The Brooklyn Health Home (BHH)

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Medicaid Health Homes

- New initiative through NYS Department of Health
- Expands on the work of the medical home model
- Fundamental to the health home is care management services to provide effective communication and comprehensive care
- A strong network of providers
- Care Managers and Care Navigators provide oversight and access to care
- Electronic information among all partners
The Brooklyn Health Home

- Maimonides Medical Center (MMC) was named by New York State as one of the first Medicaid Provider Lead Health Homes in December 2011

- Builds on the work of MMC’s HEAL 10 and 17 efforts

- 50 partner organizations and growing
Goals

• Identify and address the full range of behavioral, medical and social problems affecting chronically ill patients

• Foster collaboration and the timely exchange of patient information among involved providers

• Drive measurable improvements in patient outcomes, including reduced patient readmissions, and patient/family engagement and satisfaction with care delivery
Target BHH Population

• Medicaid patients

• High-utilizers with multiple chronic medical diseases, serious mental illness (SMI), and/or HIV/AIDS

• Patients are assigned or upwardly enrolled to health homes
Brooklyn Health Home Model

Key Feature of the BHH model: Virtual co-location of providers and services enabled by health IT and coordination of services
Providers

Care Management Providers

- Baltic Street
- Brooklyn Community Services (BCS)
- CAMBA
- Catholic Charities
- Family Services Network of New York
- FEGS
- Jewish Board of Family and Children Services (JBFCS)
- Health Care Choices
- iHealth:
  - AIDS Service Center NYC
  - APICHA
  - Argus
  - Bailey House
  - Diaspora Community Services
  - Gay Men’s Health Crisis, Inc.
  - Harlem United
  - Heartshare Human Services of NY
  - HELP/PSI Services Corp
  - Housing Works
  - Narco Freedom Inc.
  - Richmond Home Need Services
- Interborough Developmental and Consultation Services
- Kingsboro Psychiatric Center
- Lutheran Medical Center
- Maimonides Medical Center
- NADAP
- Ohel Children’s Home and Family Services
- Promoting Specialized Care and Health (PSCH)
- The Puerto Rican Family Institute, Inc.
- Services for the Underserved
- South Beach Psychiatric Center
- Village Care
- Visiting Nurse Service of New York (VNSNY)

Network Providers

- Beth Israel Medical Center
- Black Veterans for Social Justice
- Realization Center
- Bridge Back to Life
- Brookdale Hospital
- Brooklyn AIDS Task Force
- Brooklyn Hospital
- Brooklyn Plaza Medical Center
- Center for Behavioral Health Services
- Center for Urban Community Services (CUCS)
- First to Care Home Care
- Institute for Community Living
- Liberty Behavioral Management
- Medisys Health Network Providers
- National Alliance on Mental Illness (NAMI)
- Phoenix House
- Public Health Solutions (PHS)
- St. John’s Riverside Hospital
- SUNY Downstate Medical Center
- White Glove Community Care
Key Standards of Practice

- Each patient has a Care Team
- Each patient has a single integrated care plan
- Each patient must have a follow-up appointment within 7 days of a medical discharge and 5 days of a psychiatric discharge
- Outreach to patients during hospitalizations
- Involved in discharge planning
- Same or next-day appointments
- Case Conferences
Key Care Team Roles

**Care Manager**

The Care Manager has overall day-to-day responsibility for:
- Coordinating the activities of the Care Team to help improve patient experience and outcomes
- Utilizing resources efficiently and effectively to enable patients to access needed services and avoid unnecessary use of inpatient and ER services

**Care Navigator**

The Care Navigator ensures successful implementation of the care coordination activities through:
- Communication and collaboration with the Care Manager
- Utilization of health IT tools to monitor and track patient health information to accomplish care coordination
- Monitoring alerts regarding patient hospitalizations to ensure timely communication to select clinical staff and appropriate follow-up
- Monitoring and sharing information with other care team members throughout care transitions
- Monitoring that patients have follow-up appointments after a medical or psychiatric discharge as needed
Care Team Responsibilities

- Develops a single, integrated care plan with patients
- Regular communication among care team, specialists, and social service organizations
- Interdisciplinary case conferences
- Case conference notes captured via Coordinated Care Plan (CCP) with automatic updates

- Reviews individualized treatment plans and goals with patients and families
- Enables patients, families and/or other authorized designee to access their care plan

- Health Information
- Appointments
- Referrals
- Events
- Communicate with other providers about a patient
- Evaluate and diagnose a patient
- Develop a treatment plan and reevaluate regularly
- Update treatment plans

- Monitoring and Tracking
- Video Conferences
- Case Conferences
- Patient Engagement
- Collaboration
Care Coordination Platform

Platform

User Interface/
HH Dashboard

Apps

Enrollment

Care Teams

Coordinated
Care Plan

Alerts

Messages

Patient
Engagement

Population
Manager

Patient
Summary/
CareBook
Healthix

- Healthix is a Regional Health Information Exchange Organization (RHIO) that has merged with BHIX

- Electronically aggregates and shares health information for over 9 million patients and over 100 participant organizations serving over 400 locations throughout NYC and Long Island by connecting to the organization’s electronic medical records

- Access to health information through Healthix is controlled by patient consent

- Now integrated with the State Health Information Network for New York (SHIN-NY)
Expected Near-Term Outcomes

- Improved and enhanced provider communications and care coordination among care team members
- Improved response times to needed patient treatment adjustments
- Decrease in inappropriate inpatient and ER utilization
- Enhanced medication management
- Clinical improvement
- Improved patient engagement and self management
- Reduction in total cost of care
Challenges Working with Formerly Incarcerated

- Lack of information regarding health history
- Point of engagement while in the criminal justice system
- Difficulty finding member post-release
- Re-entry issues
Options to Consider

- Peer Specialists to engage with and activate members
- Care Managers embedded in correctional facilities prior release
- EHR connectivity for real time access to health information
Future of Care Coordination

• Triple Aim

• New payment models: HARPs and FIDAs

• Risk-sharing
Contact Information

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