Approved SCN Interventions:
Over 61,000 Medicaid Members Served as of June 2023

Mainstream Managed Care Interventions

Plan Name	VBP Contractor	Community Based Organization	SCN Domain(s)	Intervention Description	County(ies) Served
Excellus Health Plan	Accountable Health Partners IPA, LLC	Children's Institute, Inc.	Health and Health Care	The project focuses on providing these comprehensive screening services to three year old children enrolled in Excellus Health Plan's Medicaid Managed Care product through referrals of at risk children by AHP's pediatricians to the GROW – Rochester program. The comprehensive screenings provided by the GROW – Rochester program will allow for early identification of challenges, as well as successes. Screening at the age of three provides the opportunity to intervene and have children on their best path as soon as possible. The GROW Project has a well-coordinated, facilitated closed loop referral strategy. Children who screen as at risk or delayed are referred to the appropriate therapeutic resource.	Monroe
Fidelis	Adirondack ACO	NAMI Champlain Valley	Economic Stability, Education, Social and Community Context, Health and Healthcare, and Neighborhood and Built Environment	Adirondacks ACO will work with NAMI Champlain Valley to address the five key domains of SDH including economic stability, education, social and community context, health and health care, and neighborhood and built environment for high risk Fidelis members.Adirondacks ACO will identify high-risk members; the member population will be served in phases. The primary model of intervention is peer recovery coaching. This is an evidence-based model (recognized by CMS in 2007) that has had much success by providing non-clinical, strengths-based support to individuals with some level of shared experiences. Emerging research shows peer support makes a difference -- in a study published by SAMHSA, peer support increased self-esteem and confidence, increased sense that treatment is responsive and inclusive of needs, increased engagement in self-care and wellness, increased social supports and functioning, reduced hospital admission rates, and decreased substance use and depression.	Clinton County, potentially Essex and Franklin
Emblem (HH VBP Pilot)	Advantage Care	American Lung Association	Health and Healthcare, Neighborhood and Environment, and Economic Stability	HIP, as the MCO, and utilizing EmblemHealth Registered Nurses, will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 144 Medicaid members using ACPNY as the provider. HIP and ACPNY will service households in Brooklyn (Kings County) with members who range from the ages of 0 to 17 and who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	Brooklyn
HIP (Emblem Health)	AdvantageCare Physicians of New York	God's Love We Deliver	Economic Stability, Food Insecurity	Emblem and VBP Contractor will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC boroughs; Nassau, Suffolk, Westchester

Highmark Western and Northeastern New York, Inc.	Amerigroup IPA	Homeless Alliance of WNY	Economic Stability, Housing Security and Stability	SDH intervention will focus on identifying plan enrollees who are impacted by homelessness. As the lead on the project, Amerigroup IPA will outreach homeless enrollees or get them assigned a health home (if not already engaged) and will work with collaborating community agencies to identify stable housing opportunities in the community. For members who will not participate in the health home program, the IPA will pursue direct case management. Tier 1 CBO Requirement: The IPA has signed an agency participation agreement with the Homeless Alliance of WNY; a Tier 1 CBO. This agreement allows for the IPA to participate in the Buffalo Area Services Network (BAS-Net) Homeless Management Information System (HMIS). Access to this system creates an additional avenue for identification of homeless enrollees and opens the door for enhanced care coordination and data sharing among collaborating agencies.	Erie, Genesee Niagara, Orleans, Wyoming
Fidelis	Atlas IPA, LLC	NYREACH	Health and Healthcare, Economic Stability	Atlas IPA & NYREACH staff will work together to implement a patient education and food pantry program dedicated to improving health literacy, adhering to a nutritional diet and addressing food Insecurity for Bronx-based Atlas/Fidelis patients. Atlas will partner with NYREACH staff to implement a social determinant of health intervention aimed at supporting better population health outcomes through patient engagement activities, educational programs, and by providing affordable healthy food options to Atlas/Fidelis patients that would benefit from nutritional counselling.	Bronx
United Healthcare	Atlas IPA, LLC	NYREACH	Economic Stability, Education, Food Insecurity, Health and Health Care	Atlas will again partner with NYREACH staff to provide a social determinant of health intervention for Atlas/UnitedHealthcare patients, which will be aimed at supporting better population health outcomes through patient engagement activities, educational programs to improve health literacy, and by providing affordable healthy food options to patients who would benefit from such services. Estimated Volume: NYREACH will conduct ongoing outreach to approximately 600 members, to advise them on the various program offerings. Results captured in quarterly evaluation reports will be used to drive changes in that estimation, in either direction.	Bronx
Healthfirst, PHSP	Beth Israel Medical Center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Manhattan, Brooklyn

Fidelis	Blue Ribbon IPA	God's Love We Deliver	Economic Stability, Food Insecurity	God's Love We Deliver will provide medically-tailored home-delivered meals and nutritional counseling support to Fidelis Care/Blue Ribbon IPA members. God's Love We Deliver medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Fidelis Care/Blue Ribbon IPA members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need for 3-6 months, with certain members to be re-authorized on an as needed basis.	All 5 NYC boroughs; Rockland, Orange, Westchester, Suffolk and Nassau
HIP/Emblem	Bronx United IPA	God's Love We Deliver	Economic Stability	Emblem and VBP Contractor will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC Boroughs; Westchester, Suffolk, Nassau
Healthfirst, PHSP	BronxCare Health System	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Bronx
Empire HealthPlus (HH VBP Pilot)	CAIPA Care	St. Mary's Health Care System for Children, The American Lung Association	Health and Healthcare, Neighborhood and Environment, Economic Stability	Empire HealthPlus and CAIPA will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 53 Medicaid members (of which some live in same household) ages 0 to 17 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	All 5 NYC Boroughs

Healthfirst, PHSP	CAIPA Care	AIRnyc	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Brooklyn
Molina Healthcare	Cayuga Area Plan	Suicide Prevention & Crisis Services (SPCS)	Stigma and Discrimination-Provider level intervention	The Suicide Prevention & Crisis Service seeks to work collaboratively with CAP, the area Provider Network, to actively keep community care providers up to date on available services, promotional events, and strategies and tools to best care for patients living with challenging life situations, thereby promoting a culture of wellness.	Ithaca, Tompkins Cortland, Schuyler
Fidelis	Central Queens IPA	God's Love We Deliver	Economic Stability, Food Insecurity	God's Love We Deliver medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Fidelis Care/Central Queens IPA members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need for 3-6 months, with certain members to be re-authorized on an as needed basis.	5 Boroughs of NYC, Westchester, Suffolk, and Nassau; added in Rockland and Orange
HIP/Emblem	Chinatown True Care Medical PLLC d/b/a Rendr Care Physicians	God's Love We Deliver	Economic Stability, Food Insecurity	The VBP SDH intervention selected is from the Economic Stability domain on the state's approved SDH menu.CBO provides medically tailored home delivered meals ("MTM"). Services are approved by a registered dietitian nutritionist ("RDN") and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a registered dietician based on a session of nutrition diagnostic and therapy for disease management ("Medical Nutrition Therapy") and an EmblemHealth Care Management referral to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester
United Healthcare	Chinatown True dba Rendr Care Physicians	God's Love We Deliver	Food Insecurity	UnitedHealthcare/Rendr Care members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need for a minimum of 3 months and a maximum of 6 months, with certain members to be re-authorized on an as needed basis. Program will target members who are 2+ yrs. old and have one or more chronic conditions.	Brooklyn, Queens, Bronx, Staten Island, Manhattan, Suffolk, Nassau

Molina Healthcare	CHIPA	AIRnyc- Home visiting service provider Association for Energy Affordability (AEA)-Home remediation service provider	Health and HealthCare, Housing	A comprehensive asthma intervention that addresses environmental needs in the home for families on Medicaid by providing the following main components: 1) Assessment and monitoring of patients with asthma, (2) Education about asthma self-management, (3) Control of environmental exposures that affect asthma, and (4) Medications to treat asthma. AIRnyc will provide the in-home asthma self-management education, including review of proper medication usage; case management and coordination with Affinity Health Plan and CHIPA; basic supplies such as mattress and pillow covers; three follow-up phone calls; and referrals to other community services. AEA will provide a full home assessment and remediation of environmental asthma triggers in the home.	All Five NYC Boroughs
Fidelis	CINQ-NY IPA LLC	Greater Buffalo United Community Based Organization (GBUCBO)	Health and Healthcare, Economic Stability, Housing Instability, Food Insecurity,	Greater Buffalo United Community Based Organization was formed during 2020 to address social determinants barriers to healthcare, including food, transportation, economic benefits, education, shelter, and other resources in Western New York. GBUCBO is a social determinants of health network that assembles and forms linkages with other community-based organizations, which provide specific social care services to Medicaid beneficiaries (i.e., “SDOH Providers”). GBUCBO then contracts with VBP Provider networks, like CINQ-NY IPA LLC, to: (1) facilitate structured patient referrals from a VBP Provider network to the SDOH Provider best suited to fulfill a patient’s specific need; (2) electronically document the request, progress, completion, and supporting documentation of SDOH need fulfillment by an SDOH Provider; (3) audit the quality and completeness of SDOH services; and (4) make supplemental payments to SDOH Providers (a) as this SDH Intervention’s resources remain available and (b) until such time as the new 1115 Waiver becomes operational and expands allowable medical expenditures to include payment for SDOH services. Covered services will include: (1) emergency and transitional housing; (2) emergency food. Provider network (subject to expansion): (1) Emergency and transitional housing: Hispanics United of Buffalo; Community Services for Every1; Belmont Housing (2) Emergency food: African Heritage Food Co-op; FeedMore WNY; Community Action Organization (CAgrO Program)	Erie, Niagara, Chautauqua, Cattaraugus
Fidelis Care	CIPA Western NY IPA	Buffalo Urban League	Health and Health Care	The intervention targets high-risk pregnant moms, no-shows, and patients who have not been engaged in care for the past 18 months. Clinic providers and staff establish priorities for outreach to high-need patients. CHWs are able to receive intra-EMR “beans” (messages), participation in clinic staff meetings, no-show reports, and face-to-face contact. CHWs document patient contacts and referrals in the clinic EMR as telephone contacts, which have dropdown options to track reason for contact.	Erie, Niagara
HIP/Emblem	City BlockIPA	God's Love We Deliver	Economic Stability, Food Insecurity	HIP and VBP Contractor will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC Boroughs; Westchester, Nassau

Fidelis	Community Care of Brooklyn IPA	New York Legal Assistance Group (NYLAG)	Economic Stability, Housing	CCB, in partnership with NYLAG and 1199SEIU Training and Education Fund, developed the Social Determinants of Health and the Law training series, to educate referring providers and care coordinators/care management about achieving housing stability, income maximization and stability, behavioral health, immigration, and safe living environments. Much of a person's health is dependent upon social factors, some of which may be addressed with legal assistance. The training aims to empower the healthcare workforce to identify health-harming legal issues and advocate for their patients to prevent crises, making a referral for legal services when necessary. It also teaches healthcare professionals about their unique role in advocacy and provides tools they can use to better assist their patients. The two trainings that have been developed are: •Social Determinants & the Law- Behavioral Health, Safe Living, Immigrants' Rights •Social Determinants & the Law- Housing, Income, & Insurance Trainings are currently being recorded so they can be deployed more broadly to the CCB network through its online Learning Management System.	Brooklyn
United Healthcare	Community Care of Brooklyn IPA	New York Legal Assistance Group (NYLAG)	Economic Stability, Housing	CCB, in partnership with NYLAG and 1199SEIU Training and Education Fund, developed the Social Determinants of Health and the Law training series, to educate referring providers and care coordinators/care management about achieving housing stability, income maximization and stability, behavioral health, immigration, and safe living environments. Much of a person's health is dependent upon social factors, some of which may be addressed with legal assistance. The training aims to empower the healthcare workforce to identify health-harming legal issues and advocate for their patients to prevent crises, making a referral for legal services when necessary. It also teaches healthcare professionals about their unique role in advocacy and provides tools they can use to better assist their patients. The two trainings that have been developed are: • Social Determinants & the Law- Behavioral Health, Safe Living, Immigrants' Rights • Social Determinants & the Law- Housing, Income, & Insurance Trainings are currently being recorded so they can be deployed more broadly to the CCB network through its online Learning Management System.	Brooklyn
United Healthcare	Community Health IPA (CHIPA)	God's Love We Deliver	Economic Stability	God's Love We Deliver home-delivers medically tailored meals that are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	All 5 NYC Boroughs; Westchester, Suffolk, Nassau

Amida Care	EngageWell IPA	God's Love We Deliver	Food Insecurity	God's Love We Deliver is the Tier 1 CBO that will be the lead partner in this arrangement. God's Love is highly experienced in this service area and the premier medically-tailored meal provider in New York City. The medically-tailored meals are approved by a Registered Dietician Nutritionist based on a nutritional assessment and a referral by a health care provider to address medical diagnoses, symptoms, allergies, medication management, and/or side effects, to ensure the best possible health outcomes. These meals are delivered to the enrollees' homes or other suitable settings. Medical nutrition therapy is an evidence-based application of the Nutrition Care Process that is focused on prevention, delay and/or management of diseases and conditions, and involves an in-depth assessment, periodic reassessment and intervention through direct nutritional support. MCO is working with GLWD for MTM, Tangelo for pantry boxes, and Wellth for medication adherence. GLWD is approved tier 1 CBO for this arrangement. Approx 50 individuals will receive MTM, 100 will receive healthy food pantry boxes, and 150 will receive advanced medication adherence support.	Bronx, Kings, New York, Queens, Staten Island
Healthfirst, PHSP	Episcopal Health Services	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Queens
Fidelis	Finger Lakes IPA, Inc	Seven Valleys Health Coalition and Family Health Network of Central New York	Food Insecurity, Education, Health and Healthcare	Family Health Network and Seven Valleys Health Coalition will implement a 22-week Community Supported Agriculture (CSA) share of Fruit and Vegetable prescriptions home-delivered to identified patients weekly. Home delivery addresses transportation barriers for patients. Seven Valleys has experience implementing this intervention in past growing seasons. Patients receiving the CSA will also have the opportunity for at least one 90 minute 1:1 nutrition counseling session with a Registered Dietician with follow-up possible depending on level of need and will be provided with healthy recipes created by the R.D. with suggestions of how to prepare the vegetables with common, affordable accessories and ingredients.	Cortland County

Fidelis	Finger Lakes IPA-HARP	Seven Valleys Health Coalition and Family Health Network of Central New York	Health and Healthcare, Education	Seven Valleys Health Coalition will implement two 6-week Chronic Disease Self-Management Program (CDSMP) series that target the HARP population. CDSMP developed at Stanford University, is designed to increase self-efficacy, health behaviors, and health outcomes in participants, and is one of the most widely used self-management education programs in the United States. The effectiveness of this program for individuals with serious mental illness have shown improvements in both health indicators (quality of life, sleep, depression, etc.) and health behaviors (adherence to medical regimens, connecting with medical providers). The SDH intervention will target Fidelis Medicaid and HARP members in the Cortland, NY area. Family Health Network will identify and refer Fidelis members for the intervention based on the following criteria: (1) patient has a chronic disease diagnosis appropriate for inclusion in this program and (2) willingness to participate in the program. FHN and Seven Valleys will be responsible for providing the list of participants with their CIN.	Cortland County
Excellus Health Plan	Greater Rochester IPA	The Center for Youth Services, Inc.	Health and Healthcare, Housing	The Center for Youth will address the SDoH key area of Health and Healthcare; specifically, through their transitional living and housing programs which provide comprehensive supports to young men and women who may have been homeless or disconnected from traditional supports. The Center for Youth will focus on the lack of health literacy and healthcare system navigation including cultural context.	Monroe
CDPHP	Healthy Alliance IPA: subcontract with various CBOs	Healthy Alliance IPA:The Food Pantries for the Capital District (TFP), Catholic Charities; Life Path, Inc.; Mom's Meals	Food Insecurity	The Enhanced Food Pantry Access & Support Program will provide individualized assistance for CDPHP Medicaid members with identified food insecurity issues with a range of needs including basic food pantry referrals, medically tailored food packages and post-discharge meals. Referrals for this program can originate from CDPHP's care management team, providers pursuant to the following contracts: a) CDPHP's EPC contract; b) providers whose CDPHP Physician Participation Agreement includes the Specialty Care Quality Program Payment Methodology Addendum; c) providers whose CDPHP Physician Participation Agreement includes the Behavioral Health Specialty Care Quality Program Payment Methodology Addendum; d) providers in the Adirondack ACO contract; and e) Delta Dental contract (as geographically appropriate). For members in need of a basic food pantry referral, TFP staff will assist members in locating food pantry or free community meal resources that meet the member's needs from an accessibility, timing and nutritional perspective, whenever possible. Members with unique needs such as transportation or mobility issues or chronic disease related nutritional needs will be addressed through individualized support and creative solutions, as feasible.Mom's Meals and Life Path receive referrals (via the Healthy Alliance IPA) for CDPHP Medicaid members in need of two weeks worth of post-charge prepared meals, delivered to their doorstep.	Albany, Schenectady, Rensselaer, and Saratoga
HIP/Emblem	Heritage Network	God's Love We Deliver	Economic Stability	Emblem and VBP Contractor will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC Boroughs; Westchester, Nassau

Fidelis	Heritage New York IPA, d/b/a HealthCare Partners, IPA	God's Love We Deliver	Economic Stability, Food Insecurity	God's Love We Deliver medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Fidelis Care/Healthcare Partners IPA members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need for 3-6 months, with certain members to be re-authorized on an as needed basis.	All five boroughs of New York City, Rockland, Orange, Westchester, Suffolk and Nassau
IHA	Independent Health Foundation-Various Providers	Independent Health Foundation	Health and Health Care	Good for the Neighborhood (GFTN): GFTN brings healthy living training and tools to assist people in managing and improving their own health. The goals of GFTN are to encourage residents to develop and maintain an ongoing relationship with a primary care doctor, encourage healthier eating habits, emphasize regular exercise, and encourage individuals to quit smoking. Key program elements include health screenings and measurements, ask the expert, ask the pharmacist, health insurance, a free farmer's market, healthy activities for kids, and more. The main SDH addressed is health and health care.	Erie and Niagara
Empire HealthPlus	Independent Practice Association of New York(IPANY)	God's Love We Deliver	Economic Stability, Food Insecurity	Meals approved by a Registered Dietitian Nutritionist (RDN) that reflect appropriate dietary therapy based on evidence-based practice guidelines. Members 18 years of age or older with severe illness can receive MTMs with a referral from a health care professional or a referral from the MCO. Authorization may be given for up to three meals/day for six (6) months with ability to reauthorize if needed. A Registered Dietitian Nutritionist will perform an assessment for each eligible Member and will assist with tailoring each Member's meal based upon his/her medical needs.	New York City
Healthfirst, PHSP	Interfaith Medical Center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Brooklyn
United Healthcare	IPA of NY	God's Love We Deliver	Economic Stability, Food Insecurity	God's Love We Deliver medically tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. UnitedHealthcare/IPA NY members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need for a minimum of 3 months and a maximum of 6 months, with certain members to be re-authorized on an as needed basis.	All five boroughs of New York City, Westchester, Suffolk and Nassau counties

Healthfirst, PHSP	Jamaica Medical Center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Queens
Healthfirst	Long Island Jewish Medical Center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Queens
Healthfirst, PHSP	Maimonides Medical Center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Brooklyn
HIP(Emblem)	MediSys IPA	God's Love We Deliver	Economic Stability, Food insecurity	Emblem and VBP Contractor will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC boroughs; Nassau, Suffolk, Westchester

HealthFirst (HH VBP Pilot)	Montefiore	American Lung Association	Health and Healthcare, Neighborhood and Environment, and Economic Stability	Healthfirst PHSP and Montefiore Medical Center will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 800 households with Medicaid members ages 0 to 21 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	Bronx
Healthfirst, PHSP	Montefiore Medical Center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Bronx
Empire HealthPlus (HH VBP Pilot)	Mount Sinai Health Partners IPA	Icahn school of Medicine at Mount Sinai	Health and Healthcare, Neighborhood and Environment, Economic Stability	Empire HealthPlus and Mt. Sinai IPA will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 73 Medicaid members (of which some live in same household) ages 0 to 17 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	All 5 NYC Boroughs
Healthfirst, PHSP	Mount Sinai Hospital	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Manhattan Queens

HealthFirst (HH VBP Pilot)	Mt. Sinai	American Lung Association	Health and Healthcare, Neighborhood and Environment, and Economic Stability	Healthfirst PHSP and Mount Sinai Health System will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 107 households with Medicaid members ages 0 to 21 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	Bronx, Kings, New York, Queens, Staten Island
Fidelis	Network Solutions IPA	God's Love We Deliver	Economic Stability, Food Insecurity	God's Love We Deliver will provide medically-tailored home-delivered meals and nutritional counseling support to Fidelis Care/Network Solutions IPA members. God's Love We Deliver medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Fidelis Care/Network Solutions IPA members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need for 3-6 months, with certain members to be re-authorized on an as needed basis.	All 5 NYC boroughs; Rockland, Orange, Westchester, Suffolk and Nassau
Healthfirst	Northwell/Staten Island University Hospital	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Staten Island
Healthfirst, PHSP	NY University Hospitals	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Manhattan

Fidelis	NYC Health and Hospitals	AIRnyc	Education, Health and Healthcare, Housing	The CBO (AIRnyc) will assess enrollees over the phone or in their home and identify health education needs based on the target population, as well as community services that can help the enrollee improve their condition and meet their needs. Telephone interviews, home visits and follow ups may consist of the following, among other things: (1) medication adherence, such as use of spacers and control medication for asthma, or blood pressure monitoring for hypertension; (2) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (3) patient and caregiver education relevant to patient condition(s); (4) lifestyle improvement supports and engagement, such as healthy eating and exercise ; (5) environmental assessments (falls prevention, pests and mold remediation); (6) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions. Services provided by AIRnyc community health worker will depend on the need of the enrollee and whether the visit is conducted via telephone or as a home visit.	The 5 boroughs of New York City.
MetroPlus Health Plan	NYC Health and Hospitals Corporation ("NYC Health + Hospitals")	God's Love We Deliver	Economic Stability	Home Delivery of Medically Tailored Meals (“MTM”), approved by a Registered Dietitian and Nutritionist (“RDN”) and coordinated with the MetroPlus Case Management Department.	All Five NYC Boroughs
Healthfirst, PHSP	NYC-Health and Hospitals Corporation	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC’s patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Queens, Bronx, Brooklyn, Harlem
HealthFirst (HH VBP Pilot)	NYU Langone	American Lung Association	Health and Healthcare, Neighborhood and Environment, and Economic Stability	Healthfirst PHSP and NYU Langone Health will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 111 households with Medicaid members ages 0 to 21 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	Bronx, Kings, New York, Queens, Staten Island

Fidelis	Primary Care IPA	Every Person Influences Children (EPIC)	Education, Social, Family and Community Context, Health and Healthcare	Research demonstrates that early family support programs focused on bonding, behavior management, and reducing the negative impact of divorce/separation have the greatest impact on preventing behavioral health difficulties among children and adolescents (Colizzi, Lasalvia, & Ruggeri, 2020). Specifically, pre-school prevention programs that are child focused, combined with family support, have been associated with the most significant and lasting impacts (Colizzi, Lasalvia, & Ruggeri, 2020). This project seeks to prevent and reduce the prevalence and severity of mental health conditions among children by addressing social determinants within the family domain, among those most vulnerable, to prevent the development of behavioral health problems. This will be accomplished through the provision of evidence-based family support programs provided Every Person Influences Children, Inc. (EPIC), a tier-1 community-based organization located in Buffalo NY.	Buffalo in Western New York
Fidelis	Prominis Care IPA LLC dba Starling IPA	God's Love We Deliver	Economic Stability, Food Insecurity	God's Love We Deliver medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Fidelis Care/Prominis Care IPA, LLC dba Starling IPA members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need for 3-6 months, with certain members to be re-authorized on an as needed basis.	5 Boroughs of NYC, Westchester, Suffolk, and Nassau; added in Rockland and Orange
Molina Healthcare (Healthy Homes)	SOMOS	New York Healthy Home Collaborative-prior CBO was NMIC-now AIRNYC	Economic Stability, Housing Stability, Environment, Education	SOMOS Innovation is joining Molina Healthcare of New York, Inc to participate in the NY Healthy Homes Collaborative (NYHHC), an asthma intervention program intended to sharply decrease recurring hospital utilization for individuals aged 0-60 while producing a positive return on investment. These individuals are residents of one of the 5 boroughs: Bronx, Manhattan, Staten Island, Brooklyn, and Queens, and enrolled in one of the following Molina Healthcare programs: Medicaid, HARP, Child Health Plus, or Essential Plan. The target population also meets at least one of the following trigger event criteria within the past 12 months: One or more hospital admissions, one or more inpatient visits or two or more emergency department (ED) visits within 12 months with a primary diagnosis of asthma. NYHHC's asthma remediation efforts of the program are conducted by the Association for Energy Affordability (AEA), Green and Healthy Homes Initiative, Inc (GHHI) and AIRnyc/Fund for the City of New York. SOMOS Innovation is working with Molina Healthcare to participate in this initiative to provide an intervention that will remediate social determinants of health impacted by asthma for SOMOS attributed members. Specifically, NYHHC will seek to improve asthma outcomes by focusing efforts on home-based education and on home repairs that reduce asthma triggers. Members who meet the criteria are generated into a list and sent over to AIRNYC to be contacted and connected with a CHW who will continue the intervention and make any additional referrals. The CHW will conduct two assessments: a baseline and environmental assessment.	Bronx, Brooklyn Manhattan, Queens

United Healthcare	SOMOS	God's Love We Deliver	Food Insecurity	God's Love We Deliver will provide medically tailored home-delivered meals and nutritional counseling support to UnitedHealthcare/SOMOS members. God's Love We Deliver medically tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostics and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. UnitedHealthcare/SOMOS members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), for a period of 6 months. Minimum of 25 members will be served at initial roll-out.	Brooklyn, Bronx, Queens, Manhattan, Staten Island, Westchester, Suffolk and Nassau
Empire HealthPlus	SOMOS IPA LLC	Regional Aid for Interim Needs, Inc. ("R.A.I.N.")	Economic Instability, Food Insecurity, Housing Instability	The SDH initiative was launched in April 2018 as a core feature of the SOMOS project design and to comply with the requirements prescribed in the NYS DOH DSRIP VBP Roadmap. At the end of 2020, SOMOS re-evaluated its SDH program. After a thorough evaluation, SOMOS is targeting four components of SDH: affordable quality housing, housing security and stability, food security and access to healthy foods. These four determinants are then grouped into two major buckets for screening purposes: food and housing. The program targets the SOMOS network population enrolled in care management (CM), with an emphasis on Medicaid beneficiaries that are Spanish and Mandarin speakers. The team redesigned the workflow to transition program efforts and optimize outcomes with our contracted Community Based Organization (CBO) partnership, R.A.I.N. R.A.I.N. provides services that support food security/access and housing security/access services to our target population. SOMOS leveraged its existing care management (CM) program to target the social needs for these members. All participants of the CM program are screened for food and housing related issues. If the member screens positive, they are connected to R.A.I.N. for support. Our contract funds one full time Community Health Worker (CHW) to address the social needs.	Bronx, Brooklyn, Manhattan, Queens
HIP/Emblem	SOMOS IPA LLC	Regional Aid for Interim Needs, Inc. ("R.A.I.N.")	Economic Instability, Food Insecurity, Housing Instability	The SDH initiative was launched in April 2018 as a core feature of the SOMOS project design and to comply with the requirements prescribed in the NYS DOH DSRIP VBP Roadmap. At the end of 2020, SOMOS re-evaluated its SDH program. After a thorough evaluation, SOMOS is targeting four components of SDH: affordable quality housing, housing security and stability, food security and access to healthy foods. These four determinants are then grouped into two major buckets for screening purposes: food and housing. The program targets the SOMOS network population enrolled in care management (CM), with an emphasis on Medicaid beneficiaries that are Spanish and Mandarin speakers.	Bronx, Brooklyn, Manhattan, and Queens.

Healthfirst PHSP	SOMOS Your Health IPA	Regional Aid for Interim Needs, Inc. (“R.A.I.N.”)	Economic Stability, Food Insecurity, Housing Instability	The SDH Intervention initiative was launched in April 2018 as a core feature of SOMOS project design and to comply with the requirements prescribed in the NYS DOH DSRIP VBP Roadmap. The interventions were selected from the NYSDOH issued menu of evidenced-based SDH interventions. Through this initiative, SOMOS has gained better understanding of the design and process for integrating medical and social interventions to achieve positive health outcomes. The service delivery goals of the SDH initiative are to assist patients maximize entitlement support, incentivize medication adherence, and to mitigate the impact of housing and food insecurity through direct service delivery and referrals. The selection and prioritization of these interventions were based on a thorough review and analysis of Community Needs Assessment (CNA) and demographic data pertinent to the target population. Based on the needs of the population, SOMOS selected Economic Stability as a "Key Area of SDH." Within the Economic Stability domain, SOMOS is targeting: Economic Instability, Housing Instability, and Food Insecurity. Attachment I provides a description of the work scope for our CBO partners and includes a description of each VBP Funded Intervention, with corresponding Activities and Intervention Goals.	Bronx, Brooklyn, Staten Island, Manhattan, and Queens
Fidelis	South Asian IPA	God's Love We Deliver	Food Insecurity	God’s Love We Deliver will provide medically-tailored home-delivered meals and nutritional counseling support to Fidelis Care/South Asian IPA members. God's Love We Deliver medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Fidelis Care/South Asian IPA members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need for 3-6 months, with certain members to be re-authorized on an as needed basis.	Bronx, Brooklyn, Queens, Manhattan, Staten Island, Rockland, Orange, Westchester, Nassau, and Suffolk
Healthfirst, PHSP	St. Barnabas Health System	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC’s patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Bronx
Molina Healthcare (VBP Pilot)	St. Joseph's Hospital Health Center Foundation	Near Westside Initiative	Neighborhood and Environment	Multigenerational Community Wellness Initiative: By June 2020, increase the number of adults on the Northside and Near Westside neighborhoods of Syracuse who have access to safe places to exercise by 25% from 46% to 58%. Partners Northside-UP and the Near Westside Initiative will each work to create multigenerational wellness spaces that provide access to physical activity and nutrition resources in their neighborhoods. These efforts will include community engagement sessions, piloting programming and building a park (Westside) or designing a wellness space (Northside).	Onondaga

Healthfirst, PHSP	St. Luke Roosevelt Hospital center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Manhattan
Healthfirst	State University Medical Center at Stonybrook	A.I.R. NYC	Health and Health Care , Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Suffolk
Fidelis (HH VBP Pilot)	Summit Pediatrics	The American Lung Association 4/1/22 Update: NYS Healthy Homes VBP Pilot Partners: •New York State Energy Research and Development Authority (NYSERDA) •New York State Department of Health (NYSDOH) •The American Lung Association (ALA) •CBOs with affiliated NYSERDA participating Energy/Housing Services Providers •Visiting Nursing Association of Western New York •Catholic Charities of Buffalo	Health and Healthcare, Neighborhood and Environment, Economic Stability	Fidelis Care and Summit Pediatrics will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 53 households with Medicaid members ages 0 to 17 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	Niagara 4/1/22 Update: Niagara, Erie, and Chautauqua Counties.

Healthfirst, PHSP	SUNY Downstate Medical Center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Brooklyn
Healthfirst, PHSP	The Brooklyn Hospital Center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Brooklyn
HIP/Emblem	The Montefiore IPA, f/k/a MMC IPA No. 7 IPA, Inc.	God's Love We Deliver	Economic Stability, Food Insecurity	The VBP SDH intervention selected is from the Economic Stability domain on the state's approved SDH menu. CBO provides medically tailored home delivered meals ("MTM"). Services are approved by a registered dietitian nutritionist ("RDN") and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a registered dietician based on a session of nutrition diagnostic and therapy for disease management ("Medical Nutrition Therapy") and an EmblemHealth Care Management referral to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester.
CDPHP	Various EPC Provider	The Food Pantries for the Capital District (TFP)	Economic Stability	The Enhanced Food Pantry Access & Support Program will provide individualized assistance for CDPHP Medicaid members with identified food insecurity issues. TFP staff will assist members in locating food pantry or free community meal resources that meet the member's needs from an accessibility, timing and nutritional perspective, whenever possible. Members with unique needs such as transportation or mobility issues or chronic disease related nutritional needs will be addressed through individualized support and creative solutions, as feasible. TFP will also perform follow up outreach will be conducted telephonically 2 days post-referral and again at 30 days post-referral. Any ongoing food access issues will be addressed at those touch points.	Albany, Schenectady, Rensselaer and Saratoga

Healthfirst, PHSP	Wyckoff Heights Medical Center	A.I.R. NYC	Health and HealthCare, Neighborhood and Environment, Education, Housing	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. The CBO is contracted on a Fee-for service basis using Community Health Workers (CHWs) to provide two types of home visits: baseline and follow-up. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. Follow-up visits occur up to 1-5 visits per year as needed based on the severity of the case. Each visit entails a mix of intake/data collection, health education, and home environmental assessment. A.I.R NYC's patient-centered approach also includes chronic-disease support, education, and referrals beyond asthma. Apart from the specific work in homes, A.I.R NYC staff undertake a variety of efforts before and after the visits. Outreach, prep time and post-visit activities include: case review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Brooklyn
Managed Long Term Care (MLTC) Interventions					
Plan Name	**VBP Contractor**	**Community Based Organization**	**SCN Domain(s)**	**Intervention Description**	**County(ies) Served**
Aetna Better Health Of NY	Longevity Health Services LLC	AIRNYC	Social and Community Context, Housing	Referrals for the project were made by Prime Health Choice staff, and self-referrals from members were also accepted. Family Services was specifically chosen as a Value-Based Payment (VBP) Social Determinants of Health (SDH) contract. Their role within the project was to facilitate the coming together of Prime Health Choice members and provide the necessary support to improve their lives and the lives of their family members within the communities.	Manhattan, Brooklyn, Queens, Bronx, Nassau, Suffolk
Prime Health Choice	N/A	Family Services - The Dutchess County c/o The Family Partnership Center	Social, Family, Community Context	The design of the project implemented by Prime Health Choice aimed to ensure the safety of its members and prevent elder abuse. It involved the active participation of 100% of Prime Health Choice members across two counties. The project's scope included identifying and addressing social determinants of health, immediate safety concerns, and providing support services to enhance the well-being of members and their families. Referrals for the project were made by Prime Health Choice staff, and self-referrals from members were also accepted. Family Services was specifically chosen as a Value-Based Payment (VBP) Social Determinants of Health (SDH) contract. Their role within the project was to facilitate the coming together of Prime Health Choice members and provide the necessary support to improve their lives and the lives of their family members within the communities.	Orange and Dutchess Counties
Centers Plan for Healthy Living	N/A	Achiezer Community Resource Center	Financial Literacy	The proposed intervention will cover financial literacy including the following topics: money management, benefits/entitlements for seniors, home equity, and scams and security.	Manhattan, Brooklyn, Queens, Bronx, Staten Island, Nassau, and Suffolk
VillageCareMax	Hillside Care Management and Complete Care Management	AIRnyc	Health and Healthcare, Housing	The VCMAX population is comprised of individuals living with multiple chronic conditions such as COPD and are impacted by social factors that contribute to the exacerbation of their condition. Due to low health literacy, enrollees have limited knowledge about the management of their chronic diseases and are prone to non-compliance with medication management, leading to increased emergency room utilization, and frequent hospital readmissions. Improving health literacy and the ability of the enrollee to actively engage in self-management of their COPD will improve the members' quality of life and will decrease the overutilization of acute healthcare resources.	Brooklyn, Bronx, Manhattan, and Queens

Montefiore Diamond Care	Healthy People	Health People, INC. - Community Preventive Health Institute	Health Education	The Core of Health People's Long-term Improvement for Diabetes (LID) Program is a 4 session education program, provided in the homes of Diamond Care Diabetes patients who reside in the Bronx. These sessions of 2 hours each, one session every two weeks, build on each other to educate, empower and help patients set goals for themselves. The sessions are available in English or Spanish and at an 8th grade literacy level. Since the sessions are also available to home health care aides and family caretakers, they serve as built in socialization and "mini support groups" for the member. In order for the member to be enrolled in the program, they must be alert and oriented.	Bronx, Westchester
VNS Choice (MLTC, MAP, FIDA) Nascentia Health Options	N/A	Visiting Nurse Service of NY Home Care II DBA (VNSNY) Contracted CBO is God's Love We Deliver	Social and Community Context, Health Education	The Program to Encourage Active Rewarding Lives (PEARLS) is a national evidence-based model designed to reduce depression symptoms and improve quality of life in older adults. There will be 6-8 sessions that focus on behavioral techniques including outreach to adults 65 years + with a special focus on those who are homebound, depression screening, and engagement in treatment based on the PEARLS model.	Manhattan and Queens
Senior Whole Health of NY	N/A	God's Love We Deliver	Food Insecurity, Health Education	The project will leverage analytics from the Regional Health Information Organization (RHIO) Healthix that identifies members who are at high risk for chronic disease diagnosis such as but not necessarily limited to congestive heart failure. Senior Whole Health will provide nutrition education in conjunction with home delivered medically tailored meals for individuals living with specific disease diagnosis such as congestive heart failure or diabetes. A registered dietician nutritionist will complete sessions with identified members.	Bronx, Kings, Nassau, NY, Queens, Westchester County
Kalos Health, INC.	N/A	Food Gnomes, LLC	Social, Family, Community Context	Economic Stability is a category of SDH that many of our member's face. In particular, we have members that struggle to put adequate meals together, especially towards the end of the month when food stamps or their Social Security checks may have run out. We intend to collaborate with Food Gnomes, so that these members' struggles are either decreased, or eliminated altogether. This organization is a mobile food pantry that asks its recipients only one question "Are You Hungry"? They have no paid employees and operate on 100% donations. Kalos Health has partnered with Food Gnomes to help bridge the economic and nutritional "gaps" that some of our member's face. They service the greater Buffalo metro area, which includes a majority of the population in both Erie and Niagara counties. Kalos Health MLTCP has over 393 members that reside in this service area.	Buffalo. Eastern Erie and Niagara Counties
HealthFirst	Premier	AIR NYC	Neighborhood and Environment, Health and Healthcare, Education, Housing	Healthfirst has engaged AIR NYC a tier 1 community based organization to provide a social determinant of health intervention for asthma patients. The CBO is contracted on a fee-for service basis using Community Health Workers to provide outreach, enrollment and home visits.	Bronx
iCircle Services of the Finger Lakes	L. Woerner, INC., DBA HCR	Western NY Integrated Care Collaboration	Social, Family, and Community Context	The proposed intervention is targeted at members to address social isolation and depression. The evidence based program "Health IDEAS" will educate older adults and caregivers about depression, linking older adults to primary care and mental health providers, and empowering older adults to manage their depressive symptoms through a behavioral activation approach that encourages involvement in meaningful activities, while assessing client progress.	Orleans, Genessee, Wyoming Counties
ArchCare Community Life	N/A	God's Love We Deliver	Food Insecurity and Education	Members who have severe chronic conditions will be provided with nutritional counseling and education to help improve their nutrition and decrease ED utilization and hospitalizations. Individuals must have 2 or more hospitalizations in the last 6 months and one of the following conditions: diabetes, hypertension, CHF, CAD, and electrolyte imbalance.	Bronx, Queens, Brooklyn, Manhattan, Staten Island, Westchester, and Putnam

Kalos Health, INC.	N/A	Hearts and Hands Faith in Action, INC.	Social, Family, Community Context	A majority of Kalos Health MLTC members are age 65 or older. Unfortunately, a very common SDH category that comes with this age group is “Social, Family, and Community”. Many of these people feel disconnected from the outside world and suffer from loneliness and depression. Hearts and Hands is an organization that focuses specifically on a senior population that tend to live in rural areas, mainly Eastern Niagara County and both Eastern and Southern Erie County. Hearts and Hands offers a number of services, but the ones that will most benefit our members to combat this SDH is their Senior Companion services, as well as transportation for social purposes. Through this partnership, we can now offer our members the opportunity to get a ride to the grocery store, the hair salon, a friend’s house, church, or a number of other places they may not have been able to get to on their own. Additionally, for any members seeking companionship, in the CBO’s service area, we can arrange for a companion to go to the home and spend some quality time with the member. They can talk, play games, watch movies, or anything else that brings them joy. The intent of this partnership is to connect our members that are experiencing isolation and making them feel as they are a part of the community again. We hypothesize that these services will be pivotal in improving these member’s health outcomes.	Buffalo. Eastern Erie and Niagara Counties
ElderServe Health, INC. /DBA RiverSpring Health Plans	N/A	VISIONS	Health and Healthcare	VISIONS will augment our vision rehabilitation therapy and occupational therapy to visually impaired members of RiverSpring at Home, the Managed Long Term Care plan of ElderServe Health. VISIONS services include instruction in the use of compensatory skills and assistive devices for communication, instruction in daily living skills such as cooking, personal care, leisure activities, use of optical aids prescribed by an optometrist to enable use of remaining vision.	Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, Westchester
MetroPlus Health Plan, INC.	N/A	AIRNYC	Social and Community Context, Health and Healthcare, Housing	CHW intervention to address isolation and lack of family/community support. Using answers to questions in the UAS the MLTC plan will identify eligible members and refer them to AIRNYC. AIRNYC CHW will work with the members and conduct several assessments to identify social needs and any medical concerns. The community health worker will coordinate with the MLTC care manager and/or risk provider sharing info obtained in the home and making referrals to social services as needed.	Bronx, Kings, Manhattan, Queens and Richmond
VNA Home Care Options, LLC DBA: Nascentia Health Options, LLC	N/A	Companion Home Services, INC.	Health and Healthcare	For the purpose of this intervention, the project scope will be limited to individuals without Advance Directives who are frequent users of emergency services. We propose that by providing a targeted approach to health literacy specific to palliative care and advance directives, individuals will be empowered to make informed choices about their care and end of life decisions.	Cayuga, Oneida, Onondaga, and Oswego

Programs of All-Inclusive Care for the Elderly (PACE) Interventions

Plan Name	VBP Contractor	CBO Name	SCN Domain(s)	Intervention Description	County(ies) Served
ArchCare Senior Life dba Catholic Managed Long Term Care	N/A	God's Love We Deliver	Health education	Nutritional education by RDs. Interventions are member specific and can be provided through the delivery of medically appropriate meals, regular telephonic dietician counseling and education, and regular in-person dietician visits.	Bronx, Manhattan, Staten Island
Catholic Health LIFE	N/A	Community Music School of Buffalo	Social and Community Context	Provide Music Therapy to all LIFE members that attend the LIFE Day Center in person or virtually	Erie

Complete Senior Care-PACE	N/A	Senior Companion Program, Volunteer Center @ HANCI (Health Association of Niagara County, Inc.)	Isolation and lack of family/community support	Complete Senior Care's approved SDH intervention is to reduce isolation and enhance community support for the individuals. Senior Companion Volunteers from HANCI are trained volunteers that provide support and comfort to elderly persons (55 years of age and older) at Complete Senior Care (CSC) PACE. The target population is the participants of Complete Senior Care PACE program of Niagara County. The roles that the Senior Companion Volunteers play involves daily participation and interaction with the participants in the CSC Day Center as well as accompanying some of these individuals out in the community to shopping, provider appointments, field trips, banking, etc.	Niagara
Eddy Senior care	N/A	Food Is Medicine	Health and Healthcare, Food Insecurity	The Food is Medicine program was designed to improve the ability of PACE participants to maintain good nutrition with access to adequate food resources. Food is Medicine targets PACE participants who are at risk for food insecurity, suffer from chronic conditions and are deemed unable to shop or prepare meals independently. Other factors that determine eligibility include disease risk reduction, management of chronic disease and quality of life. Food insecurity is associated with adverse health outcomes and the primary goal of the program is to decrease overall emergency room and inpatient utilization by 10%.	Schenectady, Albany and Rensselaer
PACE- CNY	N/A	PAWS of CNY	Social Isolation	PACE CNY partners with PAWS of CNY to provide pet therapy, an animal-assisted support system, to those PACE CNY participants who are struggling with depression and loneliness. PACE CNY's animal- assisted activities are casual "meet and greet" activities where the PAWS of CNY volunteers and pets visit with the participants in both the North Syracuse, NY and East Syracuse, NY PACE CNY Day Centers.	Onondaga
Total Senior Care	N/A	County of Chautauqua	Health Education	For FY22-23, PAWS of CNY was not available for in-person visits due to the COVID-19 pandemic, which reduced the number of available volunteers and pets available for in-person visits.. PACE CNY is actively working with PAWs of CNY on a reopening plan to resume in-person visits with PACE CNY participants.	Chautauqua
***The following interventions are implemented by providers who either elected not to share their organization name or have since closed/ended.**					
			SCN Domain(s)	**Intervention Description**	**County(ies) Served**
			Health and Health Care	Intervention provides emergency childcare to families. Staff will act as navigators to facilitate access to insurance and care, provide education, and outreach to ensure universal quality access to health care services. The primary focus of the work will be to assess the health care status of clients who utilize the services. If the assessment indicates that they are uninsured or under-insured, the staff member will assist in help getting them covered. If the assessment indicates that they do not have a consistent primary care provider, the staff member will contact the VBP Contractor to facilitate an appointment.	Monroe
			Economic Stability, Neighborhood and Environment, Housing	The primary focus of the intervention's work will be to work with individuals and care teams around homelessness, housing instability, skills to maintain housing, lack of access to affordable housing in the Hudson Valley Region.	Westchester, Rockland, Orange, Ulster, Sullivan, Dutchess, Putnam
			Health and Health Care	Intervention will provide comprehensive screening processes and referral services to three-year-old children of members in Monroe County. Intervention provides comprehensive screenings for 3 year old children residing in City of Rochester. Screenings include vision, hearing, speech, language, dental health, developmental, social-emotional, height/weight. Screenings identify children at potential risk for compromised development and educational outcomes.	Monroe

			Health and Healthcare	Intervention will employ a navigator in the hospital Emergency Department (ED). The working hours will be Monday through Friday from 2:00pm – 10:00pm, the ED "hot hours." The navigator will interview patients to identify social determinants of health using a standardized tool. Patients will be informed about options in the community to help address their needs and the navigator will make referrals, track patient compliance, follow-up with patients and CBO's and keep detailed notes in the hospital EMR.	Fulton, Montgomery, and Hamilton
			Education, Health and Healthcare, Housing	Intervention will assess enrollees over the phone or in their home and identify health education needs based on the target population, as well as community services that can help the enrollee improve their condition and meet their needs. Telephone interviews, home visits and follow ups may consist of the following, among other things: (1) medication adherence, such as use of spacers and control medication for asthma, or blood pressure monitoring for hypertension; (2) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (3) patient and caregiver education relevant to patient condition(s); (4) lifestyle improvement supports and engagement, such as healthy eating and exercise ; (5) environmental assessments (falls prevention, pests and mold remediation); (6) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	Bronx, Brooklyn, Queens, Staten Island, and Manhattan
			Economic Stability, Food Insecurity	Intervention meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	New York City, Westchester, Suffolk, Nassau
			Economic Stability, Food Insecurity	Intervention meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	Service areas covered by God's Love We Deliver, which includes all five boroughs of New York City, Rockland, Orange, Westchester, Suffolk and Nassau counties and mutually agreed upon areas in New York State, and by Provider.
			Economic Stability, Food Insecurity	Intervention meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	5 Boroughs of NYC, Westchester, Suffolk, and Nassau
			Economic Stability, Food Insecurity	Intervention will provide medically-tailored home-delivered meals and nutritional counseling support to members. Intervention medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	All five boroughs of New York City, Rockland, Orange, Westchester, Suffolk and Nassau counties

			Economic Stability, Housing instability	Support of unique housing services for Plan members with identified chronic health conditions. CBO to provide housing assistance programs to allow Plan members to better focus on individual health goals. CBO housing case workers will help members find funding or housing placement in Buffalo, Jamestown, and throughout all eight counties of Western New York.	Western NY Counties
			Health and Healthcare, Neighborhood and Environment, and Economic Stability	Intervention will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage up to 43 households with Medicaid members ages 0 to 17 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	Erie, Niagara, and Chautauqua
			Education, Health and Healthcare, Housing	Intervention in coordination with VBP Provider will identify eligible members for the program and refer them to CBO for outreach and enrollment. Members who agree to the program will be visited by the CBO's community health worker, who will visit with the member and conduct several assessments to identify social needs and any medical concerns. The community health worker will coordinate with the physicians and/or care manager, sharing information obtained in the home visit and making referrals to social services as needed. Follow up visits or telephonic follow ups will be conducted based on risk.	Bronx, Brooklyn, Queens, Manhattan, and Staten Island
			Economic Stability, Food Insecurity	Intervention will provide medically-tailored home-delivered meals and nutritional counseling support to Fidelis Care/Upward Health members.	All 5 NYC boroughs; Rockland, Orange, Westchester, Suffolk and Nassau
			Health and Healthcare, Food Insecurity,	Intervention is in the process of receiving and ultimately building knowledge on the 15,000 members in the scope of this effort to risk stratify and determine if there would be specific program or intervention that would be ideal to pursue. For example, there is the option to screen for basic SDOH needs or for a specific program, for example for behavioral health, maternal/child health (birth equity) or other programs identified by the state or by the population. To support this work, Intervention will leverage a platform to connect members to the right community resources so they can stay well, meet basic needs, manage illness and care for others more effectively.	State of NY
			Health and Healthcare	Intervention has a team of 4 social workers who are experienced, behavioral healthcare managers. They are accustomed to working with individuals who have mild to moderate depression. The intervention is to address mild to moderate depression in our adult and child populations before it becomes severe. The services include initial screening and working with PCPs and patients on a collaborative model to address these issues. In addition, other socioeconomic issues and needs are identified and addressed with the help of other CBO partners.	New York, Kings, Queens, Staten Island, Bronx
			Economic Stability, Food Insecurity	Intervention will provide medically-tailored home-delivered meals and nutritional counseling support to members. Medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	5 Boroughs of NYC, Westchester, Suffolk, and Nassau; added in Rockland and Orange

			Economic Stability, Food Insecurity	Medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	All 5 NYC boroughs; Rockland, Orange, Westchester, Suffolk and Nassau
			Economic Stability, Food Insecurity	Medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	5 Boroughs of NYC, Westchester, Suffolk, and Nassau; added in Rockland and Orange
			Education, Health and Healthcare, Housing	The CBO will assess enrollees over the phone or in their home and identify health education needs based on the target population, as well as community services that can help the enrollee improve his/her condition and meet his/her needs. Telephone interviews and home visits and follow ups may consist of the following, among other things: (1) medication adherence, such as use of spacers and control medication for asthma, or blood pressure monitoring for hypertension; (2) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (3) patient and caregiver education relevant to patient condition(s); (3) lifestyle improvement supports and engagement, such as healthy eating and exercise ; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC
			Economic Stability, Health and Health Care, Education, Housing Instability, Environment	Intervention will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 51 households with Medicaid members ages 0 to 17 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	TBD
			Health and Healthcare, Neighborhood and Environment, and Economic Stability	Intervention will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 125 households with Medicaid members ages 0 to 17 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	Erie, Niagara, and Chautauqua
			Economic Stability	Intervention will provide individualized assistance for members with identified food insecurity issues, residing in a targeted geographic area. Referrals for this program can originate from care management team, providers within the network (as geographically appropriate). Staff will assist members in locating food pantry or free community meal resources that meet the member's needs from an accessibility, timing and nutritional perspective, whenever possible. Members with unique needs such as transportation, mobility issues or chronic disease related nutritional needs will be addressed through individualized support and creative solutions, as feasible.	Washington, Warren, Saratoga

			Education, Social and Community Context, Health and Health Care, Neighborhood and Environment, and Economic Stability	The primary focus of intervention will be to facilitate direct access to the appropriate community-based organization(s) that can provide direct services to help meet Program Members' various SDH needs. The VBP Contractor can provide Program Members with a warm transfer to the 2-1-1 Helpline, or Program Members can call on their own; 2-1-1 Helpline staff will complete Program Member assessments to determine need. Based on conversations with Program Members, 2-1-1 Helpline staff will link Program Members with appropriate community organizations, agencies or services that can help meet their identified SDH needs. Finally, 2-1-1 Helpline staff will follow up directly with Program Members to determine the service engagement outcomes.	Dutchess, Orange, Rockland, Sullivan, Ulster, Westchester, and Putnam
			Economic Stability	The health partners will be implementing a comprehensive and cost effective program that will focus on housing instability and food insecurity. Using a predictive modeling software the intervention will identify their high cost, high need members who also have conditions that could be impacted with an SDH intervention.	Bronx, Brooklyn Manhattan, Queens
			Health and Healthcare, Economic Stability	Intervention has a team of 4 Licensed Social Workers who are experienced behavioral care managers. They have experience working with individuals with mild to moderate depression. The intervention is to address mild to moderate depression in our adult and child population before the condition becomes severe or patients become suicidal. The services include initial screening and working with PCPs and patients on a collaborative, education model to address these issues. In addition, socioeconomic issues and needs are addressed and assisted by connecting patients to services through referrals.	New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island)
			Economic Stability	The health partners will be implementing a comprehensive and cost effective program that will focus on housing instability and food insecurity. Using a predictive modeling software intervention will identify their high cost, high need members who also have conditions that could be impacted with an SDH intervention.	Bronx, Brooklyn, Manhattan, Queens
			Health and Health Care	The intervention targets high-risk pregnant moms, no-shows, and patients who have not been engaged in care for the past 18 months. Clinic providers and staff establish priorities for outreach to high-need patients. CHWs are able to receive intra-EMR "beans" (messages), participation in clinic staff meetings, no-show reports, and face-to-face contact. CHWs document patient contacts and referrals in the clinic EMR as telephone contacts, which have dropdown options to track reason for contact.	Erie; Niagara
			Health and Healthcare, Neighborhood and Environment, and Economic Stability	Intervention will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 65 households with Medicaid members ages 0 to 17 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	Erie and Niagara
			Economic Stability	Intervention will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC Boroughs; Westchester, Suffolk, Nassau

			Economic Stability	Intervention will provide individualized assistance for members with identified food insecurity issues. Staff will assist members in locating food pantry or free community meal resources that meet the member's needs from an accessibility, timing and nutritional perspective, whenever possible. Members with unique needs such as transportation or mobility issues or chronic disease related nutritional needs will be addressed through individualized support and creative solutions, as feasible.	Albany, Schenectady, Rensselaer and Saratoga
			Economic Stability	The health partners will be implementing a comprehensive and cost effective program that will focus on housing instability and food insecurity. Using a predictive modeling software intervention will identify their high cost, high need members who also have conditions that could be impacted with an SDH intervention.	Bronx, Brooklyn Manhattan, Queens
			Economic Stability	Intervention will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC Boroughs; Westchester, Suffolk, Nassau
			Health and Healthcare, Neighborhood and Environment, and Economic Stability	Intervention will participate in the NYS Healthy Homes VPB Pilot, co-supported by NYSERDA and the NYSDOH, to engage 10 households with Medicaid members ages 0 to 17 who have persistent asthma that is not well controlled. Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services within the VBP arrangement between the above stated parties. The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability.	Erie, Niagara, and Chautauqua
			Health and Healthcare	Intervention partners with local providers, community agencies and schools to strengthen the social and emotional health of children in a variety of ways. The Intervention is an evidence-based, empirically-verified program that focuses on integrating screenings for children 0-4 years of age. The goal of the intervention is to provide annual comprehensive developmental screening and follow-up support for close-looped referrals for 1) vision, 2) hearing, 3) speech and language, 4) dental health, 5) social and emotional adjustment, 6) cognitive functioning, 7) physical development (BMI) and 8) Social Determinants of Health /Education (SDOH/E).	Alleghany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates
			Health and Healthcare	The target population for the project is Multiple Visit Patients who are members with significant Behavioral Health needs. The Pilot will aim to impact approximately 200 Multiple Visit Patients. These members are not engaged with Primary Care and/or frequently utilize potentially preventable services. These members will be identified through EHR data points as well as claims data.	Livingston, Steuben, Monroe, Chemung, and Orleans Counties
			Health and Healthcare	Intervention was formed during 2020 to address social determinants barriers to healthcare, including food, transportation, economic benefits, education, shelter, and other resources in Western New York. Intervention adapted a technology platform that enables Buffalo-area CBOs to (1) receive member referrals directly from primary care providers; (2) timely fulfill member social determinants challenges; and (3) easily and quickly report social determinants outcomes back to the prescribing primary care provider.	Erie, Niagara, Chautauqua, Cattaraugus
			Economic Stability	The proposed project will target 50 Agreement-covered beneficiaries, who are diagnosed with either (1) type 2 diabetes or (2) pre-diabetes. The two entities involved in this intervention will address participants' social determinants barriers to healthy eating and regular exercise through the a series of integrated strategies.	Erie

			Economic Stability, Health and Health Care	The proposed project will (1) use telehealth to reach and engage high-risk diabetics in effective care coordination, provider referrals, and health monitoring; (2) engage, enroll, and transport these members to wellness services, including diet and exercise programs; and (3) ensure member receipt of fresh fruits and vegetables and the nutrition knowledge to understand why such food is fundamental to diabetes management.	Erie
			Economic Stability	Intervention-delivers medically tailored meals that are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	All 5 NYC Boroughs; Westchester, Suffolk, Nassau
			Education, Health and Healthcare	The CBO will assess enrollees over the phone or in their home and identify health education needs based on the target population, as well as community services that can help the enrollee improve his/her condition and meet his/her needs. Telephone interviews and home visits and follow ups may consist of the following, among other things: (1) medication adherence, such as use of spacers and control medication for asthma, or blood pressure monitoring for hypertension; (2) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (3) patient and caregiver education relevant to patient condition(s); (3) lifestyle improvement supports and engagement, such as healthy eating and exercise ; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC
			Economic Stability	The health partners will be implementing a comprehensive and cost effective program that will focus on housing instability and food insecurity. Using a predictive modeling software the intervention will identify their high cost, high need members who also have conditions that could be impacted with an SDH intervention.	Bronx, Brooklyn Manhattan, Queens
			Economic Stability	Intervention delivers medically tailored meals that are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	All 5 NYC Boroughs; Westchester, Suffolk, Nassau
			Education, Health and Healthcare	The CBO will assess enrollees over the phone or in their home and identify health education needs based on the target population, as well as community services that can help the enrollee improve their condition and meet their needs. Telephone interviews, home visits and follow ups may consist of the following, among other things: (1) medication adherence, such as use of spacers and control medication for asthma, or blood pressure monitoring for hypertension; (2) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (3) patient and caregiver education relevant to patient condition(s); (4) lifestyle improvement supports and engagement, such as healthy eating and exercise ; (5) environmental assessments (falls prevention, pests and mold remediation); (6) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	Orange

			Economic Instability, Food Insecurity	CBO provides medically tailored home delivered meals (“MTM”). Services are approved by a registered dietitian nutritionist ("RDN") and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a registered dietician based on a session of nutrition diagnostic and therapy for disease management ("Medical Nutrition Therapy") and an EmblemHealth Care Management referral to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester.
			Education, Social and Community Context, Health and Health Care, Neighborhood and Environment, and Economic Stability	The primary focus of intervention will be to facilitate direct access to the appropriate community-based organization(s) that can provide direct services to help meet Program Members’ various SDH needs. The VBP Contractor can provide Program Members with a warm transfer to the 2-1-1 Helpline, or Program Members can call on their own; 2-1-1 Helpline staff will complete Program Member assessments to determine need. Based on conversations with Program Members, 2-1-1 Helpline staff will link Program Members with appropriate community organizations, agencies or services that can help meet their identified SDH needs. Finally, 2-1-1 Helpline staff will follow up directly with Program Members to determine the service engagement outcomes	Orange, Sullivan, Ulster
			Health and Healthcare, Social and Community Context	Through it's program, Contracted CBO's primary focus will be: • street-level outreach to the most at-risk, highest-utilizing population • connecting the under-served individuals and families in the community to healthcare-related resources in conjunction with other social resources • care coordination for patients in collaboration with partners and providers, offering to patients the unique, personal, & credible support they need to better access healthcare in the proper way	Schenectady
			Health and Health Care	Intervention will provide patients with ability to participate in free course on diabetes self-management. Intervention will provide diabetic patients the opportunity to participate in an evidence-based six-session course on diabetes self-management conducted by peer leaders. The course was designed to enhance regular treatment and disease-specific education as well as to provide participants with the skills to coordinate the things needed to manage their health and keep active in their lives. Provide patients with ability to participate in free course on diabetes self-management.	Bronx
			Economic Stability, Neighborhood and Environment, Health and Health Care	Provide home delivered free medically tailored meals and assess them for additional social determinants of health needs with appropriate referrals as needed.	Rockland
			Health and Health Care	Intervention will provide patients with ability to participate in free course on diabetes self-management. Intervention will provide diabetic patients the opportunity to participate in an evidence-based six-session course on diabetes self-management conducted by peer leaders. The course was designed to enhance regular treatment and disease-specific education as well as to provide participants with the skills to coordinate the things needed to manage their health and keep active in their lives. Provide patients with ability to participate in free course on diabetes self-management.	Bronx

			Education, Social and Community Context, Health and Health Care, Neighborhood and Environment, and Economic Stability	The primary focus of intervention will be to facilitate direct access to the appropriate community-based organization(s) that can provide direct services to help meet Program Members' various SDH needs. The VBP Contractor can provide Program Members with a warm transfer to the 2-1-1 Helpline, or Program Members can call on their own; 2-1-1 Helpline staff will complete Program Member assessments to determine need. Based on conversations with Program Members, 2-1-1 Helpline staff will link Program Members with appropriate community organizations, agencies or services that can help meet their identified SDH needs. Finally, 2-1-1 Helpline staff will follow up directly with Program Members to determine the service engagement outcomes	Dutchess, Orange, Rockland, Sullivan, Ulster, Westchester, and Putnam
			Economic Stability, Food Insecurity	Provision of medically tailored home delivery meals and nutritional counseling to support members.	All 5 NYC Boroughs, Nassau, Westchester
			Economic Stability, Food Insecurity	Intervention will implement a medically tailored meal intervention. Together, the two organizations will work together to deliver nutritious, medically tailored meals for patients too sick to shop or cook for themselves. Additionally, the intervention will work with each client to provide ongoing nutrition assessment, education, and counseling. This SDH Intervention will specifically address food insecurity, lack of adequate nutrition, and lack of access to healthy foods.	Chinatown, Manhattan; Sunset Park, Brooklyn; Flushing, Queens;
			Economic Stability and Health and Health Care	For members who have not had any visits with PCP or identified otherwise ; intervention will perform outreach to these members for the purposes of engaging in health coaching; perform an assessment of needs on engaged Members to determine those barriers that contributed to preventing a Member from attending a PCP visit; will provide recommendations to plan on implementing targeted interventions for specific barriers identified; provide coaching and education on the importance of connection with a PCP for preventive care, routine sick care and chronic care in accordance with the Integrated Primary Care bundle as noted in the New York State Department of Health (DOH) Value Based Payment Roadmap; will assist Members with connection to 1 or more community services that address SDoH and assist in overcoming barriers to seeking health care such as food insecurity, housing instability, transportation to doctor visits, family crises, etc. Engagement of peer coaches for identified members that are not engaged with primary care providers.	Orange and Sullivan
			Education, Health and Healthcare	The project will focus on priority populations who have chronic conditions and/or social needs. Plan and Provider will work together to define eligibility criteria for the program. Provider and Plan will collaborate to determine the most vulnerable members that would benefit from the additional support of CBO based on defined eligibility criteria. Members will be referred to CBO by Provider. CBO will then deploy community health workers to do telephonic or home visits. During the initial visit, one or more needs assessment(s) will be conducted to determine the gaps in health literacy, social needs and the member's priorities. Based on the results of the needs assessment(s), the community worker will provide recommendations to the provider as well as referrals to appropriate services and programs within the agency or with other community based organizations.	Bronx, Brooklyn, Queens, Manhattan, and Staten Island

			Economic Stability, Education, Social and Community context, Health and Health Care, and Neighborhood and Environment	By deploying CHWs, contracted CBO will engage members who are unengaged with primary care, through phone calls, text messages, home visits, and presence in community "hot spot" locations. CHWs will meet with members at a mutually agreed upon location, including the member's home, and assist them by: Improving health literacy; Assisting with health care, social services and community resources; Connecting to community services and socialization activities; Coordinating care through primary care providers; Accompaniment to medical appointments; Assisting with transportation; Supporting with applications for services such as housing, SNAP and HEAP; and Ultimately improving their quality of health while reducing ED visits and hospital admissions and re-admissions	Jefferson, Lewis, St. Lawrence
			Economic Stability, Food Insecurity	Intervention will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC boroughs; Nassau, Suffolk, Westchester
			Economic Stability, Food Insecurity	Intervention will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC boroughs; Nassau, Suffolk, Westchester
			Economic Stability, Food Insecurity	Home Delivery of Medically Tailored Meals ("MTM"), approved by a Registered Dietitian and Nutritionist ("RDN") and coordinated with plan.	All 5 NYC Boroughs, Nassau, Westchester
			Economic Stability	Intervention is concentrating its SDH intervention efforts on network PCPs remaining in VBP arrangements. The top 5% of high utilizers (chronic sub-population) consumes approximately 50% of total medical expenditures. While a significant number of these complex patients have health conditions (like cancer) that, at this point, will not significantly benefit from an SDH intervention, the intervention estimates that up to 20% of this high-utilizing sub-population will be impacted through SDH interventions.	Bronx, Brooklyn, Manhattan, Queens
			Economic Stability, Food Insecurity	Home Delivery of Medically Tailored Meals ("MTM"), approved by a Registered Dietitian and Nutritionist ("RDN") and coordinated with plan.	All 5 NYC Boroughs, Nassau, Westchester
			Economic Stability	The service delivery goals of the SDH initiative are to assist patients maximize entitlement support, incentivize medication adherence, and to mitigate the impact of housing and food insecurity through direct service delivery and referrals. The selection and prioritization of these interventions were based on a thorough review and analysis of Community Needs Assessment (CNA) and demographic data pertinent to the target population.	Bronx, Brooklyn, Manhattan, Queens
			Economic Stability, Food Insecurity	Intervention will provide medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	NYC, Suffolk, and Nassau; amendment

			Economic Stability, Food Insecurity	Intervention will provide medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.	5 Boroughs of NYC, Westchester, Suffolk, and Nassau; added in Rockland and Orange
			Economic Instability, Housing Instability, and Food Insecurity	The SDH Intervention initiative was launched in April 2018 as a core feature of intervention's project design and to comply with the requirements prescribed in the NYS DOH DSRIP VBP Roadmap. The interventions were selected from the NYSDOH issued menu of evidenced-based SDH interventions. Through this initiative, the intervention has gained better understanding of the design and process for integrating medical and social interventions to achieve positive health outcomes. The service delivery goals of the SDH initiative are to assist patients maximize entitlement support, incentivize medication adherence, and to mitigate the impact of housing and food insecurity through direct service delivery and referrals. The selection and prioritization of these interventions were based on a thorough review and analysis of Community Needs Assessment (CNA) and demographic data pertinent to the target population.	Bronx, Brooklyn, Manhattan, Queens
			Economic Stability	Using claims data and Identifi software, the intervention will target the top 5% high utilizers that consume approximately 50% of the total medical expenditure. SDH intervention focus on assisting patients to maximize entitlement support, incentivize medication adherence and to mitigate the impact of housing and food insecurity through direct service delivery and referrals.	Bronx, Brooklyn Manhattan, Queens
			Economic Stability	Using claims data and Identifi software, the intervention will target the top 5% high utilizers that consume approximately 50% of the total medical expenditure. SDH intervention focus on assisting patients to maximize entitlement support, incentivize medication adherence and to mitigate the impact of housing and food insecurity through direct service delivery and referrals.	Bronx, Brooklyn Manhattan, Queens
			Economic Stability	Using claims data and Identifi software, the intervention will target the top 5% high utilizers that consume approximately 50% of the total medical expenditure. SDH intervention focus on assisting patients to maximize entitlement support, incentivize medication adherence and to mitigate the impact of housing and food insecurity through direct service delivery and referrals.	Bronx, Brooklyn Manhattan, Queens
			Economic Stability	The health partners will be implementing a comprehensive and cost effective program that will focus on housing instability and food insecurity. Using a predictive modeling software the intervention will identify their high cost, high need members who also have conditions that could be impacted with an SDH intervention. Once identified, case management staff will perform an initial outreach to the member, conduct a SDH screening, identify services the intervention can provide and gauge member's willingness to access services.	Bronx, Brooklyn, Manhattan, Queens
			Economic Stability, Housing Instability, Food Insecurity, and Economic Instability	Using claims data and Identifi software, the intervention will target the top 5% high utilizers that consume approximately 50% of the total medical expenditure. SDH intervention focus on assisting patients to maximize entitlement support, incentivize medication adherence and to mitigate the impact of housing and food insecurity through direct service delivery and referrals.	Bronx, Brooklyn Manhattan, Queens

			Economic Stability, Housing Instability, Food Insecurity, and Economic Instability	Using claims data and Identifi software, the intervention will target the top 5% high utilizers that consume approximately 50% of the total medical expenditure. SDH intervention focus on assisting patients to maximize entitlement support, incentivize medication adherence and to mitigate the impact of housing and food insecurity through direct service delivery and referrals.	Bronx, Brooklyn Manhattan, Queens
			Neighborhood and Environment	Multigenerational Community Wellness Initiative: By June 2020, increase the number of adults on the Northside and Near Westside neighborhoods of Syracuse who have access to safe places to exercise by 25% from 46% to 58%. Partners Northside-UP and the Near Westside Initiative will each work to create multigenerational wellness spaces that provide access to physical activity and nutrition resources in their neighborhoods. These efforts will include community engagement sessions, piloting programming and building a park (Westside) or designing a wellness space (Northside).	Onondaga
			Health and Healthcare, Economic Stability	Intervention will focus on providing psychoeducation for individuals and families dealing with substance use disorder. The following are the VBP funded interventions: Pre-treatment/Start2Stop- will provide psychoeducational counseling to individuals who have been discharged from the hospital as a result of substance; Family education and support counseling services- can provide family members of individuals recently in the hospital system as a direct result of substance use with appropriate family education and counseling services; Crisis Calls- Calls from family members, identified clients and community members in need of immediate intervention/assistance as a result of addiction, including but not limited to high risk emergency situations, individuals in active withdrawal, homelessness, and suicidal or homicidal ideation; Relapse prevention counseling- provides relapse prevention counseling in order to help individuals maintain recovery and reduce risk of relapse, re-engagement in the healthcare and/or treatment system, and/or the criminal justice system; Harm reduction and risk-reduction counseling- will provide harm reduction and psychoeducational counseling to high-risk substance users, injection drug users, individuals who are living with or who are at risk for HIV/AIDS and Hepatitis; R.E.C.O.V.R. Program-Follow-up and re-engagement services. Intervention will conduct follow-up services and ongoing support and counseling for individuals upon discharge to ensure they receive appropriate care for substance use treatment.	Nassau
			Economic Stability, Housing instability	Social workers or other clinicians may refer patients who are in need of legal representation on a variety civil of matters including immigration, housing and benefits. The attorneys will be embedded in our health care facilities and provide free legal services to patients on a variety of civil matters, including immigration, housing, and benefits.	NYC
			Stigma and Discrimination- Provider level intervention	Intervention seeks to work collaboratively with the area Provider Network, to actively keep community care providers up to date on available services, promotional events, and strategies and tools to best care for patients living with challenging life situations, thereby promoting a culture of wellness.	Ithaca, Tompkins Cortland, Schuyler
			Economic Stability, Food Insecurity	Intervention will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC boroughs; Nassau, Suffolk, Westchester
			Economic Stability, Food Insecurity	Hospitalized patients identified with food insecurity, nutrition related diagnosis of Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) and at high risk for inpatient and emergency department readmissions will receive medically tailored home delivered meals including ongoing nutrition assessment, counseling and education based on their individualized diet prescription for 2 months post discharge.	Nassau, Queens

			Economic Stability, Housing Instability, Food Insecurity, and Economic Instability	The intervention is concentrating its SDH intervention efforts on network PCPs remaining in VBP arrangements. According to the AHRQ Medical Expenditure Panel Survey, the top 5% of high utilizers (chronic sub-population) consumes approximately 50% of total medical expenditures. While a significant number of these complex patients have health conditions (like cancer) that, at this point, will not significantly benefit from an SDH intervention, SOMOS estimates that up to 20% of this high-utilizing sub-population will be impactable through SDH interventions.	Bronx, Brooklyn, Staten Island, Manhattan, Queens.
			Economic Stability	Intervention will identify potential patients for Medically-Tailored Meal referral to address medical diagnosis, symptoms, allergies, medication management and social support systems to attain the best possible health outcomes. CBO will also provide nutritional-counseling and community-based care coordination of the health plan members they serve.	All 5 NYC Boroughs; Westchester, Suffolk, Nassau
			Economic Stability, Housing Instability, Food Insecurity, and Economic Instability	Using claims data and Identifi software, the intervention will target the top 5% high utilizers that consume approximately 50% of the total medical expenditure. SDH intervention focus on assisting patients to maximize entitlement support, incentivize medication adherence and to mitigate the impact of housing and food insecurity through direct service delivery and referrals.	Bronx, Brooklyn Manhattan, Queens
			Economic Stability	The intervention will provide individualized assistance for members with identified food insecurity issues. Staff will assist members in locating food pantry or free community meal resources that meet the member's needs from an accessibility, timing and nutritional perspective, whenever possible. Members with unique needs such as transportation or mobility issues or chronic disease related nutritional needs will be addressed through individualized support and creative solutions, as feasible.	Albany, Schenectady, Rensselaer and Saratoga
			Food Insecurity	The Intervention is highly experienced in this service area and the premier medically-tailored meal provider in New York City. The medically-tailored meals are approved by a Registered Dietician Nutritionist based on a nutritional assessment and a referral by a health care provider to address medical diagnoses, symptoms, allergies, medication management, and/or side effects, to ensure the best possible health outcomes. These meals are delivered to the enrollees' homes or other suitable settings. Medical nutrition therapy is an evidence-based application of the Nutrition Care Process that is focused on prevention, delay and/or management of diseases and conditions, and involves an in-depth assessment, periodic reassessment and intervention through direct nutritional support.	Bronx, Kings, New York, Queens, Staten Island
			Education, Health and Healthcare	The CBO will assess enrollees over the phone or in their home and identify health education needs based on the target population, as well as community services that can help the enrollee improve their condition and meet their needs. Telephone interviews, home visits and follow ups may consist of the following, among other things: (1) medication adherence, such as use of spacers and control medication for asthma, or blood pressure monitoring for hypertension; (2) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (3) patient and caregiver education relevant to patient condition(s); (4) lifestyle improvement supports and engagement, such as healthy eating and exercise ; (5) environmental assessments (falls prevention, pests and mold remediation); (6) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	Bronx, Brooklyn, Queens, Manhattan, and Staten Island; Lower Hudson Valley Region

			Education, Health and Healthcare	This is a community health worker intervention to address Education and Health and Healthcare in the Medicaid population. Using the 3M data platform, Plan will identify eligible members for the program in coordination with the VBP Provider and refer them to CBO for outreach and enrollment. Members who agree to the program will be visited by a community health worker, who will visit with the member and provide health education regarding chronic conditions, and medication adherence, as well as conduct several assessments to identify social needs and any additional medical concerns. The community health worker will coordinate with the physician and/or care manager, sharing information obtained in the home visit and making referrals to social services as needed. Follow up visits or telephonic follow ups will be conducted based on risk.	Brooklyn, Bronx, Queens, Manhattan, and Staten Island
			Neighborhood and Environment	Multigenerational Community Wellness Initiative: By June 2020, increase the number of adults on the Northside and Near Westside neighborhoods of Syracuse who have access to safe places to exercise by 25% from 46% to 58%. Partners Northside-UP and the Near Westside Initiative will each work to create multigenerational wellness spaces that provide access to physical activity and nutrition resources in their neighborhoods. These efforts will include community engagement sessions, piloting programming and building a park (Westside) or designing a wellness space (Northside).	Onondaga
			Health Education	This CBO offers a geriatric workforce program which provides training to volunteer educators or one on one educational sessions at their total senior centers on topics aimed at managing chronic health conditions and age-related disorders and community based services in Bronx communities.	Bronx
			Health and Healthcare (Health Literacy)	The plan social worker will initially determine if the member is appropriate for the referral to CBO. Once the member is deemed appropriate for services, the social worker will then provide member with information about CBO and introduce member to the CBO Team. If the member declines services, then the referral will not move forward.	Brooklyn, Bronx, Manhattan, and Queens
			Economic Stability	Intervention will assist members in maximizing entitlement support and to mitigate the impact of housing and food insecurity through direct service delivery and referrals. The SDH intervention will target economic instability, housing instability, and food insecurity. The predictive software will identify the high cost and high need members and once identified these members will be contacted by case management staff to engage in services.	Bronx, Brooklyn, Manhattan, and Queens
			Health Education	Intervention will serve as the central point of entry for enrollees of plan who demonstrate high need in the targeted risk areas. Intervention will collect and integrate SDOH information into the Plan's Person Centered Care Plan which will then be shared with intervention staff, Primary Care Physician, and the member.	Rockland, Orange, Dutchess Counties
			Economic Stability, Housing Insecurity	This intervention will provide assistance with maintaining housing through education and eviction prevention, rental arrears, back payment of utilities, landlord interventions, and other outreach activities. MLTC members that are at an increased risk of homelessness will be identified for ths intervention. The overall goal is to prevent homelessness and reduce unnecessary ED utilization.	NYC with a focus in Bronx
			Health & Healthcare	Participants will be enrolled in up to 2 evidence based interventions. The two targeted interventions include Chronic Disease Self-Management Program and Healthy Ideas.	Erie County
			Economic Stability	The proposed intervention will address the social service needs of members that we can connect with intervention to access services. These connections will assist the member in addressing their social service needs for entitlement. Plan will identify members that have conditions we believe are SDH intervention can impact.	Bronx, Brooklyn, Manhattan and Queens

			Social and Community Context	The proposed intervention with use CHW (community health worker) Peer Support Program to improve member health outcomes, promote healthy behaviors, reduce unnecessary utilization of healthcare resources, and positively impact quality measures. The peer support interventions provided by CBO may include: outreach program, independent living skills training, empowerment of vulnerable individuals through the process of developing a sense of autonomy and self confidence, individual and system advocacy, resource information and referral assistance, and community education service.	All 5 NYC Boroughs, Westchester, Nassau, Suffolk
			Health & Healthcare	The intervention will implement a Chronic Disease Self-Management Program and Diabetes Self-Management Program for members who are diagnosed with a chronic disease and/or diabetes. The peer taught education will be for 6 weeks. Each of the programs are evidence based to improve health outcomes.	ERIE AND NIAGARA COUNTIES
			Health & Healthcare	Plan will identify vulnerable members based on risk stratification. The CBO would be additional support to assist the members that are identified. Members will be assessed based on an initial home visit that the CBO CHW would perform. The CHW will then work with member to receive appropriate services and programs through other service providers if needed. CBO will work closely with plan for any additional support that may be needed	All 5 boroughs in NYC
			Health and Healthcare	The proposed intervention will promote self-care management by providing support in the critical, initial 30 days post hospitalization for clients who are identified at risk for preventable re-hospitalizations. The intervention would include surveillance of the clients progress, outcomes and utilization of health services.	NYC, Westchester, Nassau, and Suffolk. Implementation will begin in the Bronx.
			Health & Healthcare	CBO will provide assistance to members by providing home visits and follow-up visits to emphasize social support and provider referrals to agencies and/or programs that can better serve the member's social needs. The CHW will provide an initial social needs assessment in order to determine the members social needs. The CHW will then provide the needed recommendations and referrals for the member. The CHW will also provide follow up visits via in person or by phone. CBO will work closely with the plan in the event the member needs additional support. idelis will determine list of members based on risk stratification for the most vulnerable members who will benefit from the contracted CBO.	All 5 Boroughs in NYC
			Social, Family, and Community Context	Member that is identified as lonely and/or depressed will be referred by provider to the assessment. If the Care manager feels that the member will benefit from services a match will be sought.	All 5 boroughs of NYC and Westchester and Putnam Counties
			Education, Health and Healthcare	This is a community health worker intervention to address Education and Health and Healthcare in the Managed Long Term population. Using answers to questions in the UAS and other relevant indicators, Intervention will collaborate to identify eligible members for the program and refer them to CBO for outreach and enrollment. Members who agree to the program will be visited by an CBO community health worker telephonically or in person, who will visit with the member and conduct several assessments to identify social needs and any medical concerns. The community health worker will coordinate with the Provider and MLTC care manager, sharing information obtained in the telephonic or home visit and making referrals to social services as needed. Follow up visits or telephonic follow ups will be conducted based on risk.	5 Boroughs of NYC

			Education, Health and Healthcare	This is a community health worker intervention to address Education and Health and Healthcare in the Managed Long Term population. Using answers to questions in the UAS and other relevant indicators, Intervention will collaborate to identify eligible members for the program and refer them to CBO for outreach and enrollment. Members who agree to the program will be visited by an CBO community health worker telephonically or in person, who will visit with the member and conduct several assessments to identify social needs and any medical concerns. The community health worker will coordinate with the Provider and MLTC care manager, sharing information obtained in the telephonic or home visit and making referrals to social services as needed. Follow up visits or telephonic follow ups will be conducted based on risk.	5 Boroughs of NYC
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			Food Insecurity, Education	Intervention will provide medically-tailored home-delivered meals and nutritional counseling support to Provider members. Intervention provides medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Provider members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need.	5 boroughs of NYC, Orange, Rockland, Westchester, and Nassau

			Education, Health and Healthcare	This is a community health worker intervention to address Education and Health and Healthcare in the Managed Long Term population. Using answers to questions in the UAS and other relevant indicators, Intervention will collaborate to identify eligible members for the program and refer them to CBO for outreach and enrollment. Members who agree to the program will be visited by an CBO community health worker telephonically or in person, who will visit with the member and conduct several assessments to identify social needs and any medical concerns. The community health worker will coordinate with the Provider and MLTC care manager, sharing information obtained in the telephonic or home visit and making referrals to social services as needed. Follow up visits or telephonic follow ups will be conducted based on risk.	5 Boroughs of NYC
			Education, Health and Healthcare	This is a community health worker intervention to address Education and Health and Healthcare in the Managed Long Term population. Using answers to questions in the UAS and other relevant indicators, Intervention will collaborate to identify eligible members for the program and refer them to CBO for outreach and enrollment. Members who agree to the program will be visited by an CBO community health worker telephonically or in person, who will visit with the member and conduct several assessments to identify social needs and any medical concerns. The community health worker will coordinate with the Provider and MLTC care manager, sharing information obtained in the telephonic or home visit and making referrals to social services as needed. Follow up visits or telephonic follow ups will be conducted based on risk.	5 Boroughs of NYC
			Education, Health and Healthcare	This is a community health worker intervention to address Education and Health and Healthcare in the Managed Long Term population. Using answers to questions in the UAS and other relevant indicators, intervention will collaborate to identify eligible members for the program and refer them to CBO for outreach and enrollment. Members who agree to the program will be visited by an CBO community health worker telephonically or in person, who will visit with the member and conduct several assessments to identify social needs and any medical concerns. The community health worker will coordinate with the Provider and MLTC care manager, sharing information obtained in the telephonic or home visit and making referrals to social services as needed. Follow up visits or telephonic follow ups will be conducted based on risk.	5 Boroughs of NYC
			Education, Health and Healthcare	The CBO will assess enrollees (who are socially isolated) in their home and identify community services that can help the enrollee improve his/her condition and meet his/her needs. Home visits and follow ups may consist of the following, among other things: (1) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (2) referrals to services available through NYC Department of Aging; (3) lifestyle improvement supports and engagement; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC
			Education, Health and Healthcare	The CBO will assess enrollees (who are socially isolated) in their home and identify community services that can help the enrollee improve his/her condition and meet his/her needs. Home visits and follow ups may consist of the following, among other things: (1) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (2) referrals to services available through NYC Department of Aging; (3) lifestyle improvement supports and engagement; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC

			Food Insecurity, Education	Intervention will provide medically-tailored home-delivered meals and nutritional counseling support to Provider members. Intervention provides medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Provider members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need.	5 boroughs of NYC, Westchester, and Nassau
			Food Insecurity, Education	Intervention will provide medically-tailored home-delivered meals and nutritional counseling support to Provider members. Intervention provides medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Provider members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need.	5 boroughs of NYC, Westchester, and Nassau
			Education, Health and Healthcare	The CBO will assess enrollees (who are socially isolated) in their home and identify community services that can help the enrollee improve his/her condition and meet his/her needs. Home visits and follow ups may consist of the following, among other things: (1) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (2) referrals to services available through NYC Department of Aging; (3) lifestyle improvement supports and engagement; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC
			Food Insecurity, Education	Intervention will provide medically-tailored home-delivered meals and nutritional counseling support to Provider members. Intervention provides medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Provider members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need.	5 boroughs of NYC, Westchester, and Nassau

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			Education, Health and Healthcare	The CBO will assess enrollees (who are socially isolated) in their home and identify community services that can help the enrollee improve his/her condition and meet his/her needs. Home visits and follow ups may consist of the following, among other things: (1) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (2) referrals to services available through NYC Department of Aging; (3) lifestyle improvement supports and engagement; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC
			Education, Health and Healthcare	The CBO will assess enrollees (who are socially isolated) in their home and identify community services that can help the enrollee improve his/her condition and meet his/her needs. Home visits and follow ups may consist of the following, among other things: (1) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (2) referrals to services available through NYC Department of Aging; (3) lifestyle improvement supports and engagement; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC
			Food Insecurity, Education	Intervention will provide medically-tailored home-delivered meals and nutritional counseling support to Provider members. Intervention will provide medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Provider members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need.	5 boroughs of NYC, Westchester, and Nassau
			Education, Health and Healthcare	The CBO will assess enrollees (who are socially isolated) in their home and identify community services that can help the enrollee improve his/her condition and meet his/her needs. Home visits and follow ups may consist of the following, among other things: (1) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (2) referrals to services available through NYC Department of Aging; (3) lifestyle improvement supports and engagement; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC

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			Education, Health and Healthcare	The CBO will assess enrollees (who are socially isolated) in their home and identify community services that can help the enrollee improve his/her condition and meet his/her needs. Home visits and follow ups may consist of the following, among other things: (1) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (2) referrals to services available through NYC Department of Aging; (3) lifestyle improvement supports and engagement; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC
			Economic Stability, Food Insecurity	Intervention will provide medically-tailored home-delivered meals and nutritional counseling support to Provider members. Intervention's medically-tailored meals are approved by a Registered Dietitian Nutritionist (RDN) and reflect appropriate dietary therapy based on evidence-based practice guidelines. Diet and meals are recommended by a RDN based on a session of nutrition diagnostic and therapy for disease management (medical nutrition therapy) and a referral by a health care provider to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. Provider members will be authorized for either a 14 meal per week plan (lunch and dinner seven days per week) or a 21 meal per week plan (breakfast, lunch and dinner, seven days per week), depending on assessed need.	5 Boroughs of NYC, Rockland, Orange, Nassau, and Westchester
			Education, Health and Healthcare	The CBO will assess enrollees (who are socially isolated) in their home and identify community services that can help the enrollee improve his/her condition and meet his/her needs. Home visits and follow ups may consist of the following, among other things: (1) social needs assessments to address a full range of social needs, covering housing, food insecurity, income instability, employment assistance, transportation, loneliness and social isolation; (2) referrals to services available through NYC Department of Aging; (3) lifestyle improvement supports and engagement; (4) environmental assessments (falls prevention, pests and mold remediation); (5) referrals to supportive services (housing programs, smoking cessation programs, diabetes group sessions.	5 Boroughs of NYC
			Health and Healthcare (Health Literacy)	The Plan Social Worker will review the list of enrollees prior to referral to ensure that the member is not hospitalized or otherwise unavailable for a home visit by CBO. Once the Plan Social Worker has determined that the enrollee is appropriate for referral to CBO, the Social Worker will first outreach to the identified member, describe the CBO program and introduce them to the team. If the member declines the home visit, then the referral will not proceed, and the Social Work Manager will confer with the Case Manager on how best to address the needs of the enrollee.	Brooklyn, Bronx, Manhattan, and Queens

			Health and Healthcare	Intervention will employ ambassadors and health coaches to engage with clients in the field to access their needs and then provide immediate referral to community resources and/or refer client to a Health Coach for addition support. Intervention will help clients navigate and address SDH needs such as housing, food, transportation, health insurance, and accessing primary care.	Schenectady
			Isolation and lack of family/community support	Intervention will connect members to volunteers who will focus on preventing and reducing loneliness, depression, and hospitalization.	Bronx, Manhattan Staten Island, Westchester
			Isolation and lack of family/community support	Measurement of the interventions impact will be conducted based on the following; depression, behavioral incidence, socialization and engagement, pharmacological intervention, chronic pain, and emergency department utilization	Westchester, Bronx, NYC, Kings Queens, Richmond, Nassau and Suffolk
			Housing Stability	Monitor and report utilization of supportive housing, SNF and ED participants on a monthly basis.	Monroe, Ontario, Wayne
			Isolation and lack of family/community support	Providing musical entertainment which promotes socialization and physical participation. Goal is to promote socialization, prevent depression, loneliness and isolation.	Erie