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.

The Role of Care Management and Health Homes

Care managers work with adults, children and their families to develop an individualized comprehensive plan of care. They help people 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.

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. They 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 address Health Related Social Care Needs:

- 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 healthy food sources.

For More Information

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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).

Who We Are

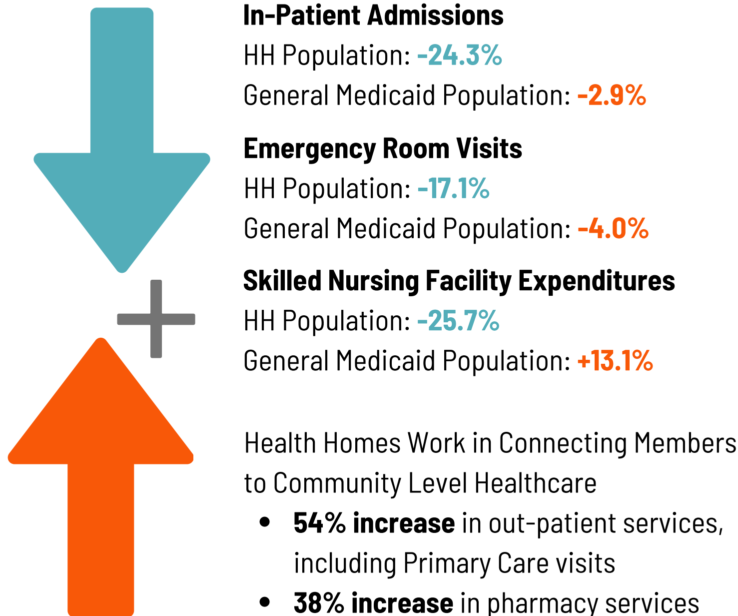
The **Coalition of New York State Health Homes (CNYSHH)** represents 22 Health Homes across every region of New York State serving Health Home membership statewide working collaboratively with the New York State Care Management Coalition.

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.

January 2025

Health Homes Achieve Savings and Improve Quality

Over 170,000 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:[1]



In-Patient Admissions
HH Population: **-24.3%**
General Medicaid Population: **-2.9%**

Emergency Room Visits
HH Population: **-17.1%**
General Medicaid Population: **-4.0%**

Skilled Nursing Facility Expenditures
HH Population: **-25.7%**
General Medicaid Population: **+13.1%**

Health Homes Work in Connecting Members to Community Level Healthcare

- **54% increase** in out-patient services, including Primary Care visits
- **38% increase** in pharmacy services

Connecting to the Most Appropriate Level of Service and Care

Health Home Care Management Advances Health Related Social Care Needs[2]

Individuals receiving Health Home Care Management reported the following:

- **35.7%** of individuals indicate **food insecurity**
- **25.8%** of individuals were concerned about **losing their current housing** or **did not have a steady place to live**
- **24.4%** 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.

Health Home Demographics

Health Homes serve a racially diverse membership, often from historically disenfranchised communities. Health Homes are increasing access and connection to care for traditionally marginalized populations:[1][3]

- Black non-Hispanic individuals are represented within the Health Home population at almost double the rate as the general Black non-Hispanic Medicaid population
- Puerto Rican/Hispanic individuals are represented within the Health Home population at about a 15% higher rate as compared to the Puerto Rican/Hispanic general Medicaid population

Health Home members have higher behavioral health needs and are more medically complex than most Medicaid members, which means the Health Home outcomes indicated below are even more significant.

Behavioral Health Diagnoses
The prevalence of all of the top 10 diagnoses were many times higher in the Health Home population than in the general Medicaid population

- **Bipolar disorder:** more than **10x higher** in the Health Home population*
- **Chronic stress and anxiety diagnoses:** more than **8x higher** in the Health Home population
- **Chronic stress and anxiety diagnoses (moderate):** more than **20x higher** in the Health Home population*
- **Schizophrenia:** more than **5x higher** in the Health Home population*
- **Major depression and depression:** nearly **10x higher** and more than **10x higher**, respectively

Medical Diagnoses
The prevalence of many medical conditions is significantly higher in the Health Home population than the general Medicaid population

- **Asthma:** more than 4x higher in the Health Home population*
- **Diabetes:** more than 5x higher in the Health Home population
- **Obesity/BMI 30-39.9:** almost 5x higher in the Health Home population
- **Hypertension:** more than 6x higher in the Health Home population
- **Hyperlipidemia:** almost 4x higher in the Health Home population

**data was only available for either dual or non-dual population rather than both*

[1] M360 Data Adult HH Population Descriptors February 2024-NYS DOH Outcomes
[2] DOH Data from the October 2023 HH/MCO Workgroup (147,559 Members Assessed-2022)
[3] NEW YORK STATE HEALTH HOME PROGRAM: 2024 DESCRIPTIVE AND PERFORMANCE DATA January 2025

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