WNY Integrated Care Social Care Network:

Meeting with Homeless Alliance network of agencies

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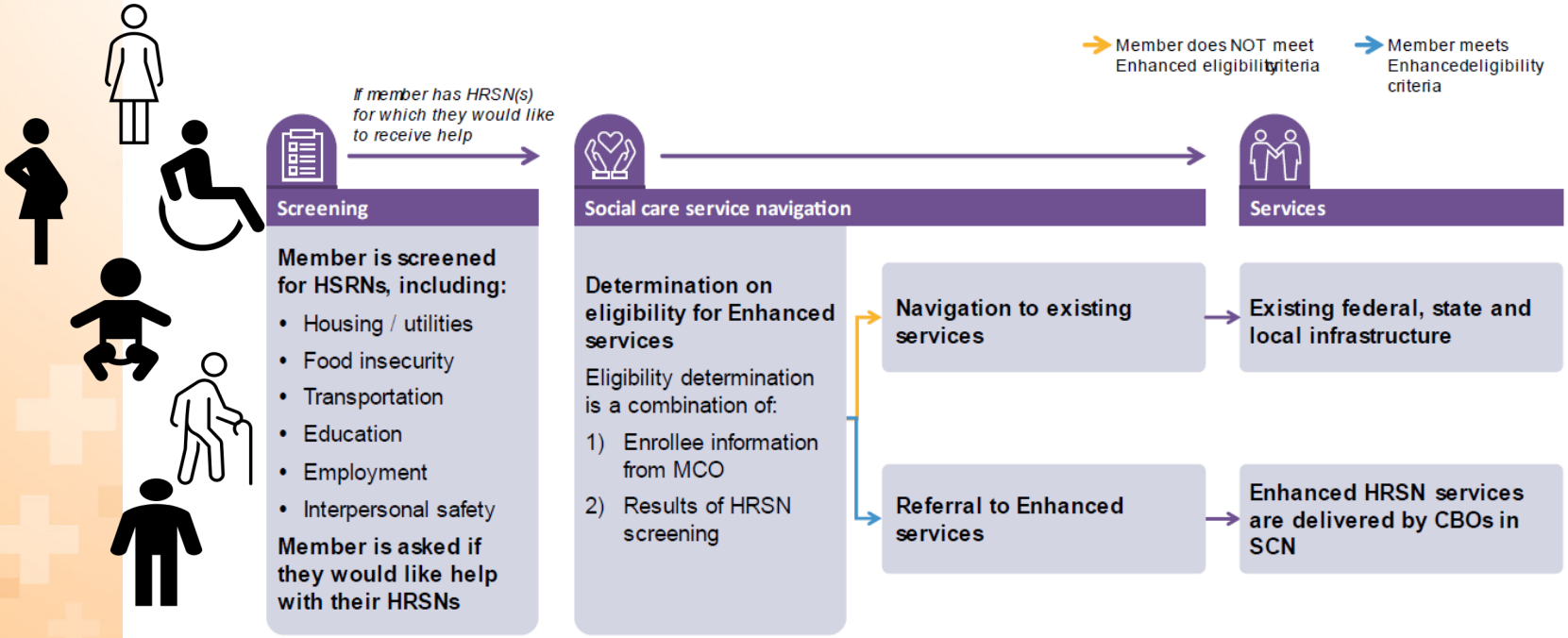
Better Health with Integrated Care.

Integrated Care – Workflows

Figure 3: Flow across member journey



Integrated Care – Screening Workflow

*Provider documents in EHR
*Provider documents in WNY Integrated Care Platform

Healthcare Location

*Partner documents in WNY Integrated Care Platform

Community Partner Location

* Self-Screen done through link on WNY Integrated Care website

Self-Screen

Contact WNY Integrated Care

1 **Screener will look up Member in WNY Integrated Care Platform:**

- Medicaid # or DOB + Name
- Verify Member Identity – verbal OK
- Check last screening date

If annual screening was done – STOP *(unless new major life event)*
If Member not found – Screener trained on Next Steps to contact Medicaid and refer to a site for self-navigation.

2 **Ask Question 0** – Consent to share information

If Member does not Consent - STOP

3 **Conduct Screen** - using NY AHC Tool
Ask required demographic questions

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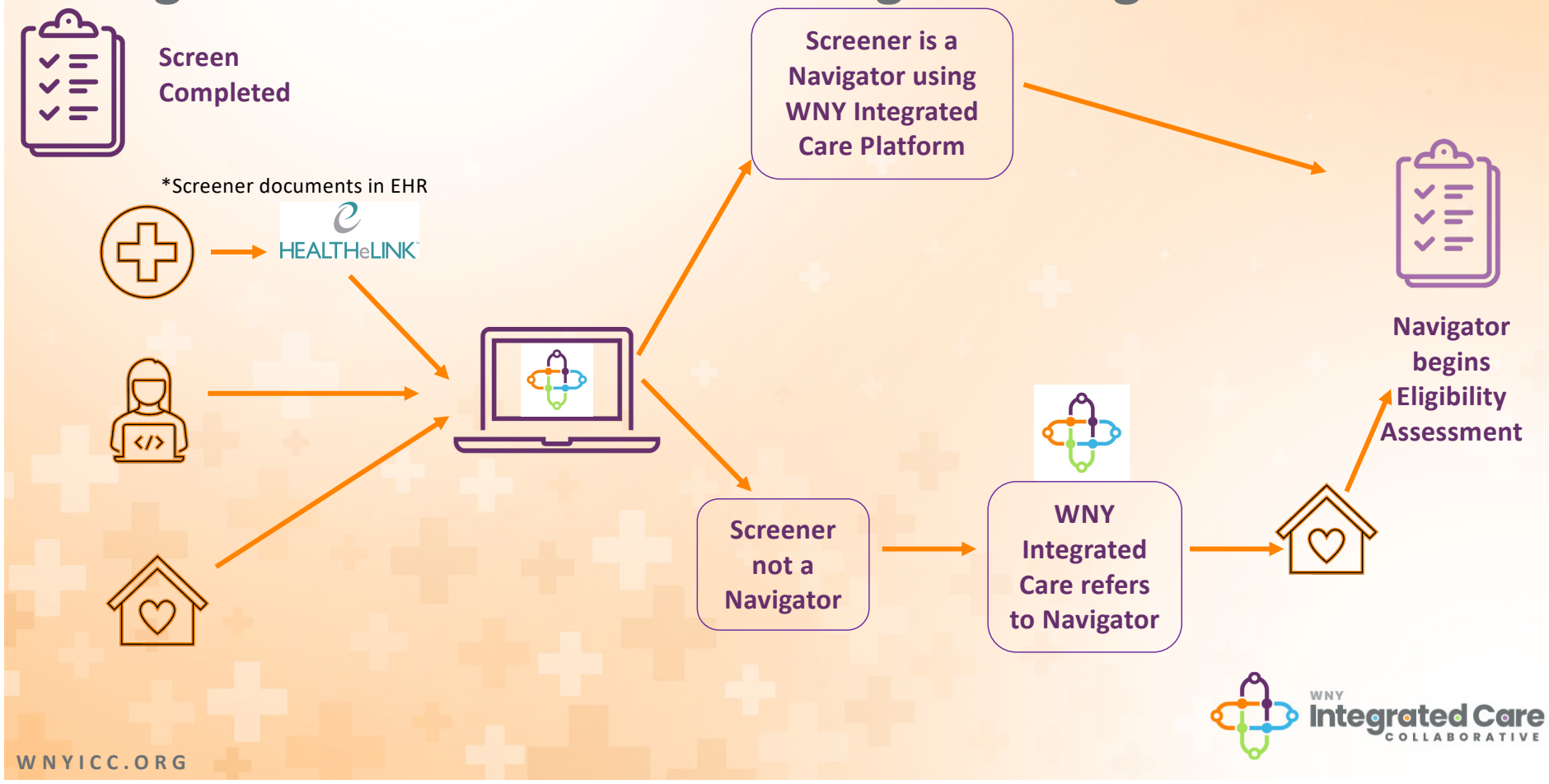
Integrated Care – Social Care Navigator Assignment



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Integrated Care – Eligibility Assessment

Eligibility Assessment must be completed on WNY Integrated Care Platform

1. **Social Care Navigator asks Member to Consent for Navigator to view medical history provided from their health plan**
2. **SC Navigator checks name in ePaces to verify Member has Medicaid Managed Care.**
3. **State-provided Data and results from screen will auto-populate. Navigator review with member.**
4. **Navigator will document any new Eligibility Criteria stated by Member**

Navigator will help member obtain Provider Attestation if required.

5. **Navigator asks Consent to receive Services**

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Integrated Care – Level 1 Navigation

1. Navigator reviews Needs with member

2. Navigator refers Member to existing Local, State, Federal services (not covered through 1115 Waiver)

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Integrated Care – Level 2 Navigation

Navigator develops Social Care Plan with Member via WNY Integrated Care Platform

1. Navigator reviews Needs with Member; Member prioritizes Needs and together begin to set Goals.
2. Navigator begins to refer Member to HRSN Services
3. Navigator follows up with Member on any HRSN Service Referrals

4. Navigator closes loop on the referrals.
5. Navigator assists Member with other existing Local, State, Federal services

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Integrated Care – Housing Services

1

Housing Navigation

- Pre-Tenancy Services
- Tenancy Sustaining Services

2

Housing Supports

- Rent for up 6 months
- Community Transition Support
- Utilities Activation, Back payments, Assistance up up to 6 months

3

Housing Accessibility and Safety Modifications

- Examples: ramps, handrail, humidifier, door widening

4

Housing Remediations

- Mold abatement
- Pest remediation

5

Medical Respite

- Pre/Post hospitalization recuperative care up to 90 days

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Integrated Care – Blending and Braiding

1 Existing Housing Funding Source

- Should be used first (ie HUD funds, Vouchers, other Waivers)
- 1115 Waiver funds can not displace other available funding

2 Filling the Gaps

- **1115 Waiver funds can be used to fill the gaps of existing funding sources.**
- **Example 1**: Member could be receiving a rapid-rehousing voucher through HUD that is about to expire - the Navigator could assist Member with obtaining housing assistance through this 1115 Waiver program upon expiration of the voucher to ensure Member has consistent Housing Support;
- **Example 2:** Member is eligible for a rapid-rehousing voucher, but does not have required birth certificate or documentation.
- **Example 3:** Member has Section 8 voucher but needs a home modification or is behind in their utilities.
- **Example 4:** Member qualifies for rapid re-housing voucher, but need furniture and assistance with utilities.

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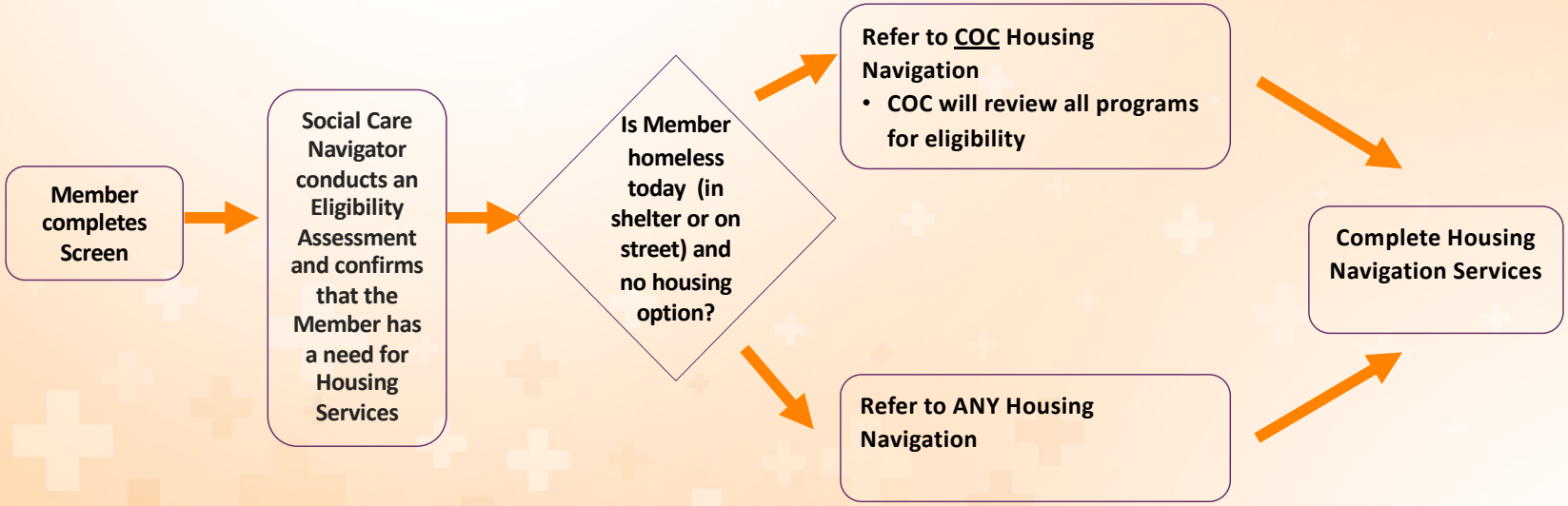
Workflow Considerations for Homeless Population



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Process to become a Service Provider/ Delivery Partner with Integrated Care Social Care Network

1 **Complete CBO Readiness Assessment**

Email Contact@wnyicc.org

- List the Services you want to provide
- Request upfront funding if needed to build capacity to deliver services.

2 **Integrated Care will review your Readiness Assessment and schedule individual meeting to review with you**

3 **Integrated Care will send you a contract for execution**

4 **Integrated Care will onboard, training and orient you to the services, requirements, and platform for documenting services**

5 **You will begin delivering services. Integrated Care will be your technical support partner.**

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Integrated Care – Questions

Thank you for Attending