Social Determinants of Health
PRAPARE Tool Training
Using eClinicalWorks

Curriculum

This 90 minute training will provide participants and understanding of the Social Determinants of Health and how to use the standardized PRAPARE tool built in eClinicalWorks Social History. At the end of the training, the participants understand the purpose of collecting data on the Social Determinants of Health, be able to ask and document patient responses to the PRAPARE tool and connect patients to enabling services.

Recommended Attendees:
- Providers
- Clinical Support Staff
- Patient Navigators
- Front Desk Staff that collect demographic data

Resources:
- PRAPARE Tool Power Point
- Computer with eClinicalWorks for hands on
- Optional Video

Assumptions:
- Health Center has configured eClinicalWorks using the Configuration Guide
- Health Center has determined which staff will ask the PRAPARE questions based on the recommended workflows
- Health Center has created and updated their enabling services resource list
- Dummy CPT codes for enabling services have been built in eClinicalWorks if using this option
Training Agenda

1. Overview of the PRAPARE tool
2. Define Social Determinants of Health
3. Purpose of collecting information
4. PRAPARE Tool
5. PRAPARE Clinical Domains
6. How to use the PRAPARE Tool built in eClinicalWorks Social History
7. Health Center Enabling Services available for patients
8. Optional – How to document enabling services in eClinicalWorks Progress Note Billing Section
9. Q & A
10. Workflow Review
11. Hands on Practice
12. Optional – Empathetic Listening techniques

   a. Example: use short video to start discussion on how to ask patients difficult questions in a responsible sensitive manner. Numerous resources online are available. This one is short and to the point.  http://www.karmatube.org/videos.php?id=4646
Social Determinants of Health
PRAPARE Tool Training

Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)
Background

The objective of this project is to help community health centers and other providers assess and address the social determinants of health (SDH) by creating, implementing, and promoting the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE).

By going beyond medical acuity to identify patient risks related to the SDH, PRAPARE positions health centers and other providers to better understand and manage their patient populations.

PRAPARE will inform the development of new programs and partnerships that ultimately improve health outcomes and curb health care spending.
Project Funding

This project was made possible with funding from the Kresge Foundation, the Blue Shield of California Foundation, and the Kaiser Permanente National Community Benefit Fund at the East Bay Community Foundation.
Health Centers Piloting PRAPARE

Four teams consisting of one or more health centers and a health center network are piloting the PRAPARE tool in 2015. This includes integrating the protocol into the health center workflow, creating templates and developing interventions to respond to the SDH risks.
# Implementation Pilot Team Demographics

<table>
<thead>
<tr>
<th>Race</th>
<th>Team 1</th>
<th>Team 2</th>
<th>Team 3</th>
<th>Team 4</th>
<th>Total Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>1.1%</td>
<td>14.6%</td>
<td>1.5%</td>
<td>5.6%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>0.1%</td>
<td>51.9%</td>
<td>0.0%</td>
<td>3.1%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>0.1</td>
<td>11.7%</td>
<td>0.1%</td>
<td>2.1%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Black</td>
<td>1.2%</td>
<td>1.7%</td>
<td>17.4%</td>
<td>11.9%</td>
<td>12.9%</td>
</tr>
<tr>
<td>American Indian</td>
<td>1.0%</td>
<td>0.2%</td>
<td>0.5%</td>
<td>0.9%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>28.0%</td>
<td>8.4%</td>
<td>56.1%</td>
<td>22.1%</td>
<td>40.8%</td>
</tr>
<tr>
<td>Non-English Speaker</td>
<td>20.2%</td>
<td>0.1%</td>
<td>48.1%</td>
<td>11.3%</td>
<td>32.2%</td>
</tr>
<tr>
<td>Agricultural Worker</td>
<td>1,734</td>
<td>0</td>
<td>8,186</td>
<td>1</td>
<td>9,921</td>
</tr>
<tr>
<td>Homeless</td>
<td>1,471</td>
<td>879</td>
<td>5,912</td>
<td>4,793</td>
<td>13,055</td>
</tr>
<tr>
<td>Veteran</td>
<td>441</td>
<td>265</td>
<td>677</td>
<td>901</td>
<td>2,284</td>
</tr>
<tr>
<td>% Federal Poverty Level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% or less (poor)</td>
<td>76.1%</td>
<td>75.0%</td>
<td>71.7%</td>
<td>70.6%</td>
<td>72.4%</td>
</tr>
<tr>
<td>200% or less (low-income)</td>
<td>95.4%</td>
<td>84.1%</td>
<td>95.8%</td>
<td>89.0%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None/Uninsured</td>
<td>52.1%</td>
<td>10.1%</td>
<td>43.3%</td>
<td>25.9%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>31.5%</td>
<td>59.0%</td>
<td>36.2%</td>
<td>45.0%</td>
<td>40.5%</td>
</tr>
<tr>
<td>Total Patients</td>
<td>22,752</td>
<td>32,905</td>
<td>111,978</td>
<td>52,210</td>
<td>260,155</td>
</tr>
</tbody>
</table>
What are Social Determinants of Health

Information about a patient’s socioeconomic and psychosocial characteristics that can impact their health.

Patient complexity includes non-clinical factors that influence their health, utilization of services, the amount of services they need and additional assistance.
Why are we doing this?

It is important that we have a full picture of our patient in order to provide them appropriate clinical support. Demographics and clinical information does not provide the full picture.

This also helps us identify patients that need enabling services.
Complex Patients Require Complex Solutions

- Complex patients have multiple needs that must be addressed to produce the desired clinical results.
- We are held accountable for patient health and cost outcomes.
- Care teams need data on patient’s Social Determinants of Health, risks, and experiences to assess and address patient complexity.
PRAPARE Tool

The tool is a set of questions that can be administered on paper or verbally.

We are going to verbally ask the questions and enter the results in Social History as structured data based on the paper tool so we can use the aggregate data to understand the impact of the risks on our populations and to consistently capture information.

Aligns with National Initiatives and uses standard protocols from the field.
Cross-walked for SDH domain commonalities

Literature reviews of SDH associations with cost and health outcomes

Monitored and aligned with national initiatives
- HP2020
- RWJF County Health Rankings
- IOM on SDH in MU Stage 3
- NQF on SDH Risk Adjustment
- SBM & NIH

Collected existing protocols from the field
- Collected 50 protocols
- Interviewed 20 protocols
- Identified top 5 protocols
Healthy People 2020 Overlap

Social

Social determinants of health reflect social factors and the physical conditions in the environment in which people are born, live, learn, play, work and age. Also known as social and physical determinants of health, they impact a wide range of health, functioning and quality of life outcomes.

Examples of social determinants include:

- Availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthful foods
- Social norms and attitudes, such as discrimination
- Exposure to crime, violence, and social disorder, such as the presence of trash
- Social support and social interactions
- Exposure to mass media and emerging technologies, such as the Internet or cell phones
- Socioeconomic conditions, such as concentrated poverty
- Quality schools
- Transportation options
- Public safety
- Residential segregation

Examples of physical determinants include:

- Natural environment, such as plants, weather, or climate change
- Built environment, such as buildings or transportation
- Worksites, schools, and recreational settings
- Housing, homes, and neighborhoods
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements, such as good lighting, trees, or benches

### AH-5.1 Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade

<table>
<thead>
<tr>
<th>Baseline:</th>
<th>74.9 percent of students attending public schools graduated with a regular diploma in 2007–08 4 years after starting 9th grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target:</td>
<td>82.4 percent</td>
</tr>
<tr>
<td>Target-Setting Method:</td>
<td>10 percent improvement</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>Common Core of Data (CCD), ED/NCES</td>
</tr>
<tr>
<td>Data:</td>
<td><img src="data2020" alt="HP2020 data for this objective" /></td>
</tr>
<tr>
<td></td>
<td>Details about the methodology and measurement of this HP2020 objective</td>
</tr>
</tbody>
</table>
PCMH 2014 Overlap

Care management focus on high-need populations

- The new standards call for identifying patients who may benefit from care management and self-care support.
- Practices will need to address social determinants of health, behavioral health, cost/utilization, poorly controlled or complex conditions and unique needs of patients referred by specialists.
PCMH 2014 Social Determinants Measures

PCMH 3C - Comprehensive Health Assessment that includes:
  2 – family, social and cultural characteristics
  6 – Behaviors affecting health

PCMH 4A – Identify Patients for Care Management
  4 – Social determinants of health

PCMH 4B – Care Planning and Self Care Support
  3 – Assess and address potential barriers to meeting goals

PCMH 4C – Medication Management
  5 – Assess patient response to medications and barriers to adherence

PCMH 4E
  7 – Assess usefulness of identified community resources

PCMH 6 – Clinical Quality Performance
  Stratify results by vulnerable population
  Affect Utilization of vulnerable populations
Institute of Medicine Meaningful Use Recommendations

Recommended MU include 8 social and behavioral domains:

- Educational attainment
- Financial Resource strain
- Stress
- Depression
- Physical activity
- Social isolation
- Intimate partner violence
- Neighborhood median-household income
ACO Overlap

- Assist patients with identifying and accessing needed community support resources
- Connect patients with social services that are part of the ACO
- Community support for medical, behavioral health, post acute care, long-term care and public health services
PRAPARE will be used to meet these goals by:

1. Patient and Family: Empowering patients
   ◦ Asking patient-centered questions about risk and allowing patients to prioritize needs
   ◦ Opening up the conversation between patients and their care team about non-clinical risks and unmet needs

2. Care Team Members: Improving point of service care management
   ◦ Giving the care team information on patient risk/needs prior to the visit to inform counseling and referrals during visit
   ◦ Giving the care team a more complete context of the patient’s medical conditions, risks, and utilization patterns

3. Health Center: Improving the health of the patient population
   ◦ Gathering data that can be aggregated to inform the allocation of resources and services and to identify disparities between patient population segments
PRAPARE will be used to meet these goals by:

4. Community Policies: Informing policies
   ◦ Gathering data that can be aggregated to inform/promote legislation and policies

5. Local Health System: Encouraging and strengthening partnerships across organizations
   ◦ Encouraging local partnerships for bi-directional referral services
   ◦ Creating an opportunity for meaningful data sharing

6. State and National Policies: Gathering evidence for advocacy and payment reform
   ◦ Gathering robust quality data to validate a risk adjustment algorithm for payment negotiation
PRAPARE promotes a better understanding the patient

Identify previously undocumented population issues: During the implementation of PRAPARE, a health center notices that there are high levels of social isolation among older black patients with diabetes and that the patients that are socially isolated have a higher a1c.

Plan and implement a solution: The health center decides to start a support group for black patients with diabetes, with support from the regional branch of the American Diabetes Association. A church near a primarily elderly community, agrees to provide a meeting place for the group.
Team Effort – Front End and Clinical

Over half of the questions are already captured as part by the front desk staff and used for other reporting.

- Address
- Race
- Ethnicity
- Preferred Language
- Veteran
- Homeless
- Sliding Fee – Income and Family Size = Poverty Level
- Insurance
Clinical Domains
Education

• Patients with lower education often have low health literacy
  ➢ Tailor teaching methods and hand outs
  ➢ Referrals to education services
  ➢ Identify patients who need higher levels of care management
  ➢ Identify patients who need special forms of outreach (phone versus letter)
Employment

• Important stressor that can compromise mental and behavioral health

- Information for state/local resources
- Opens up a conversation
- Potential exposure to toxins at work
Housing

• Provides a context for care
  • Limited material resources
  • Potential issues with substandard housing – mold, rodents, asthma triggers

• Influence on mental and behavioral health

• Identifies need for resources to prevent eviction or foreclosure

• Referrals for homeless patients to housing services
Social Integration

• High degree of social isolation
  • Greater case management and home visits/calls
  • Need for assistance with activities of daily living

• Care team can develop a plan of action

• Referrals to support groups, community activities, and volunteer services, develop plan of action in case of emergency
Stress

- Stress is a major risk for heart disease
  - Monitor blood pressure and cholesterol more closely

- High stressed patients should be questioned regarding the greatest stressors affecting them

- Referrals and recommendations to reduce stress
Incarceration

- Prisons are commonly associated with high risk of infectious diseases
- Increased tobacco use, drug use and other unhealthy behaviors
- Negative impact on physical, social and personal resources
- High need for social services
Transportation

- Impacts access to medical care, employment and other basic needs
- Identifies need for enabling services such as transportation to and from health center, identification of public transportation routes
- Advocacy for public transportation enhancements
Refugee Status

▪ Most vulnerable population
▪ Higher rates of poverty
▪ Higher risk of experiencing a range of illnesses and a more urgent need for health care
▪ Complex health needs
▪ Identify resources needed such as interpreters, housing, transportation, mental health, food and other services
▪ May be eligible for certain services provided for refugees that immigrants do not receive
Safety

Recommended by implementation team to be included
Domestic Violence

Recommended for inclusion in the EHR by the IOM (collapsed version of 4Q HARK assessment)

Identifies the need for referral to support groups
Using the PRAPARE Tool

ECW SOCIAL HISTORY QUESTIONS
Social History Questions – Social Determinants of Health

Open the Social Determinants of Health
Structured data

1. Update the date entered or updated field.
2. Ask/Review the questions and select the appropriate structured data response in the value field. Additional notes can be entered in the notes field.
3. Provide/Refer to enabling services as necessary.
4. Complete additional tools as necessary.
Money and Resources Domain
Highest Level of School Finished

<table>
<thead>
<tr>
<th>Money &amp; Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. What is the highest level of school that you have finished?</td>
</tr>
<tr>
<td>+-------------------------</td>
</tr>
<tr>
<td>Elementary school</td>
</tr>
<tr>
<td>High school or GED</td>
</tr>
<tr>
<td>2 years of college</td>
</tr>
<tr>
<td>Graduate/professional school</td>
</tr>
<tr>
<td>I choose not to answer this question.</td>
</tr>
</tbody>
</table>

Note: No formal schooling option was added based on health center feedback from paper tool testing.
Current Work Situation

<table>
<thead>
<tr>
<th>Unemployed and seeking work</th>
<th>Part time work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time work</td>
<td>Otherwise unemployed but not seeking work (ex. student, retired, disabled, unpaid primary care giver) Please write ____________</td>
</tr>
</tbody>
</table>

I choose not to answer this question.

---

**Social History Notes**

<table>
<thead>
<tr>
<th>Social Determinants of Health</th>
<th>Value</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDH Entered/Updated</td>
<td>04/28/2015</td>
<td></td>
</tr>
<tr>
<td>What is the highest level of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is your current work</td>
<td>Part time work</td>
<td></td>
</tr>
<tr>
<td>In the past year, have you</td>
<td>Unemployed and seeking work</td>
<td>Unemployed and seeking work</td>
</tr>
<tr>
<td>What is your housing situation</td>
<td>Full time work</td>
<td></td>
</tr>
<tr>
<td>How often do you see or talk to anyone</td>
<td>Otherwise unemployed but not seeking work. Please write in description.</td>
<td></td>
</tr>
<tr>
<td>How stressed are you?</td>
<td>I choose not to answer this question</td>
<td></td>
</tr>
</tbody>
</table>
12. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Food</th>
<th>Yes</th>
<th>No</th>
<th>Clothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Utilities</td>
<td>Yes</td>
<td>No</td>
<td>Rent/Mortgage payment</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Transportation</td>
<td>Yes</td>
<td>No</td>
<td>Child care</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Medicine or medical care</td>
<td>Yes</td>
<td>No</td>
<td>Phone</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Health insurance</td>
<td>Yes</td>
<td>No</td>
<td>Other (please write)</td>
</tr>
</tbody>
</table>

I choose not to answer this question

Select all items that apply. If they do not have trouble meeting their needs, select the first option “I do not have trouble meeting my needs”
Housing

7. What is your housing situation today?

- I have housing
- I do not have housing (staying with others, in a hotel, on the street, in a shelter)
- I choose not to answer this question.

Note: Other questions related to Family and Home come from Demographics
Social and Emotional Health
Connectedness

13. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, attending church or meetings)

- Less than once a week
- 1 or 2 times a week
- 3 to 5 times a week
- More than 5 times a week
- I choose not to answer this question.
Stress

14. Stress is when someone feels tense, nervous, anxious, or can’t sleep at night because their mind is troubled. How stressed are you?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much
- I choose not to answer this question.

Note: We reversed the two sentences so the clinical staff could see it better in structured data.
Additional Questions
15. In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

| Yes | No | I choose not to answer this question. |

**NOTE:** Child question for release date appears if they were incarcerated. Enter 2 digit month and 4 digit year.
Transportation Issues

16. Has lack of transportation kept you from medical appointments or from getting your medications?

- Yes
- No
- I choose not to answer this question.

Social History Notes

<table>
<thead>
<tr>
<th>Social Determinants of Health</th>
<th>Value</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDH Entered/Updated</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>What is the highest level of education</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>What is your current work</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>In the past year, have you received medical care?</td>
<td>Yes</td>
<td>✗</td>
</tr>
<tr>
<td>What is your housing situation</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>How often do you see or talk to family or friends?</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>How stressed are you? Stress level</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>In the past year, have you been in a hospital?</td>
<td>Yes</td>
<td>✗</td>
</tr>
<tr>
<td>Release date</td>
<td>/</td>
<td>✗</td>
</tr>
<tr>
<td>Has lack of transportation</td>
<td>Yes</td>
<td>✗</td>
</tr>
<tr>
<td>Are you a refugee?</td>
<td>No</td>
<td>✗</td>
</tr>
<tr>
<td>What country were you born in?</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Do you feel physically or emotionally safe?</td>
<td>I choose not to answer this question</td>
<td>✗</td>
</tr>
</tbody>
</table>
Refugee Status

17. Are you a refugee?

| Yes | No | I choose not to answer this question. |

Social Determinants of Health

- SDH Entered/Updated
- What is the highest level of education completed?
- What is your current work?
- In the past year, have you moved?
- What is your housing situation?
- How often do you see or talk to people?
- How stressed are you? Stressed
- In the past year, have you had a serious illness?
- Has lack of transportation?
- Are you a refugee?
- What country were you born in?
- Do you feel physically or emotionally unsafe?
- In the past year, have you been physically or emotionally unsafe?
Safety

19. Do you feel physically and emotionally safe where you currently live?

- Yes
- No
- Unsure
- I choose not to answer this question.
Domestic Violence

20. In the past year, have you been afraid of your partner or ex-partner?

- Yes
- No
- Unsure
- I have not had a partner in the past year
- I choose not to answer this question.
# Social History Progress Note Results

## Social Determinants of Health

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the highest level of school that you have finished?</td>
<td>High school or GED</td>
</tr>
<tr>
<td>What is your current work situation?</td>
<td>Unemployed and seeking work</td>
</tr>
<tr>
<td>In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?</td>
<td>Check all that apply. Food, Medicine or medical care, Phone</td>
</tr>
<tr>
<td>What is your housing situation today?</td>
<td>I have housing</td>
</tr>
<tr>
<td>How often do you see or talk to people you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, attending church or meetings)</td>
<td>Less than once a week</td>
</tr>
<tr>
<td>How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled</td>
<td>A little bit</td>
</tr>
<tr>
<td>In the past year, have you spent more than 2 nights in jail, prison, detention center, or juvenile correctional facility?</td>
<td>Yes</td>
</tr>
<tr>
<td>Has lack of transportation kept you from medical appointments or from getting your medications?</td>
<td>Yes</td>
</tr>
<tr>
<td>Are you a refugee?</td>
<td>No</td>
</tr>
<tr>
<td>What country are you from?</td>
<td>Country other than USA (please write in notes) Mexico</td>
</tr>
<tr>
<td>What year did you come to the US?</td>
<td>2011</td>
</tr>
<tr>
<td>Do you feel physically or emotionally safe where you currently live?</td>
<td>Yes</td>
</tr>
<tr>
<td>In the past year, have you been afraid of a partner or ex-partner?</td>
<td>No</td>
</tr>
</tbody>
</table>
Enabling Services

SAMPLE ONLY

- Local Food bank
- Medicaid Transportation
- Hispanic Coalition
- Medicaid Eligibility Assistance
- Youth development programs
  - Family and social support
  - Access to healthy foods
- Job skills, employment, and workforce development
- Health education
- Physical Activity and Exercise
- Community safety, wellbeing, and involvement
- Nutrition education
- Healthy, safe, and affordable housing
- Recreational spaces and improved air and water quality in the community
- Adult education
- Law Enforcement

Health Centers – replace sample list with the specific Enabling Services for your organization. Tell your staff what resources you have and how the patient can access this. You may want to create a Enabling Services Resource Manual for your organization and share it with the staff.

Also include where/how to document the enabling services provided.
## Enabling Service Documentation – Optional slide

### Procedure Codes

<table>
<thead>
<tr>
<th>Enabling Service Provided</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management – Assessment</td>
<td>CM001</td>
</tr>
<tr>
<td>Case Management – Treatment and Facilitation</td>
<td>CM002</td>
</tr>
<tr>
<td>Case Management – Referral</td>
<td>CM003</td>
</tr>
<tr>
<td>Financial Counseling/Eligibility Assistance</td>
<td>FC001</td>
</tr>
<tr>
<td>Health Education/Supportive Counseling</td>
<td>HE001</td>
</tr>
<tr>
<td>Interpretation Services</td>
<td>IN001</td>
</tr>
<tr>
<td>Outreach Services</td>
<td>OR001</td>
</tr>
<tr>
<td>Transportation</td>
<td>TR001</td>
</tr>
<tr>
<td>Other: describe services below</td>
<td>OT001</td>
</tr>
</tbody>
</table>

Source: NACHC Presentation  
Enabling Service Documentation – Optional slide

Structured Data under Preventive Medicine

Source: NACHC Presentation

Questions/Answers

- **Do I have to fill this out for all of my patients?**
  - We are trying to complete the questionnaire for as many patients as possible at the pilot sites.

- **How often do we have to update the questions?**
  - After the PRAPARE tool has been completed once, we should update it annually or if you feel their situation has changed.

- **Do I have to complete all of the questions?**
  - We would like you to complete as many of the questions as possible to get a complete picture of the patient’s social and economic determinants of health. If need be, you can continue updating it the next time they come in.

- **Do I have to provide enabling services for all of the items identified?**
  - Do the best you can to assist the patient. Capturing the information is the first step to knowing what services our patients need.