Background: Effective January 1 2018, all new and existing Value Based Payment (VBP) Level 2 and 3 arrangements must include at least one social determinants of health (SDH) intervention and at least one contract with a Tier 1 Community Based Organization (CBO). This requirement applies to Managed Care Organizations (MCO), Managed Long Term Care (MLTC), and PACE plans with a Level 2 or 3 VBP arrangement. Health plans and VBP contractors have the flexibility to decide on the type of intervention that they implement. The guideline recommend the SDH selection be based on information including but not limited to, SDH screenings of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources. For more information please visit: www.health.ny.gov/mrt/sdh.

New York State Approved Value Based Payment Interventions	
Mainstream Managed Care	**County(ies) Served**
Economic Stability: SDH intervention focuses 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. CBO services will include but not limited to: conducting eligibility assessment for public assistance and social services; provide legal service to patients facing eviction proceedings; create an incentive model for medication adherence; provide case management support for patients in unstable housing, provide nutritional services (coordinate meal delivery).	Bronx, Brooklyn, Manhattan, and Queens
Education; Social and Community Context; Health and Health Care; Neighborhood and Environment; and Economic Stability: The primary focus of intervention will be to screen members for Social Determinants of Health and then facilitate direct access to the appropriate community-based organization(s) that can provide direct services to help meet program members' various SDH needs.	Dutchess, Orange, Rockland, Sullivan, Ulster, Westchester, and Putnam
Health and Health Care: Intervention will focus providing comprehensive screenings and referral services to three-year-old children of Health Plan members. Screenings will include but not limited to: vision, hearing, speech language, dental health, developmental, social-emotional, height/weight. Screenings will identify children at potential risk for compromised developmental and educational outcomes and refer to appropriate services in the community.	Monroe
Health and Health Care: Through this arrangement, dedicated agency staff will act as navigators to facilitate access to insurance and primary 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 at the center. The dedicated staff member will meet with each family to assess their health insurance status and connection with primary care. If the assessment indicates that a client is uninsured or under-insured, the staff member will assist in contacting health plan to help get coverage. If the assessment indicates that the client do not have a consistent primary care provider, the staff member will help facilitate an appointment.	Monroe
Health and Health Care; Social and Community Context: Intervention will focus on street-level outreach to the most at- risk; highest-utilizing population; under-served individuals and families in the community and connecting them to healthcare- related resources in conjunction with social services; provide care coordination for patients in collaboration with health partners and providers.	Schenectady

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. 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, and Putnam
Economic Stability: Intervention will focus on performing outreach to these members who have not had any visits with PCP or identified by health plan for the purposes of engaging in health coaching; perform an assessing needs of engaged members to determine those barriers that contributed to preventing a member from attending a PCP visit; provide recommendations to health 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
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Neighborhood and Environment: This Multigenerational Community Wellness Initiative will increase the number of adults who have access to safe places to exercise in targeted neighborhoods. The intervention partners 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 or designing a wellness space.	Onondaga
Economic Stability: SDH intervention focuses 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. CBO services will include but not limited to: conducting eligibility assessment for public assistance and social services; provide legal service to patients facing eviction proceedings; create an incentive model for medication adherence; provide case management support for patients in unstable housing, provide nutritional services (coordinate meal delivery).	Bronx, Brooklyn, Manhattan, and Queens
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Health and Health Care: The partnership will focus on outreach efforts to provider groups within the health system to include education and awareness surrounding strategies and tools available through Zero Suicide, a commitment to suicide prevention in health and behavioral health care systems. The CBO will 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: SDH intervention will focus on identifying plan enrollees who are impacted by homelessness. As the lead on the project, the VBP contractor will outreach homeless enrollees to 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 VBP contractor will pursue direct case management. Partnership with CBO will enhance targeting of homeless plan members in the region.	Erie, Genesee Niagara, Orleans, and Wyoming
Economic Stability: Home Delivery of Medically Tailored Meals ("MTM"), approved by a Registered Dietitian and Nutritionist ("RDN") and coordinated with Case Management Department.	All Five NYC Counties
Economic Stability: 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 targeted patients with ability to participate in free course on diabetes self- management. The contracted CBO 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 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.	Bronx
Economic Stability: SDH intervention focuses 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. CBO services will include but not limited to: conducting eligibility assessment for public assistance and social services; provide legal service to patients facing eviction proceedings; create an incentive model for medication adherence; provide case management support for patients in unstable housing, provide nutritional services (coordinate meal delivery).	Bronx, Brooklyn, Manhattan, and Queens
Health and Health Care; Economic Stability: Intervention will focus on providing psychoeducation for individuals and families dealing with substance use disorder. Intervention will include but not limited to: Family education and support counseling services for family members of individuals recently in the hospital system as a direct result of substance use; Crisis Calls- calls from family members, 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- 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- 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- conduct follow-up services and ongoing support and counseling for individuals upon discharge to ensure they receive appropriate care for substance use treatment.	Nassau
Health and Health Care; Neighborhood and Environment; Education: SDH intervention will focus on improving engagement and asthma self-management for pediatric and adult asthma patients. The CBO will provide a baseline and follow up visits. Baseline visits will be 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. The intervention will utilize patient-centered approach, including chronic-disease support, education, and referrals beyond asthma. CBO staff will also provide case notes review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	All Five NYC Counties and Suffolk

Economic Stability: 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 and Queens
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Health and Health Care: Intervention will provide patients with ability to participate in free course on diabetes self- management. Contracted CBO will provide diabetic patients the opportunity to participate in an evidence-based course on diabetes self-management conducted by peer leaders. The course 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.	Bronx
Economic Stability: Health care partners 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 Five NYC Counties, Nassau, Suffolk, and Westchester
Health and Health Care: The intervention targets high-risk pregnant moms, no-shows, and patients who have not been engaged in care. Clinic providers and staff establish priorities for outreach to high-need patients. Community Health Workers will outreach via phone, visits to patient's homes and communities to reengage patients in care; Conduct peer-to-peer education to help bring patients back into the fold of receiving important medical care. They help provide connections to other community resources that are needed, for example setting up transportation or support through other programs.	Erie, Niagara
Economic Stability: SDH intervention focuses 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. CBO services will include but not limited to: conducting eligibility assessment for public assistance and social services; provide legal service to patients facing eviction proceedings; create an incentive model for medication adherence; provide case management support for patients in unstable housing, provide nutritional services (coordinate meal delivery).	Bronx, Brooklyn, Manhattan, and Queens
Economic Stability: Provide individualized assistance to health plan members with identified food insecurity issues. CBO 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. CBO will also perform follow up outreach telephonically post-referral. Any ongoing food access issues will be addressed at those touch points	Washington, Warren, Saratoga
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Health and Health Care: A comprehensive asthma intervention that addresses environmental needs in the home for enrolled plan members 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. Contracted CBO will provide the in-home asthma self-management education, including review of proper medication usage; case management and coordination with healthcare partners; basic supplies such as mattress and pillow covers; home assessment and remediation of environmental asthma triggers in the home, and referrals to other community services.	All Five NYC Counties
Health and Health Care: Project will target Diabetic and Pre- Diabetic plan members will address participants' social determinants barriers to healthy eating and regular exercise. Intervention will include vouchers to purchase locally grown fruits and vegetables; one-on-one and /or group coaching on health meal preparation; transportation to wellness (and fitness) class; benefit coordination to enroll in SNALP and MOW if eligible.	Erie
Programs of All-Inclusive Care for the Elderly (PACE)	
Social and Community Context: Intervention will focus on using volunteers to provide companionship. The goal is to reduce isolation, provide socialization and social supports for those lacking family/community involvement.	Niagara
Health and Health Care: Contracted CBO 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
Social and Community Context: Intervention will connect members to volunteers who will focus on preventing and reducing loneliness, depression, and hospitalization.	Bronx, Manhattan, Staten Island, Westchester (TBD)
Social and Community Context: Intervention will focus on providing opportunity for seniors who suffer from depression and loneliness to participate in social activities through pet therapy, aquatic exercise, attending social functions. The program will provide social transportation for seniors to attend social functions.	Onondaga
Social and Community Context: Provide music therapy to seniors who suffer from cognitive impairment that may benefit from intervention through reduction of behavior and improve quality of life.	Erie
Social and Community Context: Intervention will target PACE members that suffer from Dementia and Alzheimer's disease. Providing music therapy to improve motor functions and cognition in older adults while also reducing stress and anxiety.	Westchester, Bronx, Manhattan, Kings, Queens, Richmond, Nassau, and Suffolk
Economic Stability: Intervention will focus on providing supportive housing at CBO site for members who are at risk of requiring skilled nursing facility stay for social reasons.	Monroe, Ontario, and Wayne
Health and Health Care: Intervention will disease specific health education to identified at-risk participants. Targeted participants will be able to better understand disease process and how to mitigate negative outcomes. The main goal is to increased access to chronic disease health education for frail elderly plan participants.	Chautauqua
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Social and Community Context: Intervention will connect members to volunteers who will focus on preventing and reducing loneliness, depression, and hospitalization through music intervention.	Erie
Managed Long Term Care	
Health and Health Care: Intervention provides educational sessions pertaining to chronic diseases and other age-related health disorders.	Bronx
Health and Health Care: Peer lead educational sessions focusing on teaching self management techniques for members with diabetes. Education sessions are conducted in multiple languages to accommodate health plan's diverse membership.	Bronx
Health and Health Care; Social and Community Context: Intervention identifies and engages high-cost, high-need members. Members are then screened for social determinants of health and then provided needed social services.	Bronx, Brooklyn, Manhattan, and Queens
Economic Stability: Intervention educates on financial literacy including the following topics: money management, benefits/entitlements for seniors, home equity, and scams and security.	Bronx, Brooklyn, Manhattan, and Queens
Health and Health Care: 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
Economic Stability; Neighborhood and Environment: Uses Universal Assessment System- NY to identify and target plan enrollees who are identified as "currently homeless" or "being at risk for homelessness". Identified enrollees will be referred to contracted CBO to conduct a thoroughly assessment of housing status, make referrals to appropriate support services, and report back to the health plan and provider.	Brooklyn, Bronx, Manhattan, and Queens
Economic Stability, Health and Health Care: Using a standard screening tool, plan members identified as high risk will be screened for the following needs and referred to appropriate social support services in wellness programs (smoking cessation, fitness and weigh lost programs), housing resources, substance abuse and mental health services. The four SDoH domains that will be specific to this project include: 1. Housing Instability [utilities, landlord payments,] 2. Disability , Disabling Conditions , Ability to Remain Safely in the Community [overall health management, community safety, healthcare access]3. Family / External Supports [language, literacy, cultural] 4. Compliance Health, Wellness, Self-Reliance	Rockland, Orange, and Dutchess
Economic Stability: Contracted CBO will provided educational seminars to enrolled plan members on the following topic relating to Financial Literacy: Money Management; Benefits/Entitlements for Seniors; Home Equity; Scams and Security.	All 5 NYC Boroughs, Nassau, Suffolk
Health and Health Care: Intervention will focus on providing education on end-of-life and advance care planning. Contracted CBO will target plan members with 3+ chronic conditions and have had 3+ ER visits or hospitalization in the last 6months and no documented advance directives.	Cayuga, Oneida, Onondaga, Oswego
Social and Community Context: SDH project seeks to address depression and isolation among seniors living in rural areas. CBO will engage seniors in a companionship program which offers opportunity for socialization and provide free transportation to social events.	Erie and Niagara

Health and Health Care; Neighborhood and Environment; Education: SDH intervention will focus on improving engagement and asthma self-management for pediatric and adult asthma patients. The CBO will provide a baseline and follow up visits. Baseline visits will be 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. The intervention will utilize patient-centered approach, including chronic-disease support, education, and referrals beyond asthma. CBO staff will also provide case notes review, appointment confirmation, scheduling, care coordination with providers, schools and other organizations, referral assessment and connection, as well as health care planning.	Bronx