Q1 Please provide your contact information below.

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Q2 Please describe your company or organizations overall goals and mission.

Callen-Lorde Community Health Center (Callen-Lorde) provides sensitive, quality health care and related services targeted to New York's lesbian, gay, bisexual, transgender, and queer communities – in all their diversity – regardless of ability to pay. To further this mission, Callen-Lorde promotes health education and wellness, and advocates for LGBTQ health issues.

Q3 Please indicate which category your organization falls under.

Health Care Provider

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

In 2017, Callen-Lorde, with the partnership of Services & Advocacy for GLBT Elders (SAGE), the country's oldest organization dedicated to improving the lives of LGBTQ older adults, and The Lesbian, Gay, Bisexual & Transgender Community Center (The Center), the heart and home of NYC's LGBTQ community, providing programs for health, wellness and community connection, embarked upon a joint LGBTQ Shared Services Collaborative Data Project to collect and analyze client data. The three agencies created a shared intake form related to social determinants of health (SDOH), including issues such as violence, stress, access to public resources and depression. The three agencies then created a shared database to collect and analyze this shared data. The Collaborative agencies plan to use this analysis to inform strategic planning to address LGBTQ social determinants of health, plan LGBTQ-affirmative services, and address gaps in access.

Return on Investment (ROI)

The LGBTQ Shared Services Collaborative Data Project will yield a significant return of investment by improving quality of care while lowering costs. Issues such as housing instability, food insecurity and environmental and individual stress within the lives of LGBTQ New Yorkers are all important markers of social determinants of health that are not currently being measured or adequately addressed (either directly or by referral) by the Collaborative partners. With the move to value based payment, integrating social determinants of health into clinical workflows will promote increased understanding of clients' needs and facilitate the development of more cost-effective interventions for improved health and wellness outcomes.

Scaleability

The LGBTQ Shared Services Collaborative Project will result in the development of an extensive SDOH data report assessing the most pressing issues faced by LGBTQ clients and will be utilized to teach other healthcare entities across New York City and impart insight into the care management systems necessary to successfully engage LGBTQ populations. The SDOH data report will be shared with up to three distinct strategic audiences: 1) Policymakers 2) Medicaid networks and health plans; 3) health and social services providers serving LGBTQ communities.

Feasibility

The feasibility of implementing The LGBTQ Shared Services Collaborative Project is contingent on several key factors and resources. Successful implementation of the project requires the leveraging of leadership staff, who are charged to champion the project and ensure buy-in from managers and staff contributing to the project. Staff resources must be devoted to developing workflow models, training frontline staff on administering the intake form, and data reporting and analysis. There is also necessary information technology resources needed to implement the intakes and analyze the data.

Evidence-based Support for Innovation

The SDOH intake form developed by the Collaborative agencies was modeled after the PRAPARE (Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences) assessment tool, which consists of sixteen national core SDOH measures. The tool was informed by research, the experience of existing social risk assessments, and stakeholder engagement. It aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next state of Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System (UDS).

Relevance to the Medicaid population and Speed to Market

The SDOH Intake form will be used as a screening tool to identify clients eligible for Health Homes and promote access to and coordination of care for Medicaid beneficiaries (such as SNAP, housing opportunities, and Medicaid Special Needs Plans) with complex needs.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.	**No**
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Social and Community Context** , **Health and Health Care**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**