

# Social Care Networks:

## A Guide for Health Home Care Managers



### What are Social Care Networks?

Social Care Networks (SCNs) are regional networks of community-based organizations, health care providers, and other partners that provide services to address health-related social needs (HRSNs) among Medicaid members in New York State. The SCN program unlocks \$3 billion to serve Medicaid members with unmet HRSNs. Health Homes are critical partners in the SCN as their members are eligible for enhanced HRSN services provided by the SCN program.

### What enhanced HRSN services are covered?



**Housing** services such as home modifications and remediation, rent / temporary housing, utility assistance, and housing navigation



**Nutrition** services such as nutrition counseling and education, medically tailored and clinically appropriate meals, medically tailored and nutritionally appropriate food prescriptions, and pantry stocking



**Transportation** services including public and private transportation services



**Enhanced HRSN care management** to support members with HRSNs

All SCN Lead Entities currently have HRSN service provider networks in place to provide services.

### Are Health Home members eligible for enhanced HRSN services provided through a SCN?

Yes. New York State identified Health Home members as a priority population for the SCN program, and Health Home members are eligible for enhanced HRSN services. For some services, members must meet additional social and clinical criteria, as determined through an eligibility assessment.

### How do members get connected to enhanced HRSN services?

To be connected to services, members need to first be screened and receive an eligibility assessment conducted by a Social Care Navigator. Health Home Care Managers may serve as Social Care Navigators if their Health Home is contracted with an SCN. If a Health Home is contracted with an SCN, they may be reimbursed for screening and navigation to services.

Health Home Care Managers can either (1) complete screening and navigation as part of an SCN or (2) connect a member to the SCN (see figures to follow).



For more information, visit:  
<https://health.ny.gov/SocialCareNetworks>



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## 1. Health Home (HH) conducts HRSN screening, eligibility assessment (EA), and navigation (HH is part of SCN)



## 2. HH connects member to SCN for HRSN screening, EA, and navigation



 HH     Other entities in SCN

## How do I avoid service duplication?

Care management provided by Health Homes is similar to social care navigation within the SCN program, so Health Homes and their care management partners are well positioned to serve as Social Care Navigators within SCNs for both Health Home-enrolled members and other Medicaid members.

New York State considers navigation to enhanced HRSN Services **incremental to—not duplicative of—services that Health Homes already provide to Health Home members.**

For example, a Health Home-based Social Care Navigator screens a member and identifies an unmet need for nutrition. The Social Care Navigator then conducts an eligibility assessment to determine which enhanced HRSN services the member is eligible for (e.g., eligibility assessment shows pregnant member with diabetes eligible for specific nutrition supports). The Social Care Navigator develops a social care plan

in conjunction with the member and makes referrals to HRSN service providers listed in the SCN IT Platform to address the member's eligible needs (e.g., medically tailored meals and nutrition counseling). The Social Care Navigator continues to check in with the member to ensure that the HRSN services are meeting her needs. The time the Social Care Navigator spent with the member on screening, navigation, and ongoing enhanced HRSN care management can be reimbursed through the SCN program. In parallel, the Health Home should continue to use existing funding to provide other services to members.

## Where can I learn more?

For more information, visit [www.health.ny.gov/socialcarenetworks](http://www.health.ny.gov/socialcarenetworks). A map of SCN Lead Entities that can be contacted for additional information can also be found at the site above.

Additional information can be found on the New York Health Home Coalition site (<https://hhcoalition.org/>).



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