

Health-Related Social Needs of Health Home Enrollees

Department of Health | Office of Health Services Quality and Analytics | Bureau of Quality Measurement and Evaluation

Kayla Nikc, MSGH; Demi Culianos, MS; Elizabeth Nichols, PhD

Describing Health-Related Social Needs of Health Home Enrollees at Initial Assessment

Health Homes are a Medicaid benefit that provides comprehensive care management, care coordination, and referral to community, medical, and social services for Medicaid members that have qualifying conditions. Health Homes administer a health-related social need assessment to members upon enrollment and each year thereafter. Health-related social needs are evaluated using core questions of the Accountable Health Communities Health-Related Social Needs Screening Tool. The assessment responses provide the Department with granular data on health-related social needs. Needs are broken down into five core domains: housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety issues. Addressing these needs are important for improving health and reducing health disparities.¹ This brief examines the health-related social needs of individuals who newly enrolled in a Health Home between January 1, 2022 and June 30, 2025. This brief also compares enrollees' needs by race, ethnicity, and region.

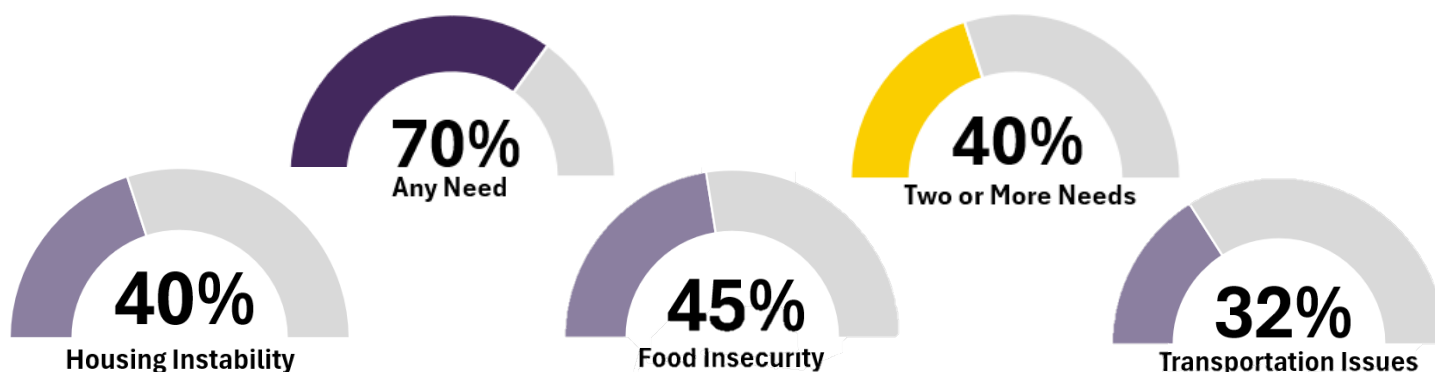
Key Findings:

- Seventy percent of Health Home enrollees reported at least one need and forty percent had two or more needs identified.
- There were variations in need by race and ethnicity. Multiracial enrollees reported the highest likelihood of health-related social needs and Hispanic enrollees reported lower needs than non-Hispanic enrollees.
- Health Home enrollees in New York City reported less likelihood of having needs compared to other regions, while those in the Capital Region of New York reported the greatest likelihood of needs.
- Health-related social needs are common in Health Home enrollees and efforts to addressing these needs are critical to supporting this population.

At the initial assessment, 70% of Health Home enrollees reported at least one health-related social need, while 40% reported two or more needs (Figure 1).

- Seventy percent of Health Home enrollees (N=64,567) reported at least one need, and 40% reported two or more health-related social needs, at the time of enrollment. Forty percent, 45% and 32% reported either housing instability, food insecurity, or transportation problems, respectively.

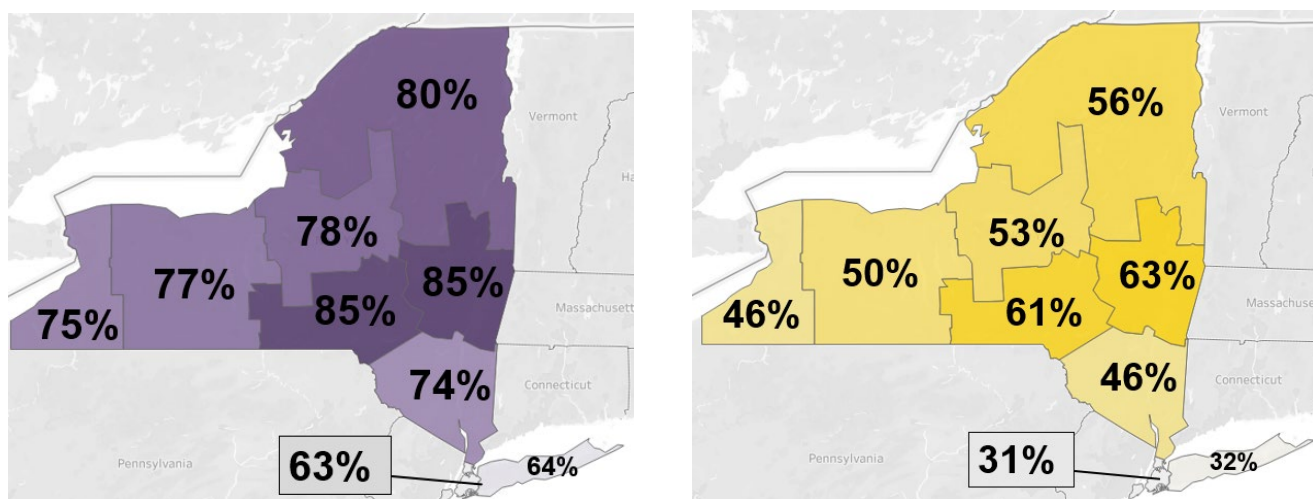
Figure 1: Percent of Health Home members with each health-related social need at the time of their initial assessment.



There was large variation in rates of “at least one” health-related social need (left) and rates of “two or more” health-related social needs (right) by region (Figure 2).

- Health Home enrollees in the Capital Region (N=2,740) and Southern Tier (N=1,874) had the highest needs rates, with a reported 85% of new enrollees having at least one need. Health Home enrollees in the Capital Region also reported the highest rates of having two or more needs at enrollment (63%).
- Conversely, Health Home enrollees in New York City (N=42,777) reported both the lowest rates of any need (63%) and two or more needs (31%).

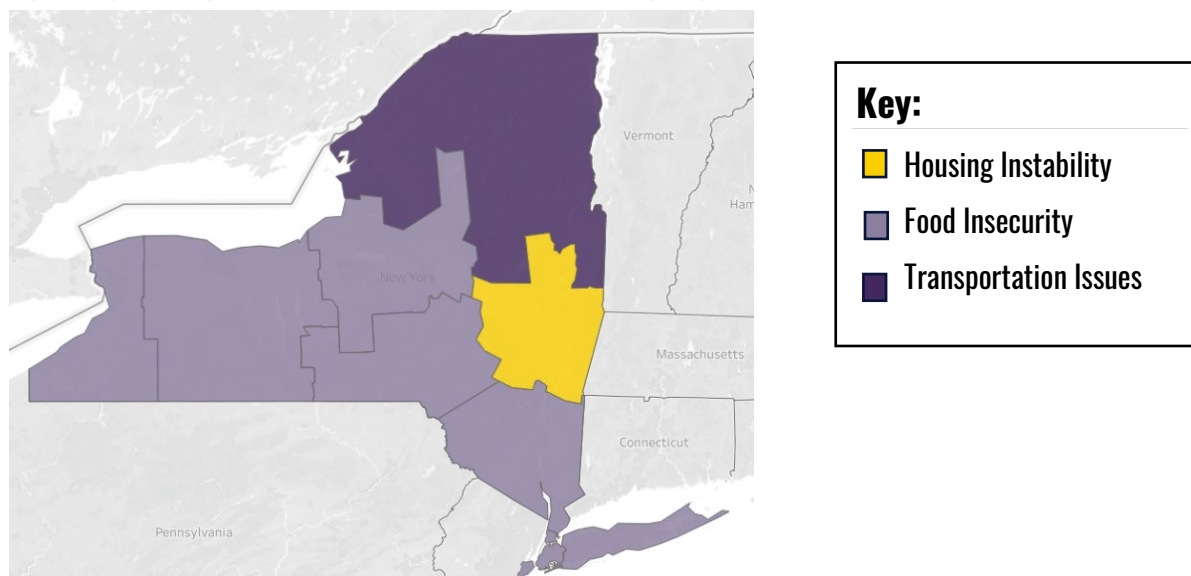
Figure 2: Percent of Health Home members with any health-related social need (left) and two or more needs (right) by region.



The most frequently reported need for most regions in New York was food insecurity (Figure 3).

- Health Home enrollees in most New York regions reported food insecurity as their greatest need.
- Enrollees in the Capital Region reported housing instability as the most reported need. In the North Country, transportation issues were the highest reported need.

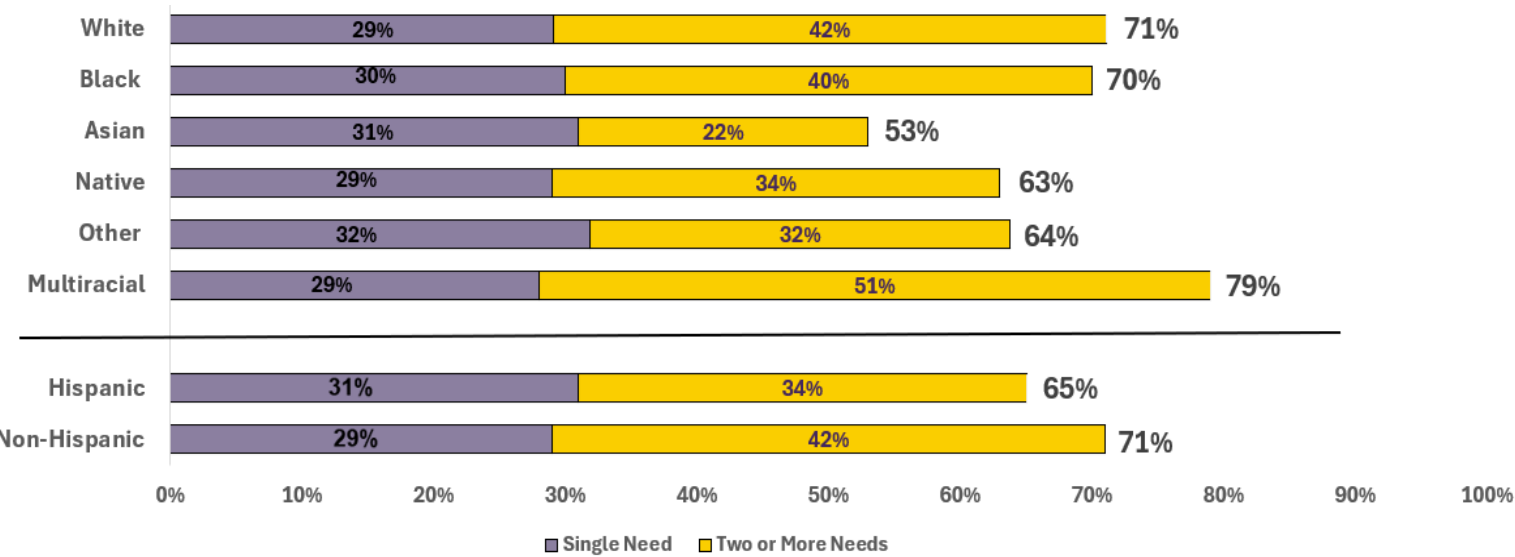
Figure 3: Map of highest reported health-related social need by region.



Health-related social needs persisted across race and ethnicity for Health Home enrollees.

- Multiracial enrollees (N=6,072) had the highest reported needs (79%). Additionally, Multiracial enrollees had the highest rate of two or more needs (51%). Individuals who identify as Asian (N=3,715) had the lowest reported needs overall (53%) as well as the lowest likelihood of having two or more needs (22%).
- Health Home enrollees who identify as White (N=18,311) or Black (N=18,076) reported slightly higher rates than those identifying as Native (N=559) and Other (N=2,732). Additional detailed information on each rate can be found in Supplemental Table 1.
- Hispanic enrollees (N=23,243) reported consistently lower prevalence of needs compared to non-Hispanic enrollees (N=54,892), with 65% of Hispanic enrollees reported having any need compared to 71% of non-Hispanic enrollees. Hispanic enrollees also reported a lower prevalence of two or more needs (34%) compared to non-Hispanic enrollees (42%).

Figure 4: Percent of Health Home members with one need or two or more needs at their initial assessment, stratified by race and ethnicity.



Summary

Seventy percent of Health Home enrollees reported at least one health-related social need at the time of their enrollment and 40% of enrollees attest to having two or more needs. This level of need is unsurprising as Health Home enrollees, by definition, experience socioeconomic and health hardships which are often intertwined with a greater likelihood of health-related social needs.² The extent of needs identified indicates the ongoing efforts to address needs via close collaboration between the Social Care Networks and Health Home program are crucial. The health-related social needs responses enhance eligibility intake data by describing the quantity and variation of needs.

There were variations in need by race, ethnicity, and region. Multiracial enrollees had the greatest likelihood (79%) of needs at enrollment compared to other races. Conversely, enrollees identifying as Asian expressed the lowest rates of any need (53%). There were also

variations by ethnicity, with newly enrolled Hispanic members less likely to express needs at enrollment (65%) than non-Hispanic enrollees (71%). Despite some variation, enrollees of all race and ethnicities reported needs, demonstrating needs are a universal struggle.

Finally, there was large variation of needs by NYS region. The Capital Region experienced both the greatest rate of any need (85%) and two or more needs (63%) when compared to other [Social Care Need regions](#). Health Home enrollees in New York City, however, expressed the lowest percentage of any need (63%) and two or more needs (31%). While this brief does not explore the specific reasons for these differences, it takes the first step in documenting and acknowledging these variations in the Health Home population, and future studies might work to better understand and mitigate these disparities.

Methods

Cohorts

We examined all individuals who were newly enrolled in a Health Home between January of 2022 and June 30, 2025. Newly enrolled individuals were defined as those that had no Health Home enrollment at least six months prior to their new enrollment. These members were required to have an initial health-related social needs assessment on file within at least 60 days of their enrollment start date. Individuals who had multiple initial health-related social needs assessments were excluded from the study. The final cohort examined included 64,567 distinct members.

Data Sources

Health Home enrollment and Health-Related Social Need Assessment data were obtained from [HHCMART data](#) and the [Medicaid Analytics Performance Portal Health Home Tracking System \(MAPP HHTS\)](#). Demographic information was pulled from the New York State Medicaid Data Warehouse.

Analysis

We calculated the rates of health-related social needs in SAS 9.4 following the guidance in the [Accountable Health Communities Health-Related Social Needs Screening tool](#). Only responses to the core questions were analyzed (1-10). When one domain had multiple questions, for example, in the living situation domain, we aggregated the results so that any response indicating a need for any question was reported as an overall housing need. For this analysis, we created both aggregate rates for “any need” and “two or more needs”. Any need was defined as a Health Home enrollee who expressed having at least one of any of the five need domains in the screening tool. Two or more needs was defined as a Health Home enrollee who expressed having at least two separate health-related social needs in the screening tool at their initial assessment.

References

- ¹ Artiga S Hinton E. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. 2018; 10. [The Role of Social Determinants in Promoting Health and Health Equity.pdf](#)
- ² Artiga S Hinton E. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. 2018; 10. [The Role of Social Determinants in Promoting Health and Health Equity.pdf](#)

Supplemental Tables

Table 1. Health-Related Social Needs at Time of Health Home Enrollment

	Housing Instability		Food Insecurity		Transportation		Any Need		Two or More Needs	
	Number of Enrollees with Need	Percent of Total Enrollees	Number of Enrollees with Need	Percent of Total Enrollees	Number of Enrollees with Need	Percent of Total Enrollees	Number of Enrollees with Need	Percent of Total Enrollees	Number of Enrollees with Need	Percent of Total Enrollees
Overall										
Overall	25,944	40.2	28,903	44.8	20,355	31.5	44,886	69.5	25,600	39.6
Race										
Asian	657	20.4	1,130	35.1	702	21.8	1,713	53.2	692	21.5
Black	6,964	42.5	7,161	43.7	4,719	28.8	11,438	69.8	6,423	39.2
Native	306	34.4	349	39.2	249	27.9	564	63.3	306	34.3
White	9,301	40.7	10,375	45.4	8,044	35.2	16,272	71.2	9,575	41.9
Other	3,122	31.2	4,303	43.0	2,512	25.1	6,365	63.6	3,212	32.1
Multiracial	3,505	52.4	3,485	52.1	2,608	39.0	5,250	78.5	3,438	51.4
Unknown	1,753	46.4	1,775	47.0	1,303	34.5	2,773	73.4	1,662	44.0
Missing	336	45.7	325	44.2	218	62.8	511	69.5	292	39.7
Ethnicity										
Hispanic	6,200	35.1	7,560	42.8	4,451	25.2	11,534	65.3	5,917	33.5
Non-Hispanic	19,436	42.1	21,052	45.6	15,696	34.0	32,824	71.1	19,390	42.0
Missing	735	41.9	291	39.6	208	28.3	528	71.8	293	39.9
Region										
Capital Region	1,908	56.4	1,883	55.6	1,873	55.3	2,881	85.1	2,130	62.9
Central New York	2,322	47.4	2,398	48.9	2,351	48.0	3,842	78.4	2,583	52.7
Finger Lakes	2,094	46.7	2,163	48.2	2,019	45.0	3,431	76.5	2,245	50.1
Hudson Valley	2,626	48.3	2,664	49.0	1,662	30.6	3,991	73.5	2,488	45.8
Long Island	1,963	32.0	2,786	45.4	1,341	21.8	3,949	64.3	1,947	31.7
New York City	10,685	34.5	12,498	40.3	6,676	21.5	19,604	63.3	9,446	30.5
North Country	1,808	50.3	1,820	50.6	1,863	51.8	2,891	80.4	2,015	56.0
Southern Tier	808	52.95	906	59.4	858	56.2	1,292	84.7	936	61.3
Western New York	1,703	43.4	1,756	44.8	1,679	42.8	2,941	75.0	1,787	45.6
Missing	27	14.3	29	15.3	33	17.5	64	33.9	23	12.2