

Health Homes Achieve Savings and Improve Quality



Over 180,000 high-risk, high-need adults and children are enrolled in Health Homes, being served by 4,000 care managers through care management agencies in their local communities. As a result:



Health Home members enrolled 9 months or more had a:⁽²⁾

- **39% reduction** in In-Patient Hospitalizations resulting in cost savings of over \$8 Million or on average \$2,486.00 per member
- **52% reduction** in Emergency Room Visits
- **38% reduction** in Potentially Preventable Readmissions (PPR)

Health Homes Work in Connecting Members to Community Level Healthcare

- **54% increase** in outpatient services, including Primary Care visits
- **34% increase** in pharmacy services

Multi Health Home Outcome Analysis⁽¹⁾

- **61%** significantly less depressed among members with major depressive behavior
- **53%** reduction among members with severe alcohol abuse
- **53%** reduction among members with severe drug abuse
- **33%** of members with detectable viral loads became undetectable
- **43%** of members housed among members experiencing homelessness

OMH HH+ Outcomes Analysis:

- Follow-Up after MH Inpatient (7 Day) 70% of members getting HH+ intervention vs. 51% of HH+ eligible
- Follow-Up after MH Inpatient (30 Day) 83% of members getting HH+ intervention vs. 68% of HH+ eligible
- 4+ Inpatient/ER-BH- 18% of members getting HH+ intervention vs. 30% HH+ eligible

What is a Health Home?

A network of community-based Care Management Agencies that work to engage individuals with serious and complex physical health, mental health and substance use disorders in their local community to achieve better health outcomes, member satisfaction and overall cost reduction.

Health Home Priorities

- Preserve and maintain funding for Health Homes – this highly effective, cost-saving program cannot sustain additional cuts;
- Invest in a diverse workforce targeting recruitment, retention and training in the highest need communities; and
- Enact measures to lessen the administrative burden on Health Homes to ensure more resources are dedicated to patient care and to protect workforce from burn out

Member Profile

- In Spring 2023, an informal survey of Care Managers demonstrated over **90% provide services to individuals with serious mental health challenges**⁽³⁾

Health Home Care Management Advances Health Related Social Care Needs

Individuals receiving Health Home Care Management reported the following:

- **36%** of individuals indicate **food insecurity**
- **26%** of individuals were concerned about **losing their current housing** or **did not have a steady place to live**
- **24%** of individuals **lacked reliable transportation** that kept them from medical appointments, meetings, work, or from getting things needed for daily living
- **7%** of individuals either had their **utility services shut off** or threatened within the past 12 months.
- **36%** of individuals had **2 or more health related social needs** as indicated above.



(1) Sourced from Foothold Care Management – Biopsychosocial Assessment (BA) PHQ-9 (Patient Health Questionnaire-9) Depression Scoring Tool AUDIT (Alcohol Use Disorders Identification Test) DAST (Drug Abuse Screening Tool)

(2) Draft Outcomes presented by DOH

(3) Presented during the 2023 NYS Care Management Coalition Annual Conference, June 2023

(4) October 2023 NYS DDH Presentation, October 2023



According to a NYSOMH HARP Focused Clinical Study - Performance Opportunity Program October 2021, members with a health home care manager were **5.0 times more likely** than those with an MCO-employed care manager to receive follow-up at 7 days and **14.4 times more likely** to receive follow-up within 30 days.

Health Homes improve outcomes for members by coordinating healthcare and social services which result in:

- A reduction of no-show appointments
- Increased engagement in treatment
- Support for members and their caregivers
- Member connections with culturally competent providers that understand and can meet their needs
- Address underlying social determinants of health such as housing and employment

Health Home Care Management improves outcomes across the entire healthcare system including:

- Reduction of avoidable or preventable inpatient stays
- Improved health outcomes for persons with mental illness and/or substance use disorders
- Improved management of disease-related care for chronic conditions, including HIV
- Focus on social determinants of health such as homelessness, housing, lack of food security, employment and benefit connectivity
- Individuals enrolled in Health Homes also saw improvements in rates of chlamydia screenings, colorectal cancer screenings, follow-up after emergency department visits, engagement in comprehensive HIV/AIDS care including viral load monitoring, medication management for people with asthma and overall prevention quality of care (HEDIS measure).

Health Homes Care Management addresses Social Determinants of Health (SDoH):

- Based on representative sample of Health Home enrolled members completing the Accountable Health Communities (AHC) health-related social needs screening tool in Foothold Care Manager (FCM) at intake and reassessment, there was a **47% reduction** in members who identified as being housing insecure after 1 year of continuous Health Home enrollment and a **52.6% reduction** in Health Home enrolled members that identified as food insecure. Additionally, transportation access for Health Home enrolled members **increased by 48%**.^[5]

The Role of Care Management and Health Homes

Care managers work with adults, children and their families who enroll in a health home to develop an individualized comprehensive plan of care, and then help them navigate the health care delivery system, schedule appointments, arrange transportation and communicate between health care providers.

Care managers also provide education about how to manage chronic conditions, taking medications properly, and understanding often complex discharge plans, next steps and follow-up after a hospitalization.

The Care Management Agencies in Health Homes networks are experts in providing care management services in communities across the state.

The care managers are located in communities where individuals live and provide culturally relevant and responsive support to their members. Care Managers meet members where they are most comfortable, providing person-centered support and coordination of services. By using individual member health data, including utilization and outcomes, care managers can connect the individual to appropriate health and social services in the least restrictive, most cost-efficient setting.

Our dedicated Care managers also help adults, children and families enrolled in Health Homes in other ways such as:

- Medicaid eligibility determination
- Enrollment and renewal of benefits
- Assessing eligibility and completing applications for other public benefits
- Securing safe and affordable housing, and
- Connecting individuals to social services.

Who We Are

The **Coalition of New York State Health Homes (CNYSHH)** represents 27 Health Homes across every region of New York State serving Health Home membership statewide working collaboratively with the New York State Care Management Coalition.

The **New York State Care Management Coalition** represents thousands of care managers from across New York State's behavioral health community and offers them the opportunity to become one voice on many issues facing the clientele and the agencies served.



For More Information

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^[5] Coalition of NYS Health Home analysis of 5603 Health Home enrolled members, in Foothold Care Manager (FCM), that had an initial Accountable Health Communities (AHC) health-related social needs screening tool and a reassessment using the same tool in 2020-2021. All Health Home members had at least one year of continuous Health Home enrollment.