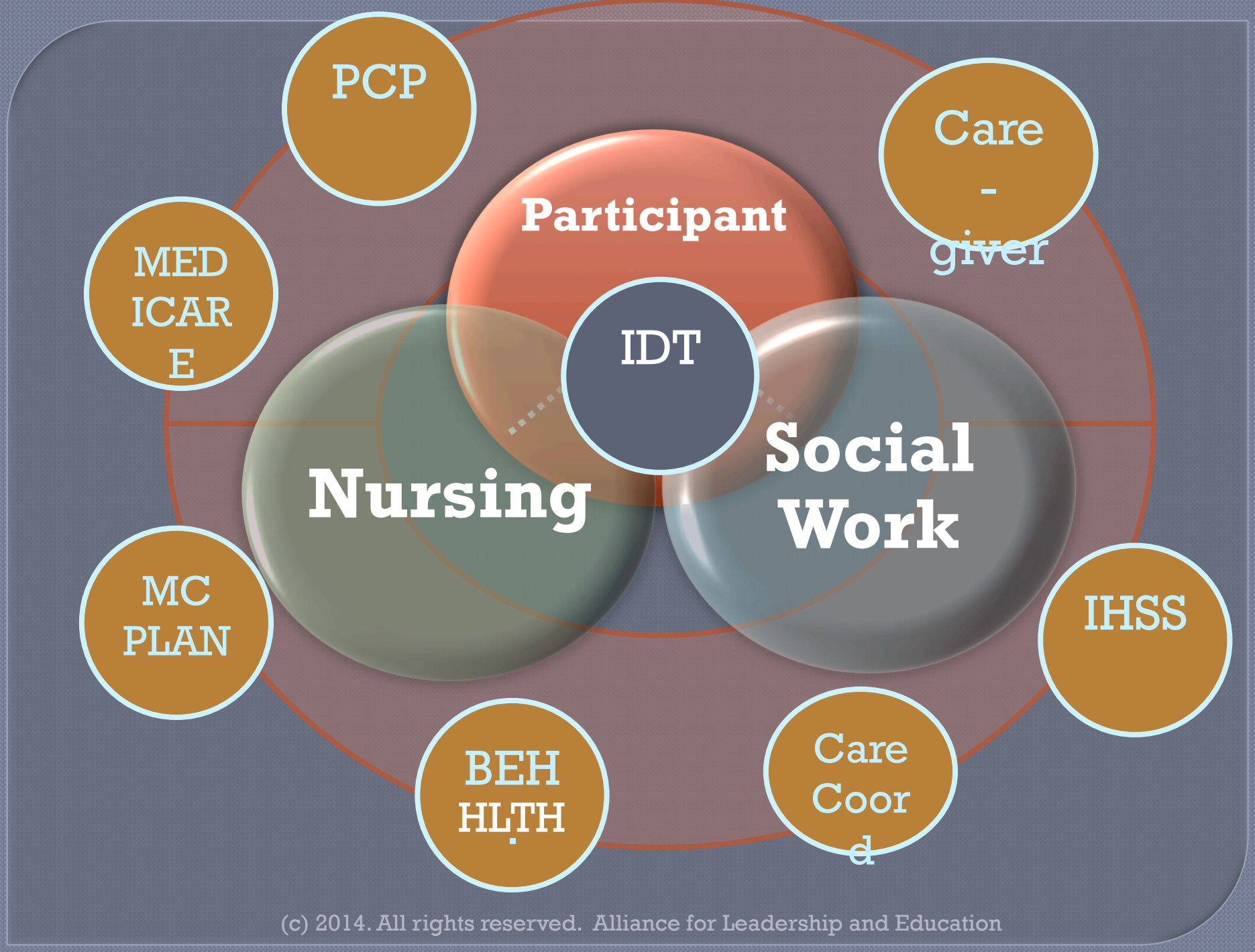
Community Based Health Home Model

A Project of the Alliance for Leadership and Education
Funded by the SCAN Health Plan - Long Beach, CA





CBHH Patient Population Profile

Identified by IDT as high risk
Participation agreement signed

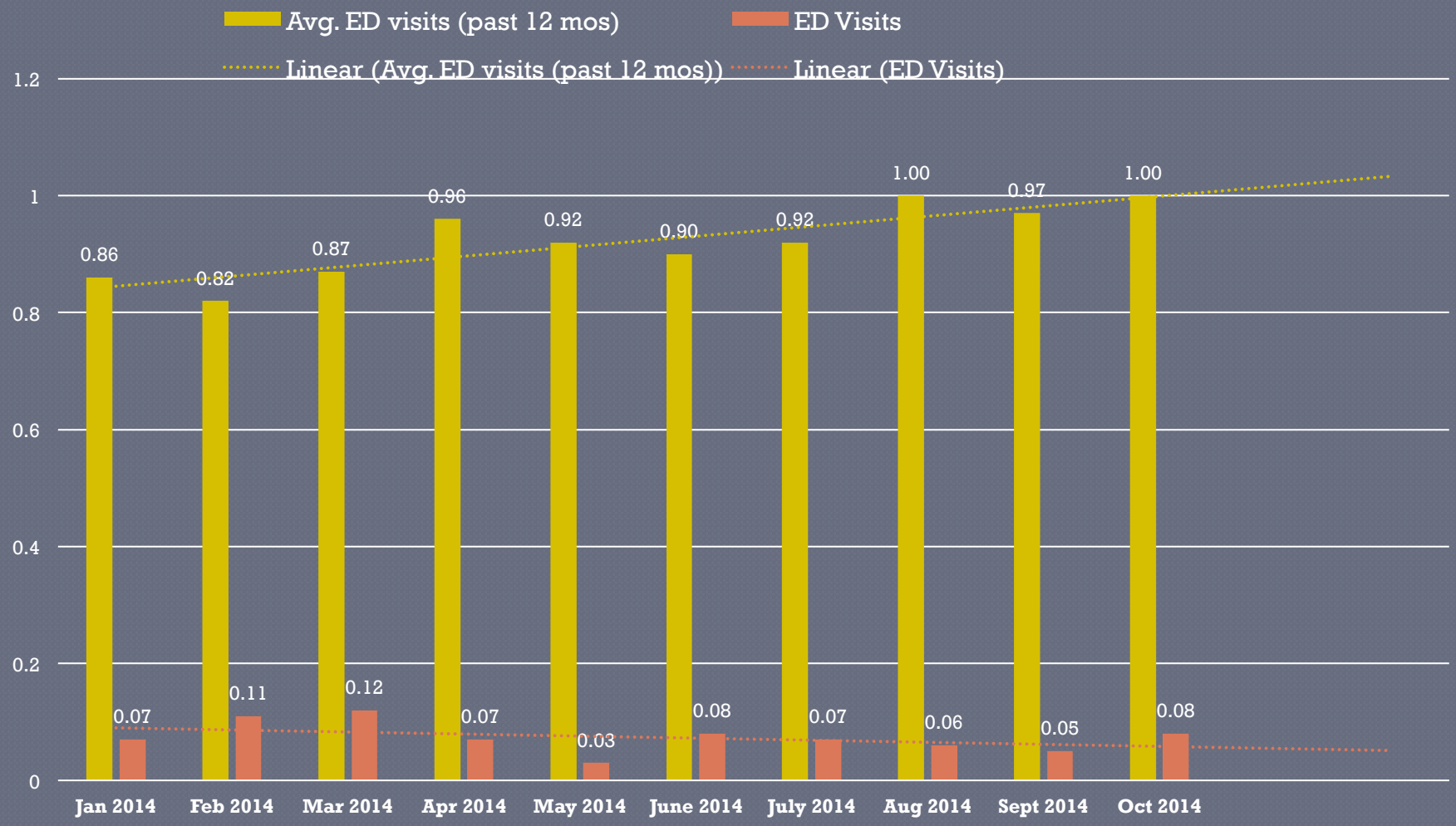
- 68 % Female
- 8.2 average chronic conditions
- 10.5 average # Medications
- 90% social risk factors
- 86% institutionalization risk
- 44% live alone or have little support
- 55% use of hospital and/or ED within prior 12 months
- 50% dementia or behavioral health diagnosis or both

	Source: May	Source: DHCS - Research and Analytic Studies Section April 2010
High Blood Pressure	85%	37%
Diabetes	52%	45%
Alzheimer's / Dementia	46%	<13%
High Cholesterol	60%	27%
Osteoporosis	33%	14%
Arthritis	42%	23%
Depression	39%	18%
Vision Impairment/Blindness	39%	25%
Other Mental Health Conditions	35%	13%
Gastrointestinal Problems	20%	13%
Genitourinary	20%	<13%
Other Neurological	25%	16%
Other Musculoskeletal	17%	25%
Chronic Kidney Disease	20%	<13%

CBAS Nursing & RN-N Comparison

CBAS/ADHC	CBHH
Mostly unable to leave center	Home visits – assessment, intervention, prevention
Reliance on self reports of incidents (after the fact)	Face to Face with providers
Reactive to what takes place in other settings, including at physician visits and in home	Point person
No involvement in discharge planning from acute or nursing facility care	Hospital visits, ER visits
Minimal transitional contact	Face to Face with hospital discharge planners
	Enhanced support to CBAS MDT
	Provide or arrange for 24/7 information and emergency consultation
	Bi-directional notification of admission/ DC
	Smoother 'hand off' back to community
	Use of TOPS data collection
	Enhanced transitional care

Emergency Department Visits Prior to CBHH Admission Compared to CBHH Intervention

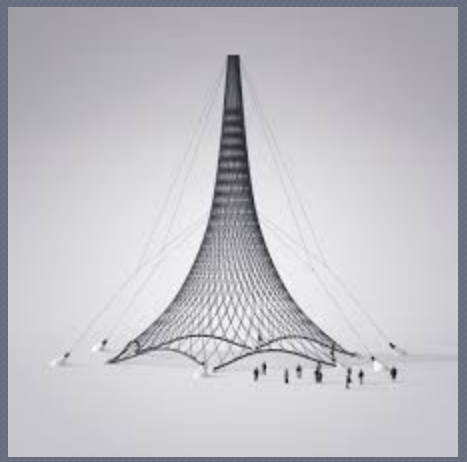


Opportunities

- ✓ Long Foundation (Bay Area has funded 2 more sites starting in Jan. 2015 (Alameda + Contra Costa)
- ✓ Additional sites being recruited who can obtain start-up funding (private foundations, Plans, owners)
  - Alliance for Leadership and Education provides readiness training and review; technical support; training and learning community ("all teach/all learn"); TOPS data access; team support.
- ✓ State ACA 2703 Health Homes Program (HHP)started
- ✓ Long Foundation granted $1million to Family Bridges for start up of HHP

Redesign

- Site Development
- Team configuration
- Partnerships
- NN role
- Community health workers
- Palliative care
- Primary care
- Behavioral Health



Priorities

- State certified Health Home Programs
- Relationship building
- MCO partnerships
- Triple Aim Philosophy
- Quality of Life/Rights to Self Determination
- Equal Access
- Person Centered Care