NY Health Home Coalition

NEW YORK STATE CARE MANAGEMENT COALITION
The Key to Integrated Care

Executive Summary based on NYSDOH 2021-22 Health Home for Adults Data

Health Homes Serve a Diverse, High Needs, and Medically Complex Population

Health Homes are networks 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 communities to achieve better health outcomes, member satisfaction and overall reduction in the cost of care. Health Homes provides comprehensive care management to the highest need, highest risk Medicaid members in NYS.

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

- 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 **20% 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 **4x higher** in the Health Home population
  - **Chronic stress and anxiety diagnoses (moderate):** more than **8x higher** in the Health Home population*
  - **Schizophrenia:** more than **5x higher** in the Health Home population*
  - **Major depression and depression:** nearly **5x higher** and more than **4x higher**, respectively

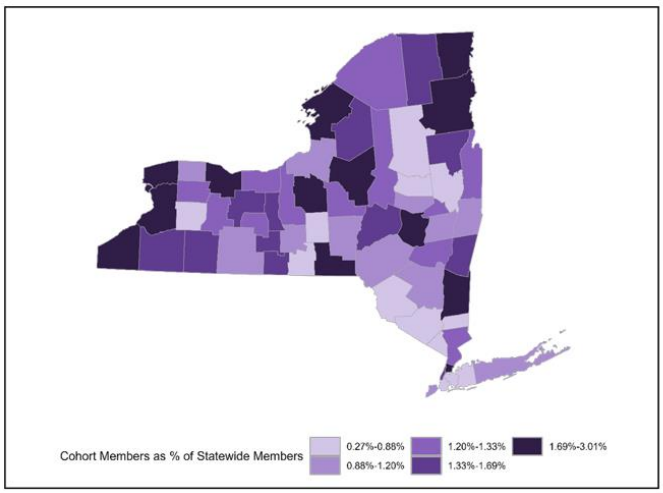
Medical Diagnoses

- The prevalence of many medical conditions is significantly higher in the Health Home population than the general Medicaid population
  - **Asthma:** more than **5x higher** in the Health Home population*
  - **Diabetes:** more than **2x higher** in the Health Home population
  - **Obesity/BMI 30-39.9:** almost **3x higher** in the Health Home population
  - **Hypertension:** more than **2x higher** in the Health Home population
  - **Hyperlipidemia:** almost **2x higher** in the Health Home population

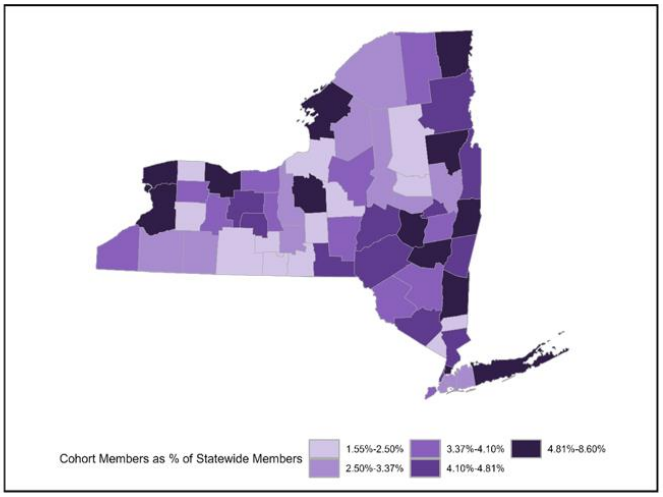
**data was only available for either dual or non-dual population rather than both*

Health Homes are in Every Community in New York

Non-Dual Members



Dual Members



Note: shading is done via Quantiles, so each subdivision in the legend has the same number of counties.

Health Homes Save Money and Improve Quality of Care

A recent fiscal analysis of health home enrollment data from 2021 – 2022 for members enrolled for 9+ months reveals ***significant savings*** as outlined below.

Health homes saw a significant reduction in Inpatient and ER visits as compared to those not enrolled in health homes:

ADMISSIONS TYPE	HEALTH HOME %	STATEWIDE %	REDUCTION
Inpatient Admissions	**-39.5%**	**-11%**	**-28.5%**
ER Visits	**-27.7%**	**+ 0.2%**	**-27.9%**

- Health Home enrollment is associated with a **38.4% reduction** in inpatient admission expenditures, while those not enrolled in health homes saw **a 3% increase** in expenditures.
- Health Home enrollment is associated with a **27.6% reduction** in emergency room expenditures, while those not enrolled in health homes saw a **2.6% increase** in expenditures.
- Health Home enrollment is associated with a **58.4% reduction** in skilled nursing facility expenditures, while those not enrolled in health homes saw a **10.2% increase** in expenditures.

Health Home care managers have been able to reduce reliance on expensive, and often, unnecessary levels of emergency care by increasing the penetration rate of less expensive community-based levels of care to maintain overall wellness. Through their member interactions health homes have:

- **Increased** use of outpatient services **by 54%**, including primary care services
- **Increased** utilization of pharmacy services by **34%**

Health homes understand the importance of the ongoing connection to outpatient care as a means of stabilizing a condition, and preventing crises that result in readmissions. Using National Quality measures, health homes have demonstrated outstanding outcomes in connecting health home members to care upon discharge from an emergency room visit or inpatient stay for a MH/SUD condition:

Measure Name	Medicaid	HH	Difference
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (30 Days)	37%	61.5%	24.5%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (7 Days)	27.2%	44.8%	17.6%
Follow-Up After Hospitalization for Mental Illness (30 Days)	60.9%	82.5%	21.6%
Follow-Up After Hospitalization for Mental Illness (7 Days)	45.1%	65.6%	20.5%
Follow-Up After Emergency Department Visit for Mental Illness (30 Days)	67.6%	83%	15.4%
Follow-Up After Emergency Department Visit for Mental Illness (7 Days)	58.5%	69.3%	10.8%

Health homes understand the **best way to prevent chronic disease is through early and periodic screenings for health conditions**. When compared to the overall Medicaid population, health home members are having a greater percentage of health care screenings.

Measure Name	Medicaid	HH	Difference
Breast Cancer Screening	56.3%	63.3%	7%
Cervical Cancer Screening	53.1%	65.5%	12.4%
Chlamydia Screening in Women	68.2%	70.2%	2%
Colorectal Cancer Screening	39.3%	50.3%	11%

Please visit the **Health Home Coalition website** for the full DOH 2021-22 report containing this data. All excerpts and conclusions in this Executive Summary were verified with DOH.

For more information:
Laurie Lanphear, Coalition of NYS Health Homes • llanphear@hhcoalition.org
Jackie Negri, NYS Care Management Coalition • nyscaremanagement@gmail.com
Evan Sullivan, Ostroff Associates • esullivan@ostroffassociates.com