Approved SCN-VBP Interventions as of May 2020
Over 31,000 Medicaid Members Served.

Mainstream Managed Care Interventions

Plan Name	VBP Contractor (IPA, ACO, Hospitals)	Community Based Organization (CBO) Name	Social Care Needs (SCN) Intervention Domain	Project Description	County(ies) Served
WellCare (VBP Pilot)	**SOMOS Your Health IPA**	Northern Manhattan Improvement Corporation	Economic Stability-housing instability, food insecurity, and economic instability	The intervention focuses on referrals for social and health services to improve the health of the priority population. SCN intervention components include assisting patients to maximize entitlement support, incentivizing medication adherence, and mitigating the impact of housing and food insecurity through direct service delivery and referrals.	Bronx, Brooklyn Manhattan, Queens
CDPHP	**Adirondack ACO**	Comfort Food Community of Washington County (CFC)	Economic Stability	The intervention will provide individualized assistance for Medicaid members with identified food insecurity issues who reside in a targeted geographic area. Referrals for this program can originate from care management teams or providers within the network (as geographically appropriate). Program 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
Affinity Health Plan	**SOMOS Your Health IPA**	Northern Manhattan Improvement Corporation	Economic Stability (Housing instability, Food insecurity, Economic instability)	SCN 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

Affinity Health Plan	**CHIPA**	**AIRnyc**- Home visiting service provider **Association for Energy Affordability (AEA)**-Home remediation service provider	Health and HealthCare	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.	All Five NYC Boroughs
CDPHP	**Various EPC Provider**	The Food Pantries for the Capital District (TFP)	Economic Stability	Program 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. Staff 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
CDPHP	**Delta Dental**	The Food Pantries for the Capital District (TFP)	Economic Stability	Program 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. Staff will also perform follow up outreach will be conducted telephonically 2 days post-	Albany, Schenectady, Rensselaer and Saratoga
Excellus Health Plan	**Accountable Health Partners IPA, LLC**	Children's Institute, Inc.	Health and Health Care	The project focuses on providing comprehensive screening services to three year old children through referrals of at risk children. The comprehensive screenings 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 program 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
Excellus Health Plan	**Greater Rochester IPA**	The Center for Youth Services, Inc.	Health and Healthcare	The primary focus of the work will be to connect youth engaged in the transitional living and housing programs with an accessible primary care provider. Staff members will work with the youth to determine current connections to primary care. If the assessment indicates that he/she is not connected with a primary care provider, the staff member will contact the VBP contractor to facilitate coordination of care.	Monroe

Fidelis Care	**Chinese American IPA**	CAIPA Social Daycare (SDC), Inc.	Health and Healthcare	The project is to address the behavioral health needs of patients with low socioeconomic status among both adults and children by doing screening for social care needs, providing education, and assisting with referral to additional services such as food banks and housing services.	All 5 NYC Boroughs
Fidelis Care	**Greater Buffalo United Accountable Care Organization**	African Heritage Food Cooperative	Economic Stability	The proposed project will target 50 Agreement-covered beneficiaries, who are diagnosed with either (1) type 2 diabetes or (2) pre-diabetes. Participants' social determinants barriers to healthy eating and regular exercise will be addressed through the a series of integrated strategies.	Erie
Fidelis Care (VBP Pilot)	**St. Joseph's Hospital Health Center Foundation**	Near Westside Initiative	Neighborhood and Environment	The primary goal of the intervention is to increase the number of adults in the service area who have access to safe places to exercise. Partners will 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 designing wellness spaces.	Onondaga
Healthfirst	**State University Medical Center at Stonybrook**	A.I.R. NYC	Health and Health Care	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma	Suffolk
Healthfirst	**Staten Island University Hospital**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Staten Island

Healthfirst	**Long Island Jewish Medical Center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Queens
Healthfirst, PHSP	**Interfaith Medical Center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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.	Brooklyn
Healthfirst, PHSP	**Jamaica Medical Center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Queens
Healthfirst, PHSP	**Maimonides Medical Center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma.	Brooklyn
Healthfirst, PHSP	**Mount Sinai Hospital**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Manhattan Queens

Healthfirst, PHSP	**NYC-Health and Hospitals Corporation**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Queens, Bronx, Brooklyn, Harlem
Healthfirst, PHSP	**St. Luke Roosevelt Hospital center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma.	Manhattan
Healthfirst, PHSP	**Wyckoff Heights Medical Center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Brooklyn
Healthfirst, PHSP	**Beth Israel Medical Center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Manhattan, Brooklyn
Healthfirst, PHSP	**The Brooklyn Hospital Center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Brooklyn

Healthfirst, PHSP	**BronxCare Health System**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Bronx
Healthfirst, PHSP	**St. Barnabas Health System**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Bronx

Healthfirst, PHSP	**NYU Langone Hospitals**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Manhattan
Healthfirst, PHSP	**SUNY Downstate Medical Center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Brooklyn
Healthfirst, PHSP	**Montefiore Medical Center**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Bronx
Healthfirst, PHSP	**Episcopal Health Services**	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SCN intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will 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. Intervention will also include chronic-disease support, education, and referrals beyond asthma. Outreach, prep time and post-visit activities include: case review, appointment confirmation,	Queens
HIP	**City BlockIPA**	God's Love We Deliver	Economic Stability: Food Insecurity	Potential patients for Medically-Tailored Meals will be referred 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

HIP (Emblem Health)	**AdvantageCare Physicians of New York**	God's Love We Deliver	Economic Stability: Food Insecurity	Intervention will consist of referral for medically-tailored meals in addition to nutritional counseling and community-based care coordinator intervention participants.	All 5 NYC boroughs; Nassau, Suffolk, Westchester
HIP(Emblem)	**MediSys IPA**	God's Love We Deliver	Economic Stability: Food insecurity	Intervention will consist of referral for medically-tailored meals in addition to nutritional counseling and community-based care coordinator intervention participants.	All 5 NYC boroughs; Nassau, Suffolk, Westchester
HIP/Emblem	**MediSys IPA**	God's Love We Deliver	Economic Stability	Program 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
IHA	**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.	Erie and Niagara
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"), coordinated through case management program.	All Five NYC Boroughs
Molina Healthcare	**Cayuga Area Plan**	Suicide Prevention & Crisis Services (SPCS)	Stigma and Discrimination-Provider level intervention	CBO and VBP contractor will work 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

Molina Healthcare (VBP Pilot)	**St. Joseph's Hospital Health Center Foundation**	Near Westside Initiative	Neighborhood and Environment	The primary goal of the intervention is to increase the number of adults in the service area who have access to safe places to exercise. Partners will 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 designing wellness spaces.	Onondaga
MVP Health Plan, Inc.	**GRIPA**	Center for Youth Services, Inc.	Health and Health Care	Through this program, 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 program. A staff member will meet with each family that uses their services in order to assess their health insurance status and connection with primary care. If the assessment indicates that they are uninsured or under-insured, the staff member will assist in obtaining coverage. If the assessment indicates that they do not have a consistent primary care provider, the staff member will assist in facilitating an appointment.	Monroe
MVP Health Plan, Inc.	**Mohawk Valley Medical Associates-MVMA**	City Mission of Schenectady	Health and Healthcare; Social and Community Context	The primary focus of the intervention 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
MVP Health Plan, Inc.	**CBH Care IPA**	The Preservation Company	Economic Stability; Neighborhood and Environment	Intervention will focus on working with individuals and care teams around homelessness, housing instability, skills to maintain housing, lack of access to affordable housing in Hudson Valley Region. CBO services will include: developing and circulating resources to support stable housing, including tenant rights, budget management; developing county-specific resource guides for seven counties; develop process for receiving and tracking housing support services to primary care patients; provide individual housing support review and application assistance for individuals in need of housing.	Westchester, Rockland, Orange, Ulster, Sullivan, Dutchess, Putnam
MVP Health Plan, Inc.	**Middletown Medical**	United Way of Westchester and Putnam, Inc.	Education; Social and Community Context; Health and Health Care; Neighborhood and Environment; and Economic Stability	The primary focus of the intervention will be to facilitate direct access to the appropriate community-based organization(s) that can provide direct services to help meet members' various SCN needs. A helpline will be available for members, and staff will be able to link program members with appropriate community organizations, agencies or services that can help meet their identified SCN needs. Finally, helpline staff will follow up directly with program members to determine the service engagement outcomes.	Orange, Sullivan, Ulster

MVP Health Plan, Inc.	**Montefiore ACO IPA**	United Way of Westchester and Putnam, Inc.	Education; Social and Community Context; Health and Health Care; Neighborhood and Environment; and Economic Stability	The primary focus of the intervention will be to facilitate direct access to the appropriate community-based organization(s) that can provide direct services to help meet members' various SCN needs. A helpline will be available for members, and staff will be able to link program members with appropriate community organizations, agencies or services that can help meet their identified SCN needs. Finally, 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-housing instability, food insecurity, and economic instability	SCN 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
			Education; Social and Community Context; Health and Health Care; Neighborhood and Environment; and Economic Stability	The primary focus of the intervention will be to facilitate direct access to the appropriate community-based organization(s) that can provide direct services to help meet members' various SCN needs. A helpline will be available for members, and staff will be able to link program members with appropriate community organizations, agencies or services that can help meet their identified SCN needs. Finally, helpline staff will follow up directly with program members to determine the service engagement outcomes.	Dutchess, Orange, Rockland, Sullivan, Ulster, Westchester, and Putnam
			Health and Health Care	Comprehensive screenings and referrals will be completed for 3 year old children in the service area. 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
			Economic Stability (Housing instability, Food insecurity, Economic instability)	SCN 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 Security & Stability	SCN intervention will focus on identifying plan enrollees who are impacted by homelessness. Lead organization will reach out to 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.	Erie, Genesee Niagara, Orleans, Wyoming
			Economic Stability (Housing instability, Food insecurity, Economic instability)	SCN 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, Economic instability)	SCN 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

			Health and Health Care	Intervention will provide patients with ability to participate in free course on diabetes self-management. The course was developed by the Stanford Patient Education Research Center and is 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 Healthcare; Economic Stability	Intervention will focus on providing psychoeducation for individuals and families dealing with substance use disorder. The following are included interventions: psychoeducational counseling to individuals who have been discharged from the hospital as a result of substance; family education and support counseling services; calls from family members, identified clients and community members in need of immediate intervention/assistance as a result of addiction; relapse prevention counseling in order to help individuals maintain recovery and reduce risk of relapse; 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; follow-up and re-engagement services.	Nassau
			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
			Health and Health Care	Intervention will provide patients with ability to participate in free course on diabetes self-management. The course was developed by the Stanford Patient Education Research Center and is 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: Food Insecurity	Intervention will consist of referral for medically-tailored meals in addition to nutritional counseling and community-based care coordinator intervention participants.	All 5 NYC boroughs; Nassau, Suffolk, Westchester
			Economic Stability: Food Insecurity	Intervention will consist of referral for medically-tailored meals in addition to nutritional counseling and community-based care coordinator intervention participants.	All 5 NYC boroughs; Nassau, Suffolk, Westchester

			Economic Stability: Food Insecurity	Intervention will consist of referral for medically-tailored meals in addition to nutritional counseling and community-based care coordinator intervention participants.	All 5 NYC boroughs; Nassau, Suffolk, Westchester
			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.	Erie; Niagara
			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 at Urban Family Practice, 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	The organization will identify their high cost, high need members who also have conditions that could be impacted with an SCN intervention. Once identified, staff will perform an initial outreach to the member, conduct a SCN screening, identify potential services and gauge member's willingness to access services. Facilitation of appointment scheduling will be completed for members.	Bronx, Brooklyn Manhattan, Queens
			Economic Stability	The organization will identify their high cost, high need members who also have conditions that could be impacted with an SCN intervention. Once identified, staff will perform an initial outreach to the member, conduct a SCN screening, identify potential services and gauge member's willingness to access services. Facilitation of appointment scheduling will be completed for members.	Bronx, Brooklyn Manhattan, Queens
			Economic Stability	The organization will identify their high cost, high need members who also have conditions that could be impacted with an SCN intervention. Once identified, staff will perform an initial outreach to the member, conduct a SCN screening, identify potential services and gauge member's willingness to access services. Facilitation of appointment scheduling will be completed for members.	Bronx, Brooklyn Manhattan, Queens
			Economic Stability: Food Insecurity	Home delivery of medically tailored meals (“MTM”) approved by a registered dietitian and nutritionist (“RDN”), coordinated through case management program.	All 5 NYC Boroughs, Nassau, Westchester

			Economic Stability: Food Insecurity	Home delivery of medically tailored meals (“MTM”) approved by a registered dietitian and nutritionist (“RDN”), coordinated through case management program.	All 5 NYC Boroughs, Nassau, Westchester
			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.	Erie, Niagara
			Economic Stability: Food Insecurity	Provision of medically tailored home delivery meals and nutritional counseling.	All 5 NYC Boroughs, Nassau, Westchester
			Health and Healthcare; Neighborhood and Environment; Economic Stability	Participating Medicaid members with persistent asthma that is not well controlled 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 program 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
			Economic Stability	The service delivery goals of the SCN 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.	Bronx, Brooklyn, Manhattan, Queens
			Economic Stability- housing instability, food insecurity, and economic instability	SCN 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, Staten Island, Manhattan, Queens.

			Economic Stability	Program 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
			Economic Stability	Program 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
			Health and Healthcare; Neighborhood and Environment; Economic Stability	Participating Medicaid members with persistent asthma that is not well controlled 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 program 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
			Economic Stability	The health partners will be implementing a comprehensive and cost effective program that will focus on housing instability and food insecurity. Organization will identify their high cost, high need members who also have conditions that could be impacted with an SCN intervention. Once identified, case management staff will perform an initial outreach to the member, conduct a SCN screening, identify applicable services, and gauge member's willingness to access services. Case managers will help facilitate appointment scheduling for services needed.	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. Organization will identify their high cost, high need members who also have conditions that could be impacted with an SCN intervention. Once identified, case management staff will perform an initial outreach to the member, conduct a SCN screening, identify applicable services, and gauge member's willingness to access services. Case managers will help facilitate appointment scheduling for services needed.	Bronx, Brooklyn, Manhattan, Queens
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			Economic Stability	Program 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	Program 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	Program 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	The intervention consists of home-delivered 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
			Economic Stability	The intervention consists of home-delivered 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
			All 5 SCN Domains	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 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 improving their quality of health while reducing ED visits and hospital admissions and re-admissions.	Jefferson, Lewis, St. Lawrence
			Economic Stability- Food Insecurities	This intervention focuses on supporting better population health outcomes through patient engagement activities, educational programs, and by providing affordable health food options for patients the would benefit from nutritional counseling. Project scope includes patient navigation services around engagement and food pantry access.	Bronx
PACE Program Interventions					

Plan Name	VBP Contractor (IPA, ACO, Hospitals)	CBO Name	SCN Intervention Domain	Project Description	County(ies) Served
Complete Senior Care-PACE	N/A	The Senior Companion Program /Volunteer Center at HANCI	Isolation and lack of family/community support	Reduce isolation, provide socialization and social supports for those lacking family/community involvement.	Niagara County
Catholic Health LIFE	N/A	Community Music School of Buffalo	Social and Community Context	Provide music therapy to PACE members with cognitive impairment that may benefit from intervention through reduction of behavior and improve quality of life.	Erie County
Eddy Senior Care	N/A	City Mission	Health and Healthcare: Access to Healthcare	The program 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 SCN needs such as housing, food, transportation, health insurance, and accessing primary care.	Schenectady County
Fallon Health	N/A	Sax Man Slim	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 County
Independent Living for Seniors. D.B.A., ElderOne	N/A	Sisters of Saint Joseph of Rochester, Inc.	Housing Stability	The program will offer and provide supportive housing and services at the CBO site for participants and monitor and report utilization of services.	Monroe, Ontario, Wayne Counties
PACE- CNY	N/A	PAWS of CNY	Social Isolation	This program will provide pet therapy, an animal-assisted support system, to participants who are struggling with depression and loneliness. The animal-assisted activities are casual “meet and greet” activities where volunteers and pets visit with the participants to provide therapies.	Onondaga County
			Isolation and lack of family/community support	Participants will be referred to the program and staff will be advised to generate referrals based on individual need. Once participants’ were matched with a volunteer, they received either a telephone call, home visit or visit at a PACE center. The volunteers collaborated with the participants and staff to determine the frequency of visits for companionship.	Bronx, Manhattan Staten Island, Westchester(TBD)
			Social isolation and lack of family/community support	Target PACE members at PACE centers and potentially enrollees homes. Providing music therapy has evidence based benefits improving motor function and cognition in older adults. Music therapy can also reduce stress and anxiety while promoting positive social interactions.	Westchester, Bronx, NYC, Kings Queens, Richmond, Nassau and Suffolk Counties
			Health education.	Increased access to chronic disease health education for frail elderly plan participants.	Allegany, Cattaraugus,and Chautauqua Counties
MLTC Interventions					

Plan Name	VBP Contractor (IPA, ACO, Hospitals)	CBO Name	SCN Intervention Domain	Project Description	County(ies) Served
			Health and Healthcare	This CBO offers a geriatric workforce program that 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.	Bronx
			Health and Healthcare; Education	This program consists of a diabetes education intervention for participants. The sessions of the class build on one another to educate, empower, and help patients set goals for themselves. In addition, since the sessions will also be available to home health care aides and family caretakers and members, they start to provide in-built socialization and “mini support groups” for the patient.	Bronx
			Health and Healthcare; Neighborhood and Environment	Program social workers will provide members with information about the program and introduce member to staff members. The clinical team will assess member, and once that member has been identified, the contracted CBO will then perform a home assessment and will provide expert recommendations regarding the member.	Brooklyn, Bronx, Manhattan, and Queens
			Economic Stability; Food Insecurity and Housing Instability	This program will assist members in maximizing entitlement support and mitigating the impact of housing and food insecurity through direct service delivery and referrals. The organization will identify high cost and high need members, and once identified, these members will be contacted by case management staff to engage in services. Case managers will provide initial outreach to members and conduct an SCN screening, identify applicable services, and gauge willingness to access services.	Bronx, Brooklyn, Manhattan, and Queens
			Education	The intervention will consist of health literacy education programs target at nutrition, disease management, mental health well-being, and medication adherence.	Brooklyn and Manhattan
			Health and Healthcare	The intervention will begin with staff identifying members with high risk and high needs to address poor health outcomes. The plan will collect and integrate SDOH information into individual's care plan, which will then be shared with staff, member, and primary care provider.	Rockland, Orange, Dutchess Counties
			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.	All 5 boroughs of NYC, Nassau, and Suffolk
			Social/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 multiple 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
			Health & Healthcare	Participants will be enrolled in 1 or 2 evidence based interventions. The two targeted interventions include Chronic Disease Self-Management Program and Healthy Ideas.	Erie County
			Health & Healthcare	This intervention provides a targeted approach to health literacy specific to palliative care and advance directives. Through the intervention, individuals will be empowered to make informed choices about their care and end of life decisions.	Cayuga, Oneida, Onondaga, and Oswego

			Social, Family, Community Context	This program will focus on senior companion and transportation services. Connecting members that are experiencing isolation and making them feel as they are a part of the community again will help improve their health outcomes.	Buffalo. Eastern Erie and Niagara Counties
			Neighborhood and Enviornment, Health&Healthcare, Education	This intervention will consist of Community Health Workers providing outreach, enrollment and home visits for individuals suffering from asthma that is not well controlled.	Bronx
			Economic Stability	The proposed intervention will address the social service needs of members that can be connected with the CBO to access services. These connections will assist the member in addressing their social service needs for entitlement.	Bronx, Brooklyn, Manhattan, and Queens
			Social, Family, and Community Context	The proposed intervention is targeted at members to address social isolation and depression. The program 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
			Social and Community Context	The proposed intervention will use community health workers 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
			Food Insecurity	This intervention 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
			Health & Healthcare	Services of this intervention 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, and Westchester
			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

			Health & 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	The organization will provide 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.	All 5 Boroughs in NYC
			Education	The intervention provides education to senior citizens on the following topics: physical health/exercise, IT assistance, and nutrition education.	Brooklyn
			Social, Family, and Community Context	Members that are identified as lonely and/or depressed will be referred by their provider to the program for 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
			Social, Family, Community Context	The proposed intervention features a 24/7 hotline that the CBO will provide. The plan will provide the CBO with the resources to dedicate a staff person at the CBO’s location where members identified with a potential need for elder abuse education or mental health services can go to be assessed and receive referrals for behavioral health counseling services, as needed. The goal is to reduce emergency department utilization through the education of other available resources.	Orange and Dutchess Counties
			Social/Community Context, Health and Healthcare	A community health worker will address isolation and lack of family / community support for members who are eligible based on screening. The CHW will conduct assessments to identify SCN concerns that affects members physical, mental, psychological and spiritual health. The CHW will coordinate with the MLTC care manager and/or risk provider sharing the information obtained from home visits and refer the member to the appropriate services.	Manhattan, Brooklyn, Queens, Bronx, Nassau, & Suffolk
			Social/Community Context, Health and Healthcare	Program staff will complete non-clinical social assessments to determine if members need to be connected to services in their community for improve housing, food, social, and safety concerns.	Bronx, Kings, Queens, NY and Richmond Areas
			Social/Community Context, Health and Healthcare	Eligible members will be referred to the program, where community health workers 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

Level 2	Tier 1	Approved
Level 3	Tier 2	Missing Info
Level 1	Tier 3	Denied