WholeYouNYC-Social Care Network

Public Health Solutions

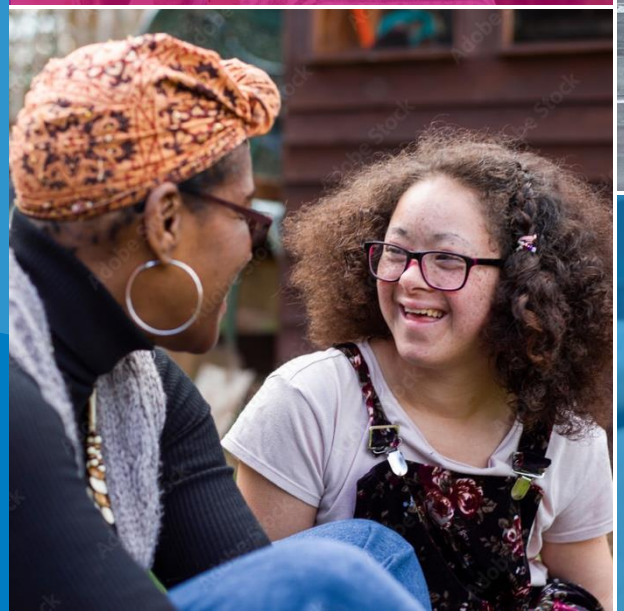
2025

Public Health Solutions | WholeYouNYC

@wearephsny








Welcome & Introductions

PHS WholeYouNYC-Social Care Network Brooklyn Community Engagement Team

William Chambers
(he/him)
Community Engagement Manager

Sahil Alvarez
(he/him)
Senior Community Engagement Specialist

Hervé Talleyrand
(she/her)
Community Engagement Specialist

Yuki Yang
(she/her)
Community Engagement Specialist

About Public Health Solutions (PHS)

For 65+ years, we have improved health for vulnerable New Yorkers and their families by providing direct services to communities in need, and by supporting 200+ community-based organizations annually in doing their work through contracting and management services.

Community Work

Working directly with individuals and families to improve their health outcomes

Contracting and Management Services

Delivering robust fiscal and administrative support for community-based organizations

WholeYouNYC

Developing coordinated and accountable networks that connect healthcare and community services to make a sustainable impact on health

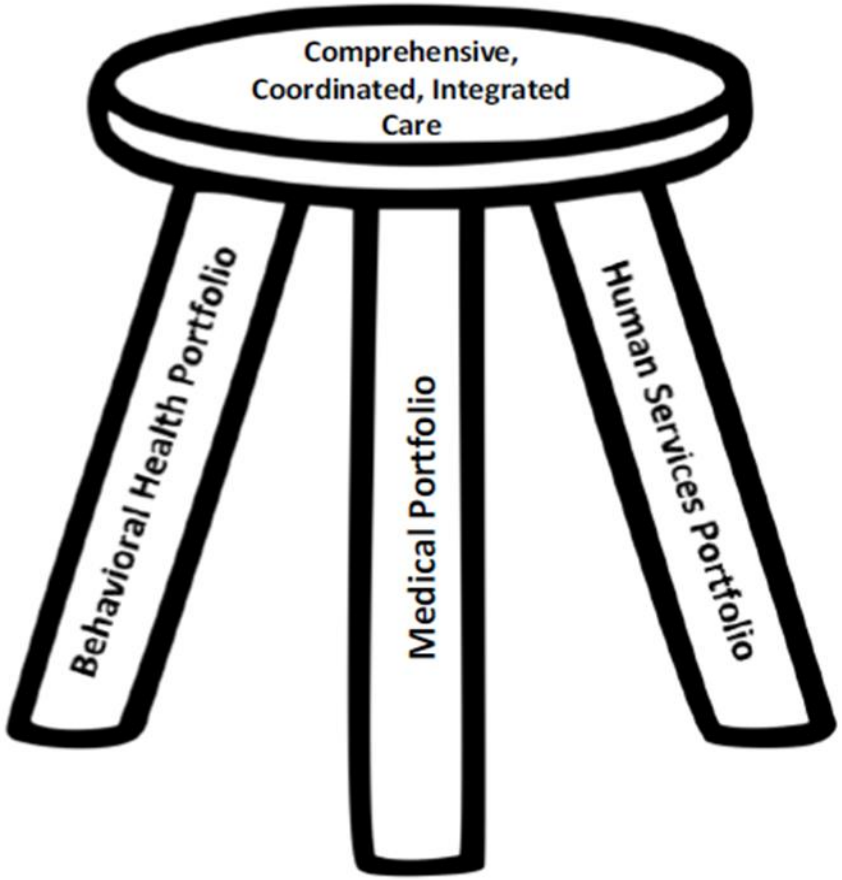
Making Health Equity a Reality

What is a Social Care Network under the NYS Medicaid Waiver?

An organized, technology-enabled network of community-based organizations that addresses the unmet, health-related social needs of Medicaid members

1115 Waiver Theory of Change: when basic needs are met, people can engage in preventive healthcare, better manage their chronic conditions, and are less likely to require emergency care or hospitalization, therefore driving down healthcare costs over time.

Goal of the Social Care Network Program



There is a growing recognition that fully achieving health for all requires a focus on Health-Related Social Needs (HRSNs).

Addressing social needs such as food insecurity, housing instability, and lack of transportation improves health and lowers health care costs.

New York State is funding the creation of a coordinated infrastructure and set of processes to identify the unmet HRSNs of Medicaid members.

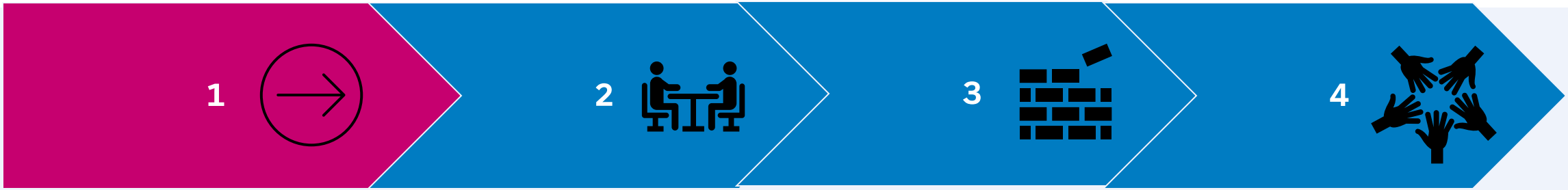
These members need to be connected to services that address these needs.

Organizations who can provide these services will be paid for providing them.

Who are the Social Care Networks (SCNs)?

Lead Entities	Map Color	Counties
Care Compass Collaborative		Broome, Chenango, Delaware, Otsego, Tioga, Tompkins
Forward Leading IPA		Allegany, Cayuga, Chemung, Genesee, Livingston,Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates
Health and Welfare Council of Long Island		Nassau, Suffolk
Healthy Alliance Foundation Inc.	1	Albany, Columbia, Greene, Rensselaer, Montgomery, Saratoga, Schenectady, Schoharie
	2	Cortland, Herkimer, Madison, Oneida, Onondaga, Oswego
	3	Clinton, Essex, Franklin, Fulton, Hamilton, Jefferson, Lewis, St. Lawrence, Warren, Washington
Hudson Valley Care Coalition, Inc.		Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Public Health Solutions		Manhattan, Queens, Brooklyn
Staten Island Performing Provider System		Richmond
Somos Healthcare Providers, Inc.		Bronx
Western New York Integrated Care Collaborative Inc.		Cattaraugus, Chautauqua, Erie, Niagara

The WholeYouNYC Approach



Put New Yorkers at the center of our work.

Create partnerships for coordinated care.

Build a coordinated network of community resources throughout NYC.

Incorporate a hands-on community engagement process that ensures services are equitably accessed and delivered.

WholeYouNYC – Social Care Network Funding

Overall Funding Estimate
(3 Years)

Borough	Infrastructure Grant from NYS	Potential PMPM + Incentive Funding via Plans
Manhattan	$52,080,677	$330,503,976
Queens	$34,602,335	$219,586,418
Brooklyn	$65,676,397	$416,782,415
Total	$152,359,409	$966,872,809

Goal: Establish Core Functions of SCN and Support CBOs with Capacity-Building

Goal: Administer the fee schedule via contracts with MCOs

Key Elements

Infrastructure Grant

- Invest in technology and other necessary SCN infrastructure
- CBO Capacity Building Grants
- 10% Indirect Rate

PMPM (Per Member Per Month) + Incentive Funding*

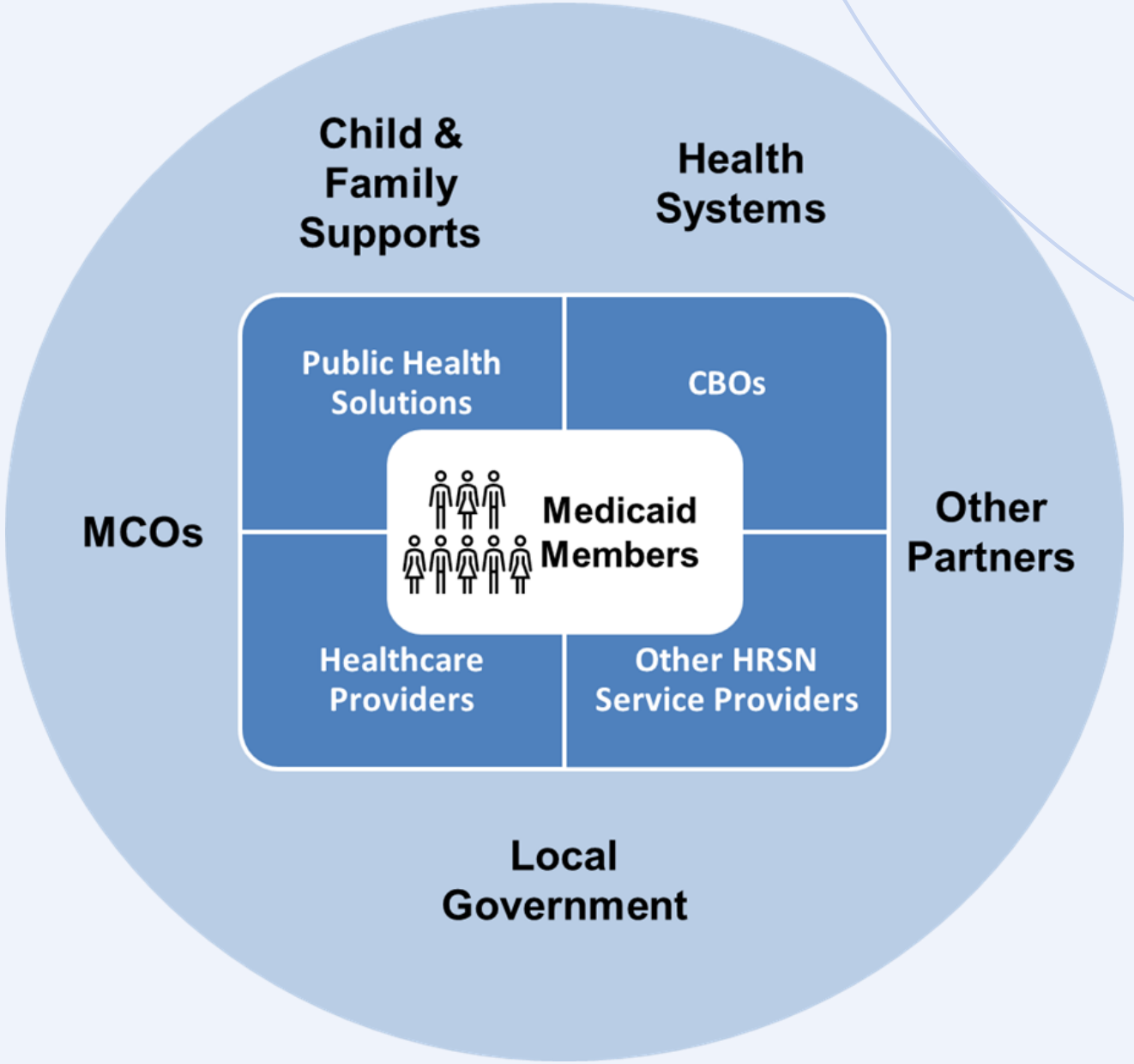
- Used to support screening, navigation and services provided by the network to members
- May include performance and quality-based incentives (TBD)
- MCOs may charge 3% for administrative costs
- SCNs may charge 3% for operational and administrative costs

**These figures are estimates*

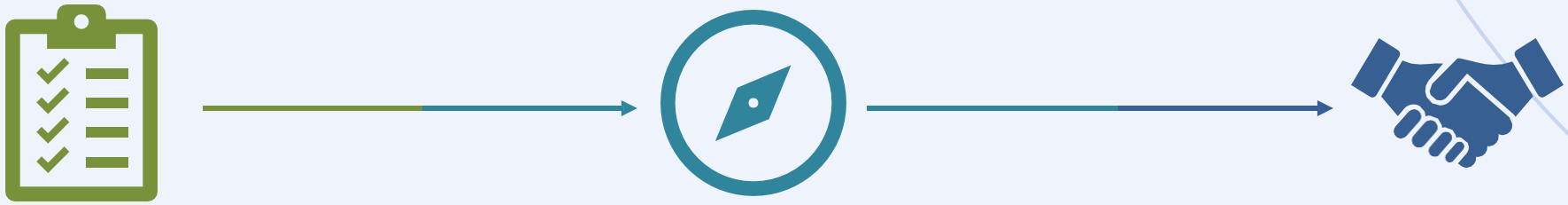
WholeYouNYC-Social Care Network Ecosystem

WholeYouNYC-Social Care Network

Ecosystem Partners



SCN Service Delivery



Screening

Member is comprehensively **screened for HRSNs** using the Accountable Health Communities (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.**

Enhanced Services Provided By Network Partners

Care Management

- Navigation
- Enhanced Care Management

Housing

- Home Accessibility & Safety Modifications
- Home Remediation Service
- Asthma Remediation
- Medical Respite
- Rent/Temporary Housing
- Utility Setup & Assistance
- Pre-tenancy Services
- Community Transitional Supports
- Tenancy Sustaining Services
- Housing Transition & Navigation Services

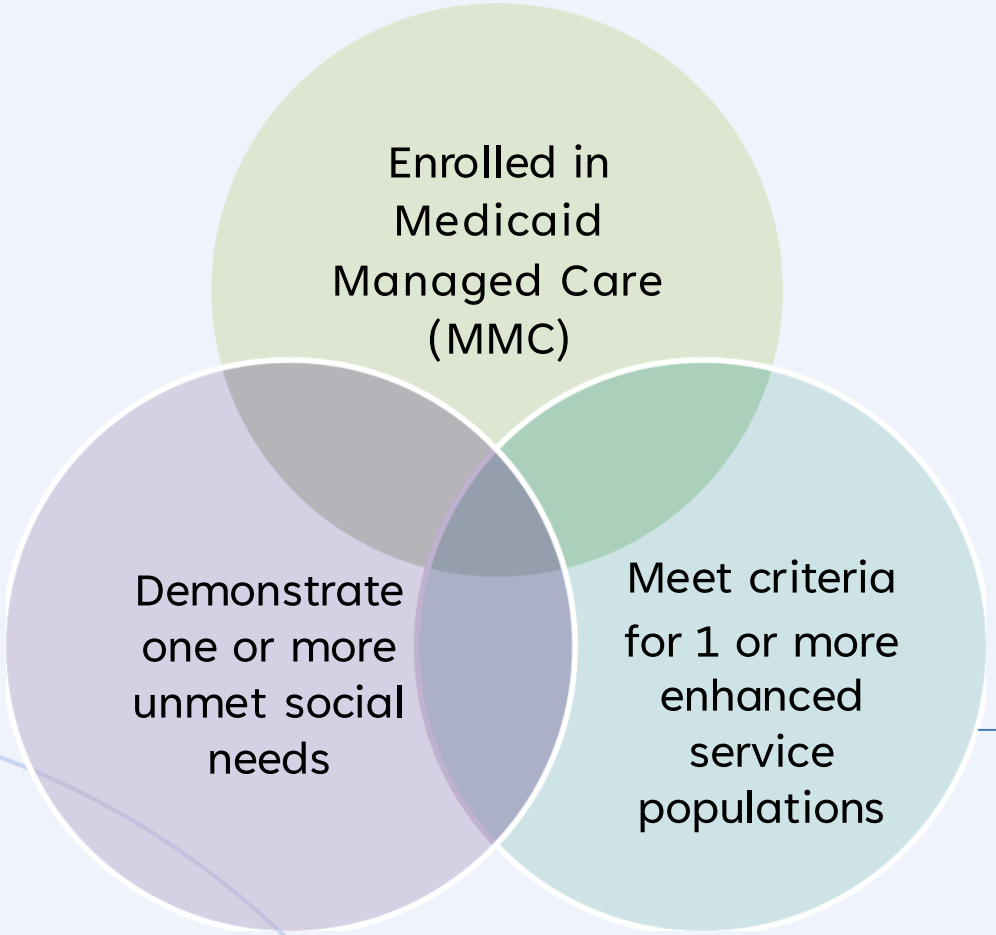
Nutrition

- Nutrition Counseling & Education
- Medically Tailored or Clinically Appropriate Home Delivered Meals
- Medically Tailored or Nutritionally Appropriate Food Prescriptions
- Fresh Produce and Nonperishable Groceries (Pantry Stocking)
- Cooking Supplies

Transportation

- Transportation Services (Non-medical)

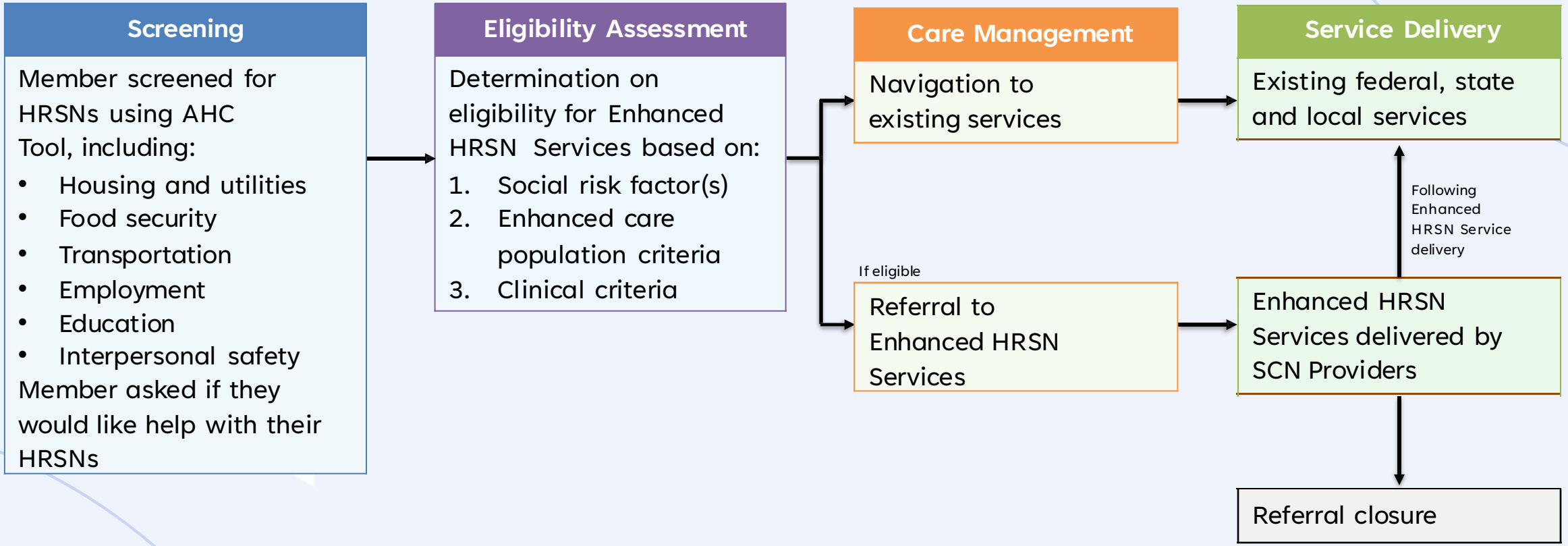
Eligibility for Enhanced HRSN Services



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 up to 1 year*
Members who are up to 90 days post-release from incarceration with a chronic health condition(s)
High risk children under the age of 18

If a member does not meet the criteria for Enhanced HRSN services, they will receive navigation to existing state, federal and local programs to address HRSN.

Member Journey



Questions

Thank You!

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

SupportWholeYouNYCSCN@healthsolutions.org

William Chambers
Community Engagement Manager(Brooklyn)
WChambers@healthsolutions.org

Swetha Tanjore
Practice Improvement Specialist
stanjore@healthsolutions.org

Sahil Alvarez
Community Engagement Specialist
Salvarez@healthsolutions.org

Yuki Yang
Community Engagement Specialist
Yyang@healthsolutions.org

Herve Talleyrand
Community Engagement Specialist
Hervetalleyrand@healthsolutions.org