Health Homes Achieve Savings and Improve Quality

NEW YORK STATE CARE MANAGEMENT COALITION
The Key to Integrated Care

NY Health Home Coalition

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]

- **37.8% reduction** in In-Patient Hospitalizations resulting in cost savings of $8.764 Million or on average $2,486.00 per member
- **17.2% reduction** in Potentially Preventable Visits (PPV) Emergency Room
- **37% reduction** in Potentially Preventable Readmissions (PPR)

Health Homes Work in Connecting Members to Community Level Healthcare

- **54.3% increase** in outpatient services, including Primary Care visits
- **32.2% increase** in pharmacy services

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

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

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 Fall 2022, an informal survey of Care Managers demonstrated over **90% provide services to individuals with serious mental health challenges**[3]

Health Home Fast Facts

Over the last 5-6 years individuals enrolled in a Health Home saw an:

- **11.4%** improvement in follow-up after hospitalization for mental illness within 30 days statewide for health home enrollees
- **8.4%** increase in adherence to antipsychotics for individuals with schizophrenia enrolled in HH (State established measure)
- **86%** of Health Homes improved comprehensive diabetes care rates with a corresponding statewide **4.5%** improvement rate during that time period
- **29%** reduction in homelessness and a **37.5%** reduction in incarceration from 2018 to 2019 for the same cohort of individuals, based on a representative sample.
- In 2018-2019, this program achieved over $70 million in savings through the restructuring of the outreach component of the program, placing additional burden on the remaining rates to support all outreach, engagement, enrollment and ongoing care management.

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

[2] *Draft Outcomes presented by DOH, November 18, 2022 HH/MCO Workgroup*

[3] *Presented during the 2022 NYS Care Management Coalition Annual Conference, November 2022*

The Role of Care Management and Health Homes

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
- 2019 HHSA PM Dashboard data showed a **26.2% decrease** in emergency department utilization after Health Home enrollment
- Improved health outcomes for persons with mental illness and/or substance use disorders
- Improved management of disease-related care for chronic conditions, including HIV
- 2019 HHSA PM Dashboard data showed a **10.3% increase** in connectivity to primary care after Health Home enrollment
- 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): [3]

- 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%**.

[3] *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.*

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

Laurie Lanphear, Coalition of NYS Health Homes llanphear@hhcoalition.org
Jackie Negri, NYS Care Management Coalition nyscaremanagement@gmail.com