The Brooklyn Health Home (BHH), led by Maimonides Medical Center, holistically addresses the needs of individuals with complex chronic illness by delivering coordinated and comprehensive medical, behavioral health, and social services. It uses Maimonides’ own integrated health information technology tools to “virtually co-locate” providers across the more than 50 partner organizations that are part of the health home.

BHH evolved out of a collaborative effort between Maimonides and South Beach Psychiatric Center that placed primary care providers inside behavioral health clinics, resulting in improved communication between providers and coordination of care. Building on this initial project, Maimonides received two New York State Health Care Efficiency and Affordability Law (HEAL) Grants to demonstrate that a robust health information exchange system could advance similar improvements in care for individuals with complex needs on a larger scale by virtually co-locating medical and social service providers. The final missing piece – care coordination – was added when the program became a New York State Department of Health-recognized Medicaid health home under the Affordable Care Act in December 2011.

► **Delivery Model:** Every patient enrolled in BHH is assigned a care manager who is responsible for identifying and addressing an individual’s needs. In addition to the care manager, members of an individual’s care team may include a primary care internist, a psychiatrist, a therapist, and a care navigator (who monitors real-time data via an electronic dashboard and ensures issues are addressed when alerts are generated for hospital admission/discharge, jail admission, etc.). Care navigators can also pull in social service partners to address specific problems like an eviction notice, housing needs, and job training. Each time a patient interacts with the health home, this contact is recorded in the information technology (IT) system and can be shown on an electronic dashboard, which allows all members of the care team to be on the same page regarding the individual’s needs and status.

► **Financing:** BHH services are primarily funded via a per member per month care coordination fee paid by Medicaid; Maimonides also received a $14.8 million Center for Medicare & Medicaid Innovation (CMMI) grant to enhance health home services specifically for Brooklyn residents with serious mental illness.

**KEYS TO SUCCESS**

1. **Collaborate to develop an IT infrastructure** that holds together all of the various service providers.
2. **Recognize that medical providers do not have all of the answers**, and that the input of community organizations and social services providers in developing effective programs is invaluable.
3. **Develop a sense of trust** to ensure that collaboration between the medical and social services communities is effective.
Spotlight: Integrated Health Information Technology Infrastructure

Members of the care management teams in Maimonides’ network of health home providers have access to a robust integrated health information system that supports several of the hospital’s signature initiatives, including its work to co-locate behavioral health and medical providers with funding from New York’s HEAL grants, the health home, and its CMMI award.

The system’s interoperability allows teams, which may be comprised of individuals across multiple organizations, to develop a dynamic plan of care in real-time for enrollees with complex, chronic conditions. The system’s dashboard, where the care plan is housed, allows the care team members to see what others are working on with the patient – in essence allowing for “virtual” huddles.

Maimonides’ system also interfaces with New York City’s regional health information organizations (RHIOs) – multi-stakeholder organizations created throughout the state to facilitate health information exchange – and pulls clinical and utilization information from the RHIOs into the dashboard. Small organizations without electronic records, such as social services agencies and community-based organizations are able to manually enter data into the web-based IT platform.

Unique functionality has recently been added to the system, including: (1) the ability to assign care teams around patients; (2) secure messaging; (3) data analytic functions; (4) new alerting capabilities; and (5) a dynamic consent process that allows patients to determine which organizations may have access to their information.

BEHIND THE INNOVATION

David Cohen, MD, MSc is executive vice president for clinical affairs and affiliations, and chair of population health at Maimonides Medical Center in Brooklyn, New York. Previously, Dr. Cohen held the position of vice president for medical operations at the New York Health and Hospitals Corporation, and was medical director at Bellevue Hospital Center for seven years.

Karen Nelson, MD, MPH is senior vice president for integrated delivery systems at Maimonides Medical Center, where she leads the organization’s efforts to establish a health home for high-risk, high-cost Medicaid patients. She previously served as chief executive officer and medical director of Union Health Center and medical director for Dorchester House Community Health Center in Boston.

PROFILES IN INNOVATION SERIES FROM THE COMPLEX CARE INNOVATION LAB

These profiles highlight the organizations and individuals participating in the Center for Health Care Strategies’ Complex Care Innovation Lab. The Innovation Lab, made possible by Kaiser Permanente Community Benefit, is bringing together innovative organizations from across the country working to improve care for vulnerable populations with complex medical and social needs. Participants are exploring new ways to advance complex care delivery at the local, state, and national level. For more information, visit www.chcs.org.