

Managed Care Organization	VBP Contractor	Community Based Organization	SDH Domain(s)	Intervention Description	County(ies) Served
Mainstream Managed Care					
Affinity Health Plan	SOMOS Your Health IPA	Northern Manhattan Improvement Corporation	Economic Stability (Housing instability, Food insecurity, Economic instability)	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
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	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. Program staff will assist members in locating food pantry or free community meal resources that meet the member's individual needs from an accessibility, timing and nutritional perspective, whenever possible.	Washington, Warren, Saratoga
CDPHP	Delta Dental	The Food Pantries for the Capital District (TFP)	Economic Stability	The intervention will provide individualized assistance for Medicaid members with identified food insecurity issues. Program staff will assist members in locating food pantry or free community meal resources that meet the member's individual needs from an accessibility, timing and nutritional perspective, whenever possible.	Albany, Schenectady, Rensselaer and Saratoga
CDPHP	Various EPC Provider	The Food Pantries for the Capital District (TFP)	Economic Stability	The intervention will provide individualized assistance for Medicaid members with identified food insecurity issues. Program staff will assist members in locating food pantry or free community meal resources that meet the member's individual needs from an accessibility, timing and nutritional perspective, whenever possible.	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. Screening at the age of three provides the opportunity to identify challenges and successes and intervene accordingly. 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	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 addresses the behavioral health needs of patients with low socioeconomic status among both adults and children by screening for SDH needs, providing education, and assisting with referral to additional services, such as food banks and housing services.	All 5 NYC Boroughs
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.	Erie, Niagara
Fidelis Care	Greater Buffalo United Accountable Care Organization	African Heritage Food Cooperative	Economic Stability	The proposed project will target individuals who are diagnosed with either type 2 diabetes or pre-diabetes. Participants' 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, pilot programming, and designing wellness spaces.	Onondaga
Healthfirst	State University Medical Center at Stonybrook	A.I.R. NYC	Health and Health Care	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Suffolk

Healthfirst	Staten Island University Hospital	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Staten Island
Healthfirst	Long Island Jewish Medical Center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Queens
Healthfirst, PHSP	Interfaith Medical Center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Brooklyn

Healthfirst, PHSP	Jamaica Medical Center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Queens
Healthfirst, PHSP	Maimonides Medical Center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Brooklyn
Healthfirst, PHSP	Mount Sinai Hospital	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Manhattan, Queens

Healthfirst, PHSP	NYC-Health and Hospitals Corporation	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Queens, Bronx, Brooklyn, Harlem
Healthfirst, PHSP	St. Luke Roosevelt Hospital center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Manhattan
Healthfirst, PHSP	Wyckoff Heights Medical Center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Brooklyn

Healthfirst, PHSP	Beth Israel Medical Center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Manhattan, Brooklyn
Healthfirst, PHSP	The Brooklyn Hospital Center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Brooklyn
Healthfirst, PHSP	BronxCare Health System	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Bronx

Healthfirst, PHSP	St. Barnabas Health System	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Bronx
Healthfirst, PHSP	NYU Langone Hospitals	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Manhattan
Healthfirst, PHSP	SUNY Downstate Medical Center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Brooklyn

Healthfirst, PHSP	Montefiore Medical Center	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Bronx
Healthfirst, PHSP	Episcopal Health Services	A.I.R. NYC	Health and HealthCare; Neighborhood and Environment; Education	SDH intervention will focus on improving engagement and asthma self-management for pediatric asthma patients. Community Health Workers (CHWs) will provide baseline and follow-up visits. The baseline is provided to everyone, whereas, the follow up visits are tailored to each family. 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. Care coordination, appointment scheduling and confirmation, and health care planning are also activities of the program.	Queens
HealthNow	Amerigroup IPA	Homeless Alliance of WNY	Economic Stability- Housing Security & Stability	SDH 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
HealthPlus	SOMOS IPA	Northern Manhattan Improvement Corporation	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.	Bronx, Brooklyn, Manhattan, Queens
HIP	City Block IPA	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 coordination for 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 coordination for intervention participants.	All 5 NYC boroughs; Nassau, Suffolk, Westchester
HIP/Emblem	Heritage NY 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
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
HIP/Emblem	Bronx United 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, Suffolk, Nassau
HIP/Emblem	Corinthian 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, Suffolk, Nassau

HIP/Emblem	The Montefiore 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, Suffolk, Nassau
IHA	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.	Erie; Niagara
IHA	Various Providers	Independent Health Foundation	Health and Health Care	Good for the Neighborhood brings healthy living training and tools to assist people in managing and improving their own health. The goals 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, and healthy activities for kids.	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 a 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 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 programs, 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. If the assessment indicates that they are uninsured or under-insured or do not have a primary care provider, the staff member will assist in obtaining insurance coverage and a relationship with a provider.	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: <ul style="list-style-type: none"> • 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, and lack of access to affordable housing. Services will include: developing and circulating resources to support stable housing (including tenant rights and budget management); developing county-specific resource guides for seven counties; developing a process for receiving and tracking housing support services to primary care patients; and providing 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 SDH 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 SDH needs.	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 SDH 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 SDH needs.	Dutchess, Orange, Rockland, Sullivan, Ulster, Westchester, and Putnam
United Healthcare	CAIPA Care	God's Love We Deliver	Economic Stability: Food Insecurity	Provision of medically tailored home delivery meals and nutritional counseling.	All 5 NYC Boroughs, Nassau, Westchester
United Healthcare	Community Health IPA	God's Love We Deliver	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
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. SDH 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
WellCare of New York	Eastern Chinese American Physician IPA	Northern Manhattan Improvement Corporation	Economic Stability	The organization will identify their high cost, high need members who also have conditions that could be impacted with an SDH intervention. Once identified, staff will perform an initial outreach to the member, conduct a SDH 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
WellCare of New York	Hudson Heights IPA	Northern Manhattan Improvement Corporation	Economic Stability	The organization will identify their high cost, high need members who also have conditions that could be impacted with an SDH intervention. Once identified, staff will perform an initial outreach to the member, conduct a SDH 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

WellCare of New York	Bronx United IPA	Northern Manhattan Improvement Corporation	Economic Stability	The organization will identify their high cost, high need members who also have conditions that could be impacted with an SDH intervention. Once identified, staff will perform an initial outreach to the member, conduct a SDH 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
WellCare of New York	Central Queens IPA	Northern Manhattan Improvement Corporation	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 SDH intervention. Once identified, case management staff will perform an initial outreach to the member, conduct an SDH 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
WellCare of New York	South Asian IPA	Northern Manhattan Improvement Corporation	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 SDH intervention. Once identified, case management staff will perform an initial outreach to the member, conduct an SDH 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
Managed Long Term Care Interventions					
Aetna Better Health Of NY	N/A	AIRNYC	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 SDH 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
AgeWell New York	N/A	Jewish Association Services for Aging	Education	The intervention will consist of health literacy education programs targed at nutrition, disease management, mental health well-being, and medication adherence.	Brooklyn and Manhattan

Catholic Managed Long Term Care, INC. D/B/A/ ArchCare Community Life	N/A	ArchCare Community Services, INC. (Timebank)	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
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.	All 5 boroughs of NYC, Nassau, and Suffolk
Elderplan/Homefirst	N/A	Regional Aid for Interim Needs, INC. (RAIN)	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
ElderServe Health, INC. /DBA RiverSpring Health Plans	N/A	VISIONS	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, and use of optical aids prescribed by an optometrist to enable use of remaining vision.	Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester
Elderwood Health Plan	N/A	Western NY Integrated Care Collaborative	Health & Healthcare	Participants will be enrolled in 1 or 2 evidence based interventions. The two targeted interventions include the Chronic Disease Self-Management Program and the Healthy Ideas Program.	Erie County
EverCare Choice	N/A	Maternal Infant Service Network	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
Fidelis Care	Five Star	Council Center For Senior Citizens	Education	The intervention provides education to senior citizens on the following topics: physical health/exercise, IT assistance, and nutrition education.	Brooklyn
iCircle Services of the Finger Lakes	N/A	Western NY Integrated Care Collaboration	Social, Family, and Community Context	The proposed intervention will address social isolation and depression. The program will: educate older adults and caregivers about depression, link older adults to primary care and mental health providers, and empower older adults to manage their depressive symptoms through a behavioral activation approach.	Orleans, Genessee, Wyoming Counties

Integra MLTC, INC.	N/A	Brooklyn Center for Independence for the Disabled	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 intervention will also include a peer support component.	All 5 NYC Boroughs, Westchester, Nassau, Suffolk
Kalos Health, INC.	N/A	Food Gnomes, LLC	Economic Stability	Kalos Health will partner with Food Gnomes, a mobile food pantry, to help bridge the economic and nutritional gaps that some of its member's face.	Buffalo. Eastern Erie and Niagara Counties
Kalos Health, INC.	N/A	Hearts and Hands Faith in Action, INC.	Social, Family, Community Context	This program will focus on senior companion and transportation services. Connecting members that are experiencing isolation and helping them become involved in their communities.	Buffalo. Eastern Erie and Niagara Counties
VillageCareMAX/ Premier	N/A	AIR NYC	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 members, and the contracted CBO will perform a home assessment and provide expert recommendations regarding the member.	Brooklyn, Bronx, Manhattan, and Queens
VNA Home Care Options, LLC DBA: Nascentia Health Options, LLC	N/A	Companion Home Services, INC.	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
VNS Choice (MLTC, MAP, FIDA)	N/A	Visiting Nurse Service of NY Home Care II DBA (VNSNY)	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

WellCare of NY	Americare, Inc. and The Royal Care	Northern Manhattan Improvement Corporation	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 SDH screening, identify applicable services, and gauge willingness to access services.	Bronx, Brooklyn, Manhattan, and Queens
Programs of All-Inclusive Care for the Elderly Interventions					
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
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
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 SDH 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

*The following interventions are implemented by providers who elected not to share their organizations' names.

SDH Domain(s)	Intervention Description	County(ies) Served
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 (Housing instability, Food insecurity, Economic instability)	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
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Health and Healthcare; Economic Stability	Intervention will focus on providing psychoeducation for individuals and families dealing with substance use disorder.	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
Economic Stability-housing instability, food insecurity, and economic instability	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, Staten Island, Manhattan, Queens.
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.	All 5 NYC Boroughs
Economic Stability (Housing instability, Food insecurity, Economic instability)	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

Health and Health Care	Intervention will provide patients with ability to participate in free course on diabetes self-management. 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: 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	Intervention will provide patients with ability to participate in free course on diabetes self-management. 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: Food Insecurity	Intervention will consist of referral for medically-tailored meals in addition to nutritional counseling and community-based care coordination for 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 coordination for intervention participants.	All 5 NYC boroughs; Nassau, Suffolk, Westchester
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, Suffolk, Nassau
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, and economic instability	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.	Bronx, Brooklyn Manhattan, Queens
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 SDH Domains	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 Insecurity	This intervention focuses on supporting better population health outcomes through patient engagement activities, educational programs, and by providing affordable health food options for patients that would benefit from nutritional counseling. Project scope includes patient navigation services around engagement and food pantry access.	Bronx
Economic Stability	This 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; 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
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 to improve housing, food, social, and safety concerns.	Bronx, Kings, Queens, NY and Richmond Areas
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.	Erie and Niagara
Health & Healthcare	The proposed intervention will promote self-care management by providing support in the initial 30 days post hospitalization for clients who are identified as 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.	All 5 Boroughs in NYC
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.	All 5 Boroughs in NYC
Neighborhood and Environment, 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
Social/Community Context, Health and Healthcare	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 to make referrals to social services as needed.	Bronx Kings Manhattan Queens and Richmond

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, the sessions will also be available to home health care aides and family caretakers to help reinforce program components.	Bronx
Social, Family, Community Context	The proposed intervention features a 24/7 hotline to assist individuals identified with a potential need for elder abuse education or mental health services. Individuals can 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
Food Insecurity	This intervention will provide nutrition education in conjunction with home delivered medically tailored meals for individuals living with specific disease diagnoses, such as congestive heart failure or diabetes. A registered dietitian nutritionist will complete sessions with identified members.	Bronx, Kings, Nassau, NY, Queens, Westchester 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 are matched with a volunteer, they received either a telephone call, home visit or visit at a PACE center. Volunteers collaborated with 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	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