Introducing the Community Based Health Home

The California-based Alliance for Leadership and Education has designed and successfully tested the Community Based Health Home (CBHH), the first model in the nation to advance the Triple Aim by aligning national health home standards with the multi-faceted Adult Day Health Care (ADHC)/Community Based Adult Services (CBAS) team-based service platform. In partnership with the primary physician, the CBHH model comprehensively strengthens effective care and support for vulnerable, chronically ill adults by intensifying ADHC’s “high touch” nursing care coordination and in-depth assessment of needs, as well as the addition of transitional care support, patient activation, and education to advance health literacy.

The result is the creation of a uniquely effective person-centered health home to support choice, independence and dignity through community living for adults at high risk of institutional placement. With an exceptional track record to date, the CBHH model is poised to be an integral part of the service network for California’s 2703 state plan option under the Affordable Care Act starting in 2017.

The CBHH model functions through the integration of a “Nurse Navigator” within the ADHC interdisciplinary team (IDT). This highly trained CBHH nurse deepens understanding of the highest-risk individuals’ unique challenges and social environments by conducting in-depth health and psycho-social assessments, making home visits whenever needed, and facilitating care transitions. As a result, specialized nursing and care management expertise are seamlessly extended beyond the walls of the ADHC center and into the participant’s home, medical and community care settings to create a well-functioning system of care.

CBHH Nurse Navigators work closely with the ADHC center’s IDT (RN, PT, OT, SPT, social worker and dietician) and the participant’s personal physician to quickly address emerging crises for the Nurse Navigator’s high-risk caseloads, wherever they occur; support the physician’s care plan; coordinate with caregivers and other providers; and formulate person-centered action plans to stabilize and improve each individual’s health. Close communication with the physician results in more effective medical treatment plans; in turn, this better supports the goals set in the person-centered ADHC care plan to stabilize the individual’s social, medical and psychological conditions and reduce unnecessary utilization of health services. Overall, this unique combination of services achieves the core health home principle of unifying care across the continuum and bridging the gaps for persons with multi-faceted chronic conditions.

The CBHH project was initially funded through a SCAN Health Plan Community Giving Grant beginning in January 2013 and ending December 2015. Since that time, the Thomas J. Long Foundation has funded two new sites in Alameda and Contra Costa Counties for a three year period. The San Francisco Foundation provided one year funding for two new sites in San Francisco.

Results: The outcomes from the pilot phase of the CBHH model are highly promising: a 12-month pre- and post-comparison shows reductions in hospitalization rates (24.15%), emergency department visits (23.6%), and 30-day readmissions (1.8%, compared to a Medicare average of 20%). Outcome data is gathered using standardized evidence-based tools consistent with national standards and which address cultural diversity, measure quality of life for participants and caregivers, and are effective with participants who have cognitive disabilities. TOPSTM (Tracking Outcomes for Program Success), a web-based data and benchmarking system developed for adult day services, is used to aggregate this data and create reports to communicate with physicians and track participant well-being over time. These assessment tools are available in eight languages, reflecting the diversity of the CBHH population.