The **Coalition of New York State Health Homes (CNYSHH)** represents 30 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 both the clientele and the agencies served.

Currently, we serve over 300,000 individuals a year connecting them to crucial healthcare, housing, social services, benefits and advocating for them for better access to care.

Health Home Stories:

Valerie had a history of opioid dependence and her four year old son had stomach cancer. Valerie's care manager helped connect them to therapists, specialists and she completed a substance use program. Read more about how Judy, her care manager, is a large part of her support network and other stories at hhcoalition.org/why-health-homes/stories/.

A Health Home is 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 to achieve better health outcomes, member satisfaction and overall cost reduction.

The Role of Care Management & Health Homes

When an individual is enrolled in a Health Home, a care manager develops a comprehensive plan of care with the member and helps the member navigate the health care delivery system, schedule appointments, arrange transportation and communicate between health care providers. Additionally, care managers educate members about chronic conditions, taking medications properly understanding often times complex discharge plans and the next steps after a hospitalization.

The Care Management Agencies in Health Homes networks are experts in providing care management services to their communities. The care managers are located in communities where individuals live, and provide both in-person and telephone support to their members. Health Home care management services are "boots-on-the-ground", the Care Managers meet members where they are most comfortable and provide the highest level of person-centered support and coordination of services. The Care Managers work with the individual in a person-centered approach to assure appropriate use of services in the healthcare system by collecting and using member health data to connect the individual to appropriate health and social services in the least restrictive, most cost-efficient setting.

Furthermore, our dedicated Care managers help members in other ways including but not limited to:

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

Current Health Home Populations Fast Facts

- ✓ From 2013 to 2018 There was an **8.3% increase** in adherence to antipsychotics for individuals with schizophrenia who were enrolled in Health Homes
- ✓ **4.5% improvement** in comprehensive diabetes care for individuals enrolled in Health Homes from 2013-2018
- ✓ **27% improvement** in follow-up after hospitalizations with mental illness within 30 days for individuals enrolled in Health Homes from 2013-2018
- ✓ **11.1% reduction** in Plan All-Cause Readmissions (a measure of readmission following acute inpatient stays) from 2014-2018
- ✓ **Reduction of 27%** PMPM inpatient costs for Health Home members post enrollment compared to the same period prior to enrolling in Health Homes

For More Information Contact:
Meggan Schilkie, Executive Director
Coalition of NYS Health Homes
mschilkie@hhcoalition.org

Jackie Negri, Director
NYS Care Management Coalition
jackienegrillc@gmail.com

Health Home and Care Management

Outcomes

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, and
- Addressed 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 in- patient stays,
- Reduction of avoidable emergency department visits,
- Improved health outcomes for persons with mental illness and/or substance use disorders.
- Improved management of disease related care for chronic conditions including HIV,
- Improved connectivity to preventive care and appropriate outpatient providers, and
- Focus on social determinants of health such as homelessness, housing, lack of food security, employment and benefit connectivity.

SFY 2019-20 Budget Recommendations

In SFY's 18 & 19 Health Homes suffered significant budget cuts totaling over $100 million. This cut was implemented with the intention of restructuring engagement but in actuality slashed rates reducing engagement activities.

We respectfully request that you reject any further proposed cuts and restore the previous cuts directly to Health Homes and community-based care management providers to:

- Preserve and maintain current funding levels to community-based Health Homes for care management; 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.

Health Homes Achieve Savings

There are currently 168,000 members enrolled in the Health Home program statewide, being served by approximately 4,000 care managers through over 500 Care Management Agencies. Health Homes Serving Children (HHSC) opened in December 2016, and Health Homes now serve members of all ages.

Inpatient costs per member per month are down 8%, according to the NYS Department of Health, and emergency room utilization is down 6 percent.

17% decrease in preventable hospital readmissions between 2014 and 2015, according to the NYS Department of Health.

Individuals increased visits to Primary Care and increased compliance with medication according to the NYS Department of Health.

This results in decreased hospital readmissions and emergency room visits.

NY Health Home Coalition

The Key to Integrated Care
NEW YORK STATE CARE MANAGEMENT COALITION