

North Carolina Community Health Center Association's Use of PRAPARE to Move Toward Delivery System Transformation

Through the participation in the PRAPARE Train the Trainer Academy, the North Carolina Community Health Center Association (NCCHCA) identified numerous opportunities to use lessons learned with PRAPARE implementation and social determinant of health (SDH) data utilization to drive policy and advocacy efforts. North Carolina's most promising opportunities for delivery transformation and value-based care are related to the state's Medicaid program transitioning to managed care. NCCHCA has been able to utilize their experience with PRAPARE in discussions with the state and other organizations involved in Medicaid transformation.

NCCHCA plans to leverage their experience in the PRAPARE Academy and existing partnerships with statewide enabling service organizations to serve as content experts for navigating community-based resources, forming community-based partnerships to address SDH needs, and developing user-friendly SDH data collection protocols. In addition, a North Carolina based organization, the Foundation for Health Leadership and Innovation is leading a public-private partnership, along with the NC Department of Health and Human Services (NC DHHS), to create the North Carolina Resource Platform, a robust statewide resource database similar to Aunt Bertha or Healthify, which will be available to anyone in the state. By creating a standard platform, health centers and social service providers across the state will be able to use the same tool for stronger feedback loops on referrals. For more information, [please click here](#).

PRAPARE Training and Support Strategies

NCCHCA found the following activities helpful to support their health centers with PRAPARE implementation and responding to SDH needs:

- Strategizing messaging around social needs screening and response activities for various staffing roles at the health center (providers, enabling services staff, billing/coding, etc.)
- Identifying workflows for documenting, reviewing, and addressing patient social needs within the EHR and/or care management software
- Expanding the "No Wrong Door" implementation and training approach such that any staff can assist with PRAPARE
- Working with clinical and quality improvement staff to prioritize team-based care staffing models and workflows
- Exploring confidentiality, diversity, and cultural competency training for all health center staff to respond to patients' social needs
- Featuring health center and other safety-net provider success stories with PRAPARE screening at NCCHCA conferences

Strengthening State-Level Partnerships to Support Social Determinant Efforts

NCCHCA found it helpful to develop the following partnerships to support SDH efforts in their state:

- Developing partnerships with payers throughout the state with interest in SDH
- Forming partnerships and spreading innovative social needs intervention programs, such as a SNAP "Double Bucks" program that originated in one health center
- Tying screening to PCMH standards and exploring screening as a part of risk stratification to ensure all patients receive social needs screening regardless of their payer status

Next Steps: Spreading PRAPARE Implementation to Other Health Center Members

- NCCHCA has plans for a nine-month social needs learning collaborative for interested health centers based on their staffing capacity to integrate social needs screening in the EHR.
- The training will be designed to enable health centers to assess their readiness and strategically outline a plan to integrate PRAPARE social needs screening into organizational workflows.

"A big surprise for us was how many health centers have innovative programming going on around SDH that the PCA was not aware of & how health centers don't necessarily understand how special these programs are. For example, one of the health centers in the pilot set up a Good Neighbor Fund, in which they can help patients with time-limited necessary expenditures (i.e., if a patient needs gas to get to a specialist appointment). NCCHCA is thinking through how we can better get information from health centers to understand the impact of their work. -NCCHCA PRAPARE Team

"Our biggest lesson learned is the importance of persistence. The health center community in North Carolina understands the importance of assessing and responding to social determinants of health. But, there are a lot of other things that are on the priority list. As the PCA, we have to be consistent and persistent in our message so that health centers can stay engaged and make this a part of their practice." -NCCHCA PRAPARE Team

Health Center-Level Changes as a Result of PRAPARE Implementation

- **Identification of Champions**

Each health center has seen new leaders emerge who are champions for PRAPARE implementation. For example, at **Gaston Family Health Services (GFHS)**, a Community Health Worker and Director of Quality and Clinical Informatics have emerged as champions for PRAPARE based on their experience with utilizing PRAPARE with patients. The Program Director has driven a lot of the initial work around PRAPARE. At **Caswell Family Medical Centers (CFMC)**, several champions have emerged. The Clinical Operations Manager has been encouraging nursing staff during implementation and has been a resource for identifying community resources. In addition, the Health Care Informatics Manager has spearheaded much of the health center's efforts, as well as expressed a desire to get more involved with SDH issues at the state level. In addition, a new staff person has been tasked with participation in the PRAPARE Academy at the health center. It seems that she has felt empowered by their initial success with PRAPARE and was excited to share the results during our peer learning call. These staff were already leaders at their health centers, but they have become champions for social needs screening and response programs.

- **Identifying Unknown Needs & Changing Perceptions**

Health center staff report that they have been able to identify needs that the health center was not aware of and that would not have come out during a visit without PRAPARE. "There are things that we have identified that are not captured in a regular visit." The PRAPARE tool has also "opened the door for the patient to be more comfortable with staff" in some situations. This has sometimes helped to change staff perceptions of a patient. According to one staff person, instead of tagging a patient as non-compliant, the staff have been able to think more critically about something that may be going on in the patient's life that makes it difficult for them to follow instructions.

- **Increasing Staff Buy-In**

One of the health centers indicated that staff buy-in has increased, as staff are able to see the impact of identifying SDH needs and connecting patients to services. Initially, staff were hesitant about adding another task to their plate and burdening the patient with more questions. However, they have quickly been able to see the value of adding the PRAPARE questions, as they have encountered needs they are able to provide resources to address. One staff leader has been very helpful in reminding staff that the PRAPARE tool is not just a set of questions to add, but also a "means of getting somewhere" for the patient and community.

- **New Services**

One health center has been able to add new services to address patients' SDH needs. CFMC has created a food pantry on site around the time of their PRAPARE implementation that employees can donate non-perishable food to. Patients who have emergency food needs and are not able to get to a traditional pantry or other delivery site are able to get food to carry them until they are able to locate other resources.

Community Partnerships

- Both health centers have been able to refine community resource lists, even prior to PRAPARE implementation. Our pilot sites report that having a robust resource list prior to implementation was seen as essential to health center staff. One health center has noted that they have identified some gaps in community services. For example, their patients were being referred to a community partner that was not able to provide the services the patients needed for various reasons. This has helped identify gaps in resources--even in cases where there may be the perception that there are resources.