





WholeYouNYC Social Care Network

Manhattan CB3 – Human Services Committee

January 7, 2025







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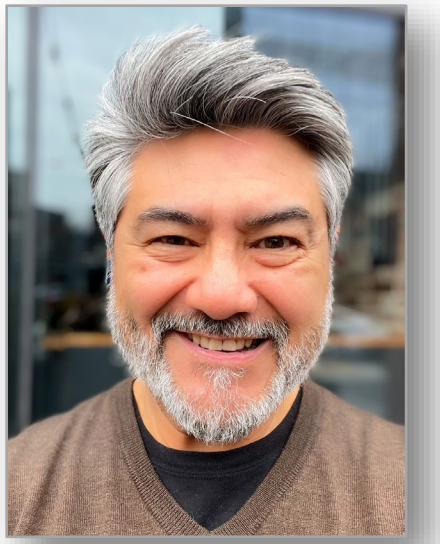
wholeyou.nyc

Welcome & Introductions

PHS Social Care Network Community Engagement Managers



Michael A. Hernandez (he/him)
Community Engagement Manager,
Manhattan and Queens

William Chambers (he/him)
Community Engagement Manager,
Brooklyn

About PHS

Public Health Solutions (PHS) is the largest public health nonprofit serving New York City. For over 65 years, PHS has improved health outcomes and helped families thrive by directly providing services to the city's most vulnerable populations, publishing groundbreaking research, and supporting hundreds of community-based organizations through our long-standing government partnerships. We are a leader in addressing crucial public health issues, including food and nutrition, health insurance access, maternal and child health, reproductive health, tobacco control and HIV/AIDS prevention. PHS has a strong focus on health equity to ensure New York City families have the basics for a healthier life.

Community Work

Contracting and Management Services

Healthcare Community Partnerships

PHS WholeYouNYC - SCN

PHS WholeYouNYC - SCN encompasses 3 counties (SCN regions)

- Manhattan (Region 4)
- Queens (Region 5)
- Brooklyn (Region 6)
- More than 200 SCN service providers (and growing!), including CBOs, healthcare providers, and other HRSN service providers.

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Core Functions – SCN Lead Entity (PHS)

Network development, operations and governance

Coordination of HRSN service delivery activities to Medicaid Members in a timely, accessible and equitable manner

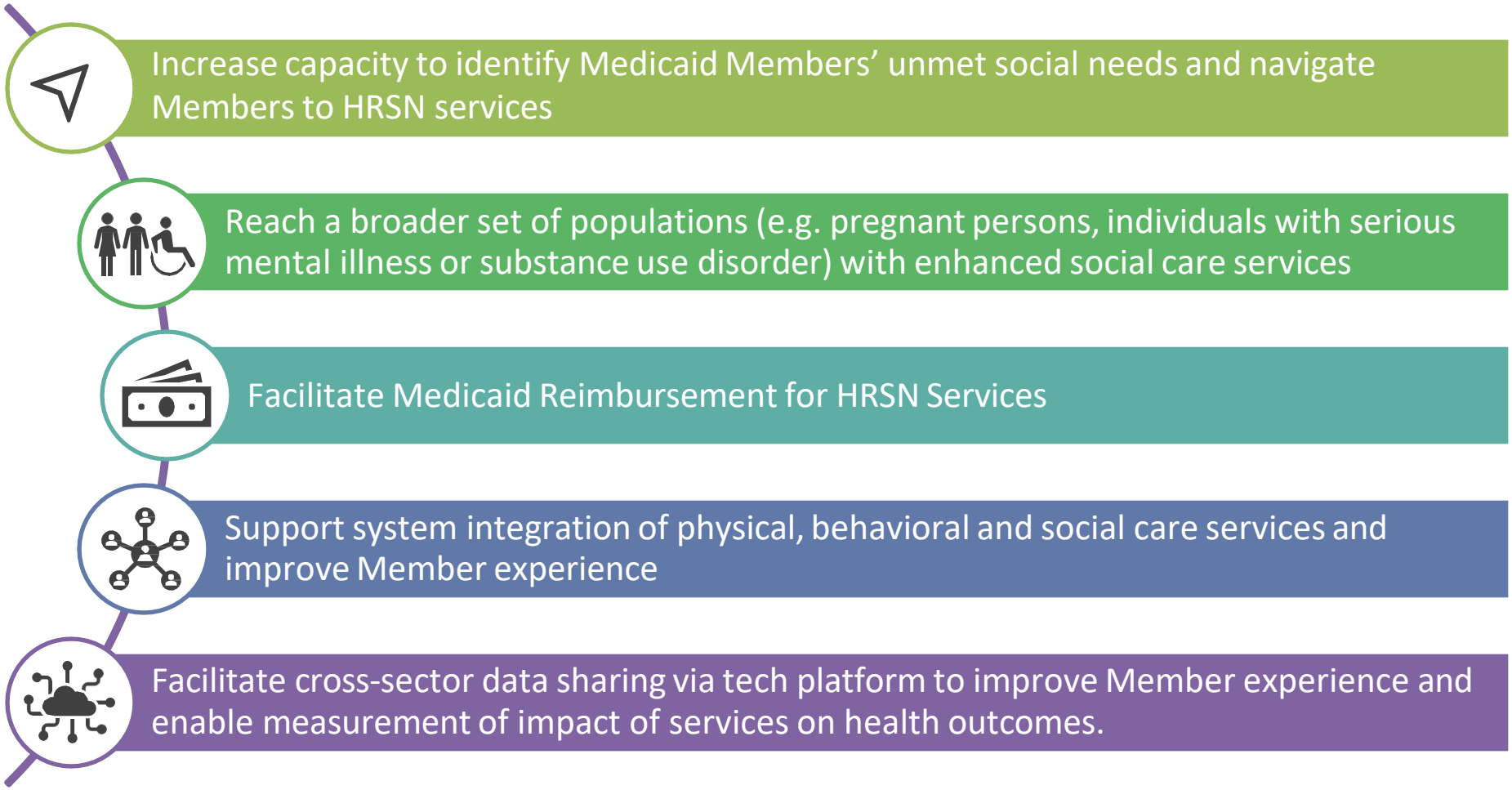
Performance management

Facilitation of data-sharing to support HRSN service navigation and delivery

Contracting and fiscal management

Capacity building to meet the demand for HRSN services via direct investments, trainings and technical assistance

SCN Objectives



SCN Community Engagement

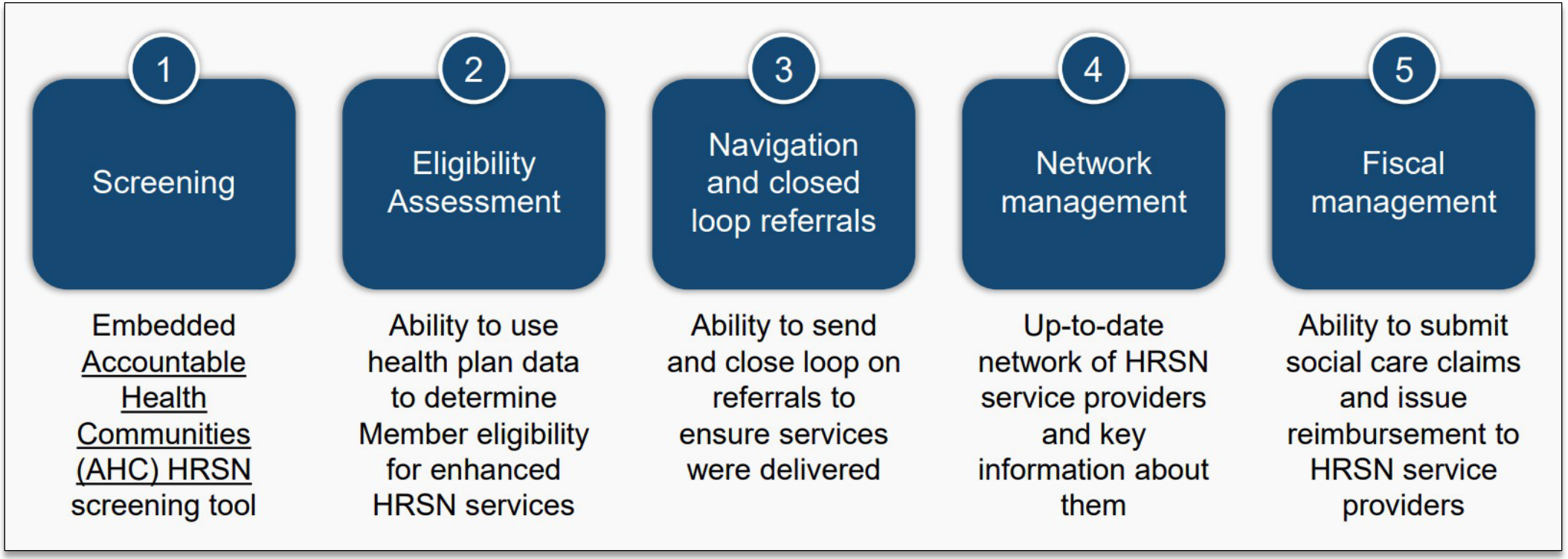
Foster relationships and curate activities to ensure that WholeYouNYC - SCN remains connected to the communities we serve and is responsive to its evolving needs.

This will be achieved through:

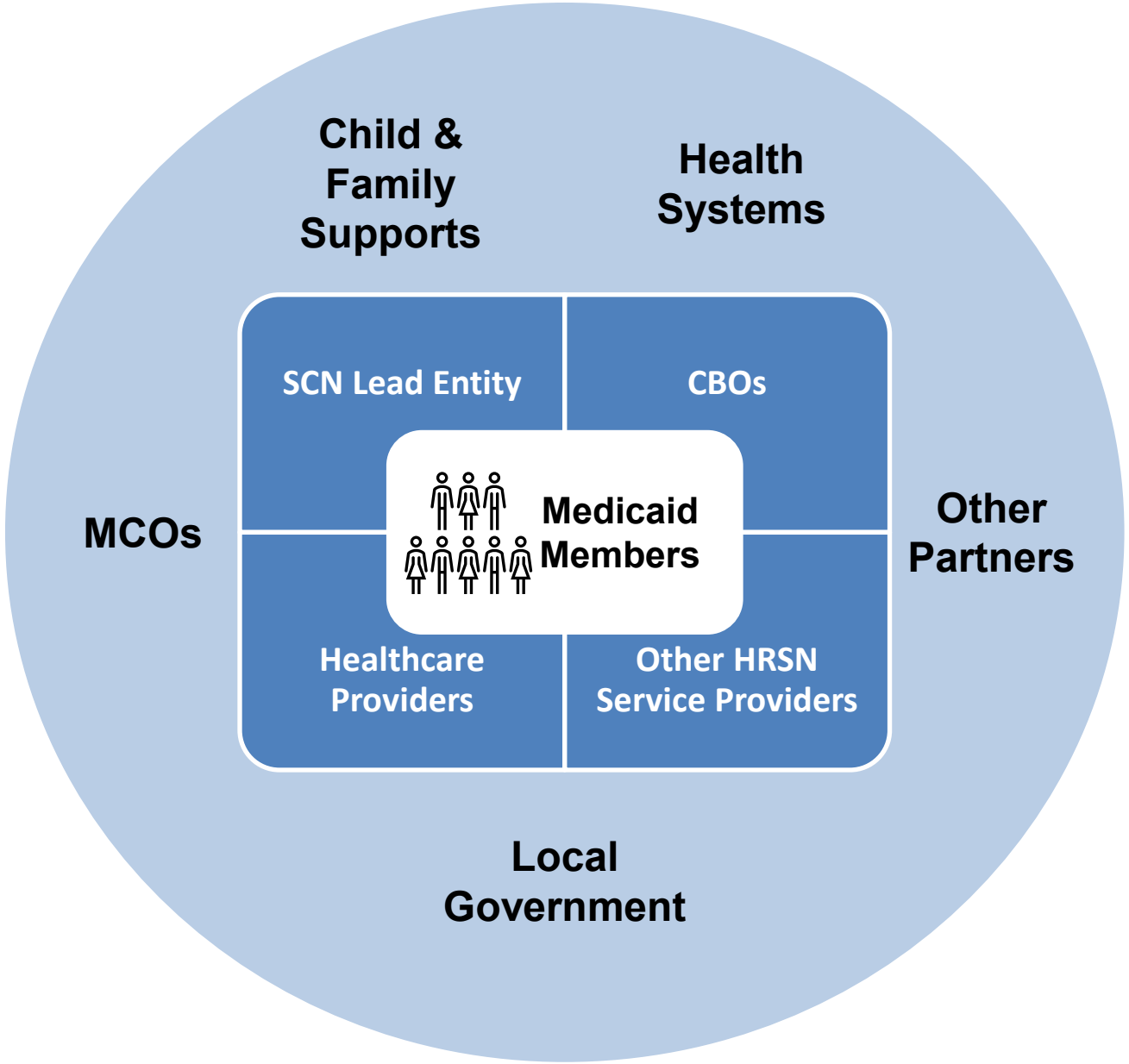
- Collaboration with community-based organizations (CBOs), Community Boards, health care agencies, elected officials, and other key stakeholders and community groups.
- Facilitate community listening sessions, info sessions, and town halls with SCN partners and community members.
- Leverage various social media platforms to bring visibility to the SCN.
- Utilize a “No Wrong Door” approach to meet people where they are — schools, barbershops/salons, Faith-Based Institution, shelters, and other community venues where people gather.

PHS WholeYouNYC - SCN

Our network leverages **Unite Us** - an accountable closed-loop referral software platform for managing and tracking HRSN Screenings, Navigation, Referrals, service delivery, invoicing and reimbursement for HRSN services, as well as ensuring connectivity across the Network.



SCN Ecosystem



Social Care Network

Ecosystem Partners

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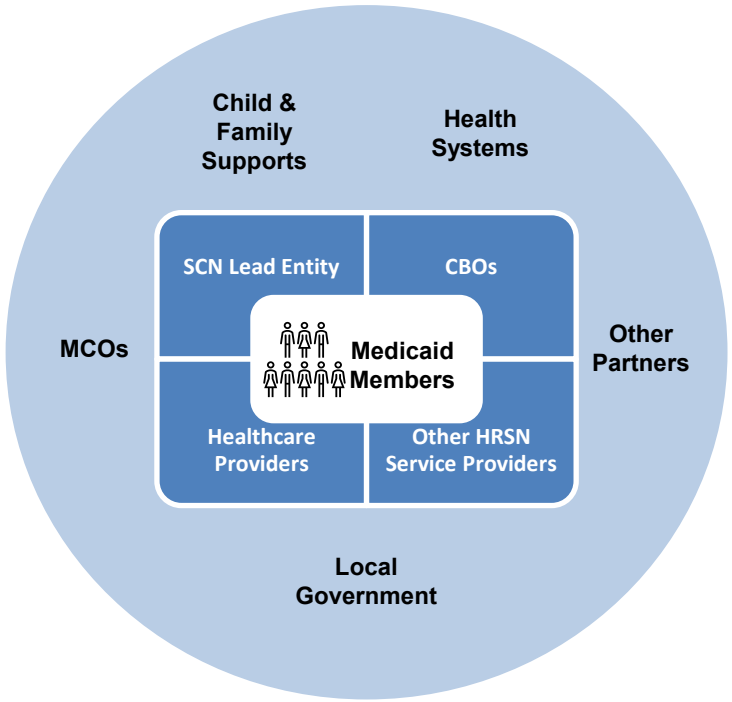
SCN Ecosystem Stakeholders

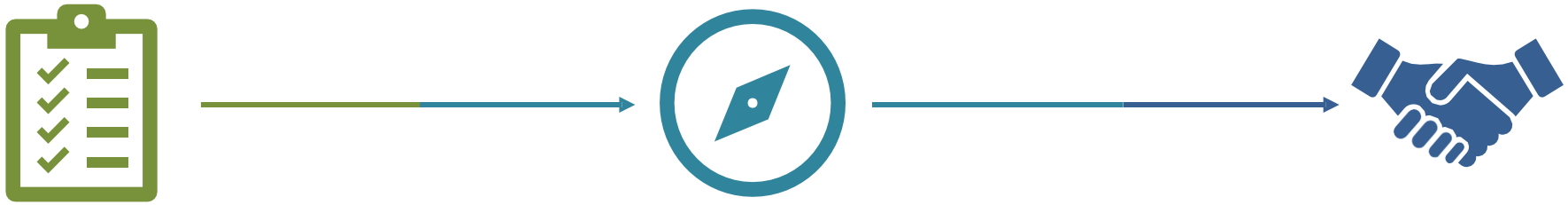


Social Care Network

Ecosystem Partners

Term	Definition and Details
SCN Lead Entity	Entity responsible for coordinating the Network of HRSN service providers and healthcare providers. The SCN Lead Entity contracts with OHIP, MCOs, and organizations within the Network
Ecosystem partners	Entities not contracted into the SCN but that may collaborate with the SCN, including but not limited to MCOs, local agencies / departments, and healthcare providers, inclusive of behavioral health and primary care providers, that may work with SCN but are not formally part of the Network
HRSN service provider (also "the Network" or "organizations in the Network")	Entities contracted into the SCN that conduct NYHER activities and deliver HRSN services (including but not limited to CBOs, healthcare providers, for-profit organizations, etc.)
CBO	501(c)(3) or 501(c)(4) non-profit community focused organization that provides HRSN services directly to Members, including conducting HRSN screening, navigation to existing and/or enhanced services, delivering HRSN services to Members.
Healthcare Provider	Healthcare providers include providers of behavioral health, primary care, and other licensed practitioners who conduct screening and navigation of Members to existing and/or enhanced HRSN services.
Managed Care Organizations	Provide information on Medicaid Members through secure channels to identify who may benefit from and be eligible for HRSN services, and support reimbursement of HRSN services via payment flow to SCNs.

SCN Service Delivery



Screening

Member is comprehensively **screened for HRSNs** using AHC standardized screening tool.

If an unmet HRSN is identified and the screening entity is not a Social Care Navigator, the Member will be referred for navigation services.

Navigation

The Social Care Navigator **determines the Member's eligibility for Enhanced HRSN Services** and **navigates** the Member to relevant HRSN Services based on the results of the Eligibility Assessment.

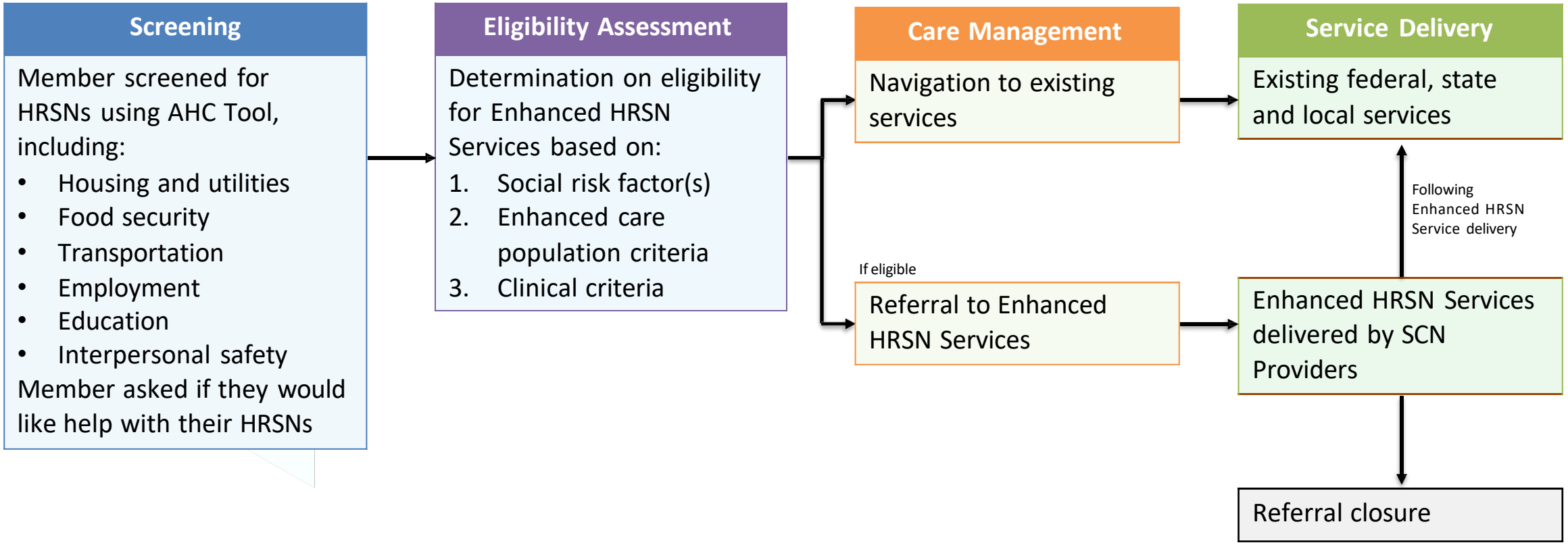
HRSN Service Delivery

If the Member is eligible, they are navigated to and provided **Enhanced HRSN Services.**

If the Member is not eligible for Enhanced HRSN Services, they are navigated to **other relevant federal, state, and local programs**.

After service delivery, HRSN Provider **closes the referral loop.**

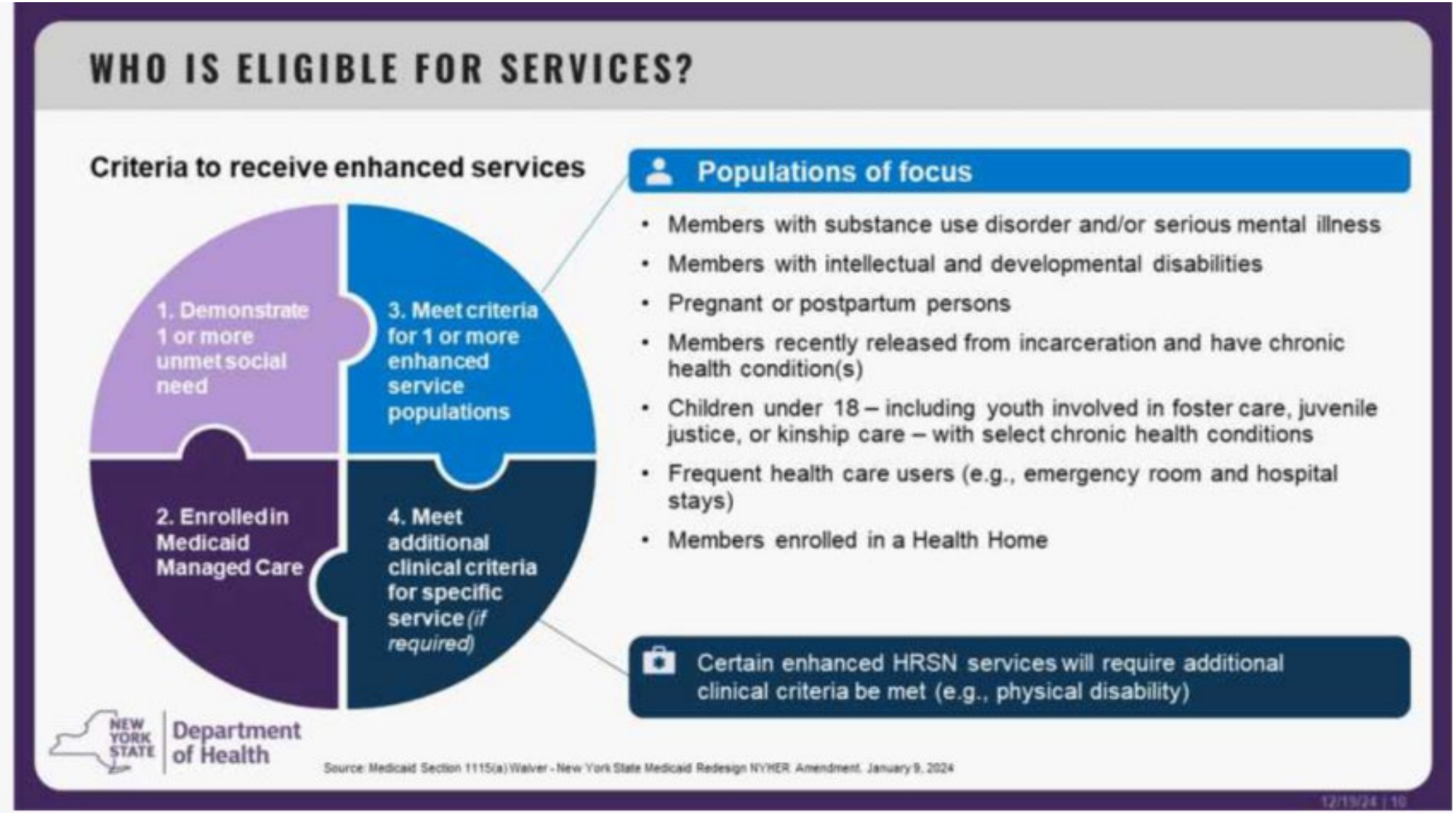
Member Journey



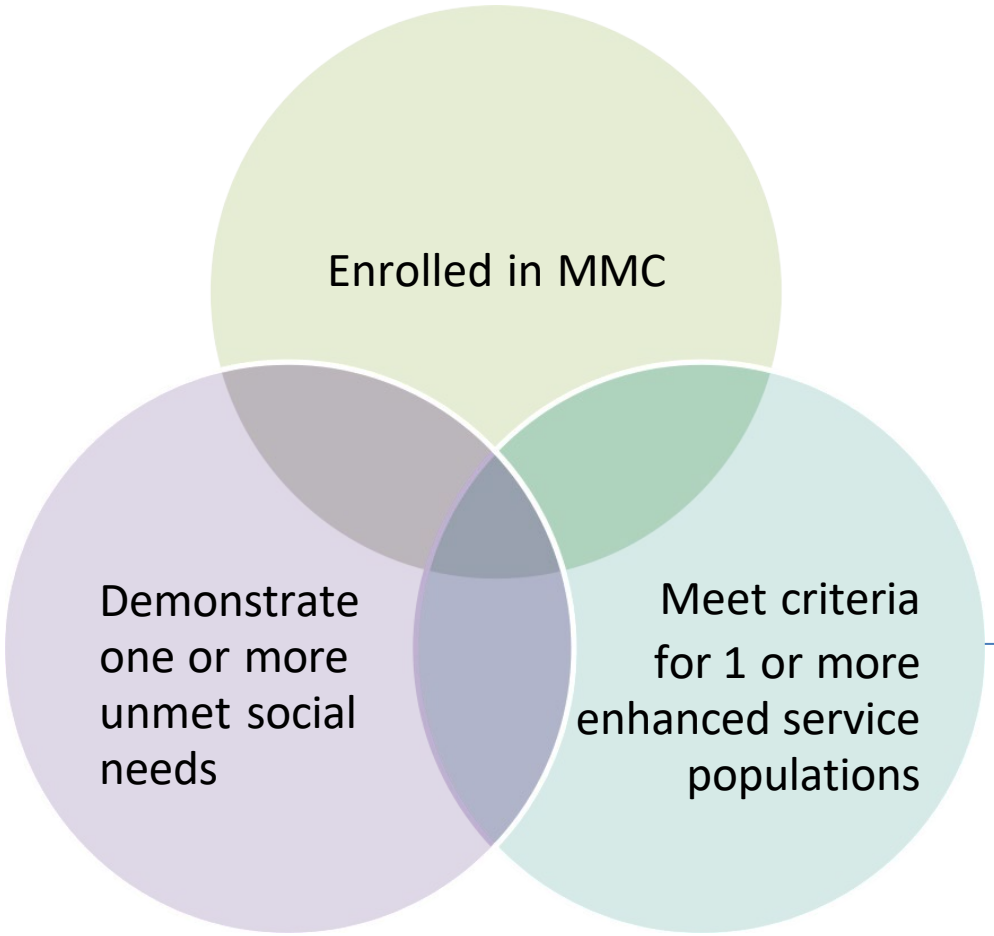
Screening

- **Process of identifying the unmet HRSNs of Medicaid Members**.
  - SCN's goal is to conduct an HRSN screening with every Medicaid Member annually and on an as-needed basis.
  - Members will be screened using a standardized New York version of the Accountable Health Communities (AHC) screening tool to assess Member HRSNs related to housing and utilities, food security, transportation, employment, education, and interpersonal safety
  - Screening involves asking a standard series of questions, coupled with the empathetic engagement with individuals to understand their life context, specific needs, and HRSN service preferences.
  - Regularly screening Members across these domains will improve the identification of HRSNs and show how HRSNs are evolving over time.

Eligibility



Eligibility for Enhanced HRSN Services



Populations eligible for Enhanced HRSN Services
Medicaid High Utilizer (*defined by Emergency Department or inpatient utilization)*
Members enrolled in a NYS-designated Health Home
Members with Substance Use Disorder and/or serious mental illness
Members with intellectual and developmental disabilities
Pregnant and postpartum persons
Members who are up to 90 days post-release from incarceration with a chronic health condition(s)
Youth in care (*e.g., foster care, juvenile justice, kinship care*) who are high risk
High risk and children under the age of18

Screening: Frequency

Each Medicaid Member will receive a HRSN Screening annually and as-needed due to a self-reported major life event.

Annual Screening

- Members will be eligible for reimbursed HRSN Screening annually.
- Member's annual screening applies 12 months after their original screening date, regardless of any re-screens due to a Major Life Event.

Major Life Event (MLE)

- If the Screener identifies a Major Life Event during their interaction with the Member, or if a Member was referred to the SCN for a Screening as a result of a Major Life Event, the Member may be re-screened within the same year and the Screener may be reimbursed for the re-screen

Social Care Navigation

Medicaid FFS and MMC Members who have an identified unmet HRSN and who do not meet Enhanced Population criteria for Enhanced HRSN Services	Enrolled MMC Members who have an identified unmet HRSN and meet Enhanced HRSN Service criteria
Receive navigation to existing federal, state, and local services to address HRSNs.	Receive navigation to Enhanced HRSN Services
	May receive navigation to existing federal, state, and local services, as per their preference.
Eligibility criteria are subject to change by the NYS OHIP	

Social Care Navigation

Process by which eligible Members are referred to the appropriate services and/or resources.

- The Navigation process includes
  - Validating Member eligibility for Enhanced HRSN Services
  - Developing Social Care Plans for eligible Medicaid Managed Care Member
  - Managing Closed Loop Referrals for HRSN Services

Eligibility for Screening and Navigation

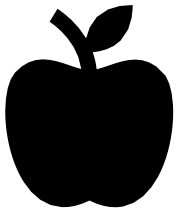
Some Medicaid Members **are not eligible for Screening, Navigation or Enhanced HRSN Services.** A preliminary list of these populations includes:

- Members with provisional eligibility for Medicaid benefits
- Members participating in the Medicare Savings Program
- Members exclusively in the Family Planning Benefit Programs
- Members residing in a state psychiatric facility
- Members who are currently incarcerated
- Members who are eligible for emergency services only
- Members who are permanently placed in Nursing Home
- Individuals residing in a state Office of Mental Health facility
- Individuals in an Office for People with Developmental Disabilities (OPWDD) facility or treatment center
- Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention (CDC) breast, cervical, colorectal and/or prostate early detection program and need treatment for breast, cervical, colorectal or prostate cancer and who are not otherwise covered under creditable health coverage

Enhanced HRSN Services

- OHIP has defined evidence-based Enhanced HRSN Services that may be delivered by the SCN and reimbursed by SCN for the Enhanced services population.

Key Domains of Enhanced HRSN Services



Nutrition

- Nutritional counseling and classes
- Medically tailored home-delivered meals
- Food prescriptions
- Pantry stocking
- Cooking supplies (pots, pans, etc.)

Housing

- Medically necessary home modifications and remediation, including asthma remediation
- Medical respite
- Rent / temporary housing
- Utility set-up / assistance
- Housing Navigation
- Pre-tenancy services
- Community transitional services
- Tenancy sustaining services

Social Care Management

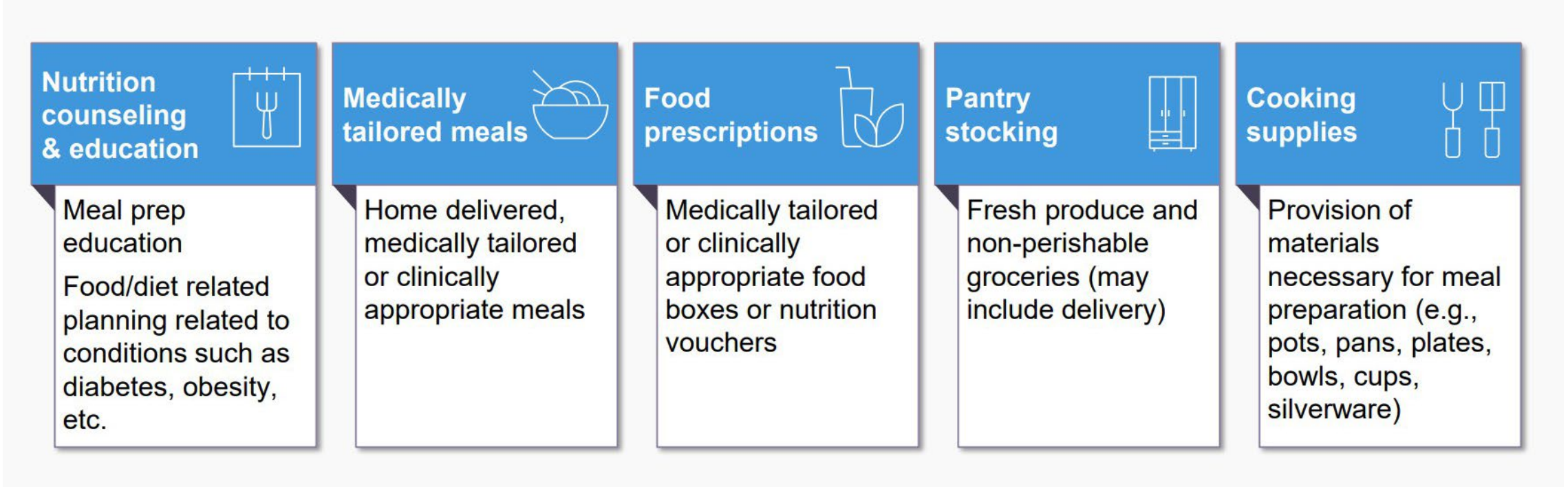
- Navigation to social care services (including other enhanced HRSN services and existing services such as education, childcare, interpersonal violence resources, etc.)

Transportation

- Reimbursement for public and private transportation to connect to HRSN services and HRSN care management activities (e.g., get to an appointment with housing navigator).

Enhanced HRSN Services

Nutrition Services



*Managed Long Term Care Plan (MLTCP) and Medicare Advantage Plus (MAP) Members are **NOT eligible** for Nutrition services, since they are provided as a plan benefit.
However, they may be eligible to receive other Enhanced HRSN Services.

Enhanced HRSN Services

Housing

Medically necessary home accessibility / safety modifications
- Ramps
- Handrails
- Electric door openers
- Widening of doorways
- Non-skid surfaces

Medically necessary home remediation
- Mold / pest
- Ventilation, AC, heater, etc. repair
- Refrigeration for medical treatment
- Home environment assessment

Asthma remediation
- Home remediation / equipment provisioning tailored to individuals with asthma
- Home environment assessment

Medical respite
- Recuperative care: pre-procedure and post-hospitalization
- Care coordination and connection to supportive housing

Rent / temporary housing
- Rent / temporary housing support (up to six months)
- Utility assistance

Utility set-up / assistance
- Activation expenses and back payments to secure / keep utilities (e.g., electric)

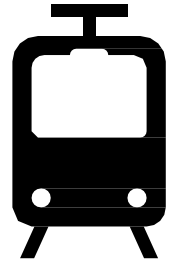
Pre-tenancy services
- Tenant rights education
- Housing interviews
- Application assistance

Community transitional services
- Security deposits
- First month's rent
- Utility activation fees

Tenancy sustaining services
- Eviction prevention
- Fiscal planning
- Emergency planning
- Independent community living skills

Housing transition and navigation
- Assistance with housing search

Enhanced HRSN Services



Transportation

Transportation services

Public or private transportation (e.g., taxi/livery, rideshare/transportation network company (TNC), public transportation) to **utilize enhanced HRSN services and/or social care management activities** for which a Member has been referred including:

- Housing appointments
- Nutrition class
- Pick up of food prescription box

These enhanced transportation services are a separate but complementary benefit to NEMT and meant to be used to access enhanced social care services (not clinical care)

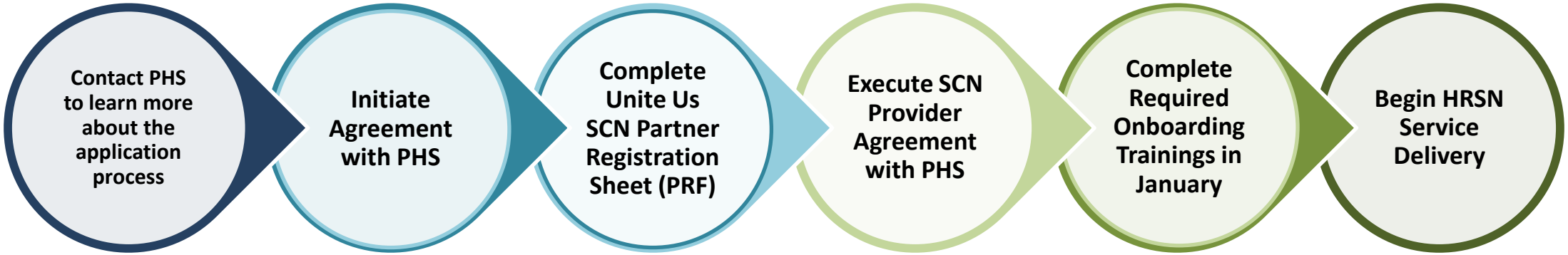
Enhanced HRSN Services

Enhanced Care Management

Social Care Management

- Application Assistance
- Application Fees
- Assistance
- Behavioral Health Services
- Childcare Level
- Clinical Care Management
- Crisis Services Level
- Education
- Employment
- Existing Benefit Programs
- Follow-up
- Interpersonal Violence Resources
- Legal Assistance

Joining our PHS WholeYouNYC-SCN



QUESTIONS

To learn more about becoming a SCN partner, please email…

SupportWholeYouNYCSCN@healthsolutions.org

THANK YOU!

William Chambers
WChambers@healthsolutions.org

Michael A. Hernandez
MHernandez@healthsolutions.org