About This Document
This document contains information collected during a ten-month national Train the Trainer Academy conducted by NACHC, AAPCHO, and OPCA. The first round of the Train the Trainer Academy included eight Primary Care Associations and/or Health Center Controlled Networks: (1) Arizona Alliance for Community Health Centers, (2) Colorado Community Health Network, (3) Indiana Primary Care Association, (4) Maine Primary Care Association, (5) Massachusetts League of Community Health Center, (6) Minnesota Association of Community Health Centers, (7) North Carolina Community Health Center Association, (8) Washington Association of Community & Migrant Health Centers.

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The Arizona Alliance for Community Health Centers (AACHC) worked closely with the Collaborative Venture Network (CVN) to support and provide training and technical support to six participating health centers during the Train the Trainer Academy. To implement PRAPARE, AACHC and CVN hosted monthly training sessions for health center staff for eight months. Trainings were conducted in-person for two to three hours every month and tailored specifically for the Arizona health centers. AACHC and CVN’s training sessions mirrored the PRAPARE Train the Trainer Academy sessions to reflect the discussions shared with NACHC and other participating primary care associations. The training sessions paired with shared learning opportunities to report out their lessons learned and challenges was the most important component for the health centers during the sessions. They also included a thorough PRAPARE overview for health centers at the onset of implementation and specifically on how to utilize the PRAPARE Implementation and Action Toolkit. This allowed more tools, resources, and opportunities for group teamwork with the health centers based on their current level of implementation and next steps.

**PCA Benefits of PRAPARE Implementation**

AACHC and CVN saw several benefits in supporting their health centers to screen for the social determinants of health using PRAPARE, such as:

- the potential impact of the social determinants data collected to improve health outcomes for their patients,
- the ability to develop and improve appropriate referral services available for the social determinant of health needs identified,
- demonstrating the value and effectiveness of health centers in meeting the needs of patients with complex needs
- staying ahead of the curve of SDH implementation as the nation pushes forward in addressing the SDH by having monthly in-person trainings for 2-3 hours, and
- establishing a PCA information sharing platform for participating health centers

**Next Steps**

Because of its involvement with PRAPARE, AACHC strategized how the PCA could help support health centers’ response to the social determinant needs identified and worked with its health centers to:

- Participate in an Intimate Personal Violence training of trainers on appropriate interventions and partnerships with domestic violence service agencies through Futures Without Violence
- Discuss a potential pilot where health centers serve as food distribution sites and collaborate with the Arizona summer meals program for kids to address food insecurity
- Develop a resource to show the different ways that data may be utilized post-PRAPARE rollout based on current data as a sample
- Compile the community resource lists from the health centers to share additional resources/referral agencies to identify gaps in resources

**Best Practices and Lessons Learned**

- Listening and responding to health center feedback about the trainings presentations delivered was the most critical piece in ensuring AACHC and CVN supported their health centers appropriately
- Connecting with and partnering with two respective EHRs that the health centers used was very valuable so that health centers could visualize data collection and reporting possibilities
- Ensure training discussions were focused on health centers’ future plans and what they would do differently in addition to what they have accomplished

“Be flexible to the varied needs of health centers. Health centers will be at various levels of readiness and will implement different workflow models, which can make it challenging to develop training that meets health centers where they are. However, there is still value in shared learning to troubleshoot common challenges and to hear tradeoffs of different implementation models as health centers test their workflows.” – AACHC PRAPARE Team
The Minnesota Association of Community Health Centers (MNACHC) worked with the Breakwater Health Network to support their health center members with various PRAPARE implementation and social determinant of health (SDH) data utilization strategies. At the onset of implementation, the Minnesota (MN) PRAPARE team originally planned to use a more structured training model, but they determined that it did not align with the various competing priorities at the different health centers. To begin the restructure of their training model and to promote buy-in and increased motivation amongst the health centers, the MN PRAPARE team hosted an in-person kick-off meeting to discuss the PRAPARE project, review the basics of PRAPARE, assess the health centers’ readiness, and using PRAPARE data for population health management. MNACHC and the Breakwater Health Network also discussed training methodology models and realistic timelines that would work best and efficiently for each individual health center.

After learning more of the needs and expectations of the health centers, the PCA worked with the HCCN to integrate PRAPARE trainings into existing scheduled monthly meetings with the health centers. The health centers received thirty minutes of training based on a newly developed PRAPARE implementation guide. MNACHC designed the implementation guide to be used as a training aid by both its staff as well as a self-guide for health centers. Each monthly meeting reserved time at the end for questions, comments and shared learning of successes and challenges. Every MN health centers received all training materials and resources regardless of their readiness to begin the PRAPARE implementation process.

### Successes

- Leadership buy-in due to the importance of collecting SDH data for public quality measure reporting and transiting to value based payment arrangements
- Consistent and ongoing marketing of the PRAPARE tool
- Being flexible and thoughtful in the PCA approach and always keeping in mind the larger context of health center circumstances and how they can use the data
- Tracking and managing the technical infrastructure by the HCCN, who managed the loading and implementation of the electronic form into the HER

### Challenges and Solutions

- **Scheduling:** Adding PRAPARE meetings to existing meetings with health centers helped align schedules while not adding additional time away from work
- **Staffing:** Providing guidance to health centers on the right staff to include on PRAPARE implementation teams
- **Other Competing Priorities:** HIT implementation, funding, and a variety of other barriers (e.g., flu season) stood in the way of PRAPARE implementation. MNACHC worked with participating health centers to find a specific time when they could start with implementation.

### Developing Resources for Health Centers

- **Developed a new PRAPARE website to host all of the resources:** This allowed the health centers to access PRAPARE materials whenever they were ready or had time in their schedules. Resources include MNACHC’s PRAPARE Kick-Off Presentation, materials from a HITEQ Population Health Management Training, ICD-10 Z code list for social determinants and many more. To check out more, the website is [https://mnachc.org/member-resources/prapareresources/](https://mnachc.org/member-resources/prapareresources/)

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*Meeting health centers where they were was the one strategy that MNACHC believed was instrumental in PRAPARE Implementation. Integrating trainings into already existing meetings was key. Additionally, asking them to be honest about realistic timelines was also helpful, as it provided an opportunity for the staff to be included in the PCA strategic decision-making process.”* -MNACHC PRAPARE team
Health Center Perspective: Increased Awareness of Patients Risks Related to SDH

- Although many health centers are still in the pilot and preliminary PRAPARE data collection phases, they have already begun performing risk stratification related to chronic disease. For example, one health center pulled data reports on all patients with an HbA1c over 9% and reviewed rates of positive responses, further breaking it down into races. The data showed that uncontrolled diabetic Asian patients were at least 12% more likely to feel stressed than other races.

- To respond to the health center staff concerns about not having access to resources to respond to the positive findings, MNACHC and its health centers are considering a partnership with NowPow, as they are interested in working with health centers to integrate PRAPARE into their EHRs and referral systems. In addition, one health center found significant value in adding a question related to their immediate needs at the specific visit, “Do you need help today?” This helped the health center staff prioritize needs and provide behavioral health and/or enabling services the same day of the visit.
New PRAPARE WEBPAGE!

PRAPARE

The Principles for Responding to and Assessing Risks, Needs, and Opportunities (PRAPARE) is a standardized tool for collecting social determinants of health (SDOH) data in a consistent manner across a population. PRAPARE was developed by the CDC and has been adapted collaboratively with CDC’s partners to reflect the needs of states and local health departments. The data collected is used to help address health disparities and improve population health outcomes.

How to Get Started with PRAPARE

PRAPARE Implementation

Thinking about implementing PRAPARE?

Check out this implementation guide that will help you with the implementation process.

PRAPARE Implementation Guide

Additional PRAPARE Resources

Access Resources and Templates


Access Resources and Templates


Strategic Implementation and Plan Draft

PRAPARE Principles Chapter 1.1.1: Implementation

5 Steps Planning Document

THinking about implementing PRAPARE Questions

MOOC Getting Started in Using PRAPARE to Assess and Address Social Determinants of Health (SDOH) and Recording them in Your EHIS: Module 1.1.1: Implementation Assessment idealized

Empathy Inquiry Values

- Video 1: PRAPARE to be interpreted
- Video 2: Empathy Inquiry A Practical Outreach Approach to Social Determinants of Health Interventions
As Washington State moves toward 90% implementation of Value Based Payment by 2021 under the APM4 model, Washington Community and Migrant Health Centers (WACMHC) continues to emphasize the importance of collecting and tracking social determinant of health (SDH) data. At the state level, WACMHC hopes to align health centers’ SDH measures with the Department of Health, Health Care Authority, and Managed Care Organizations for several reasons, including: (1) to support payment reform and other health care related policy issues, (2) to better describe state-level population health outcomes, and (3) to advocate for funding of SDH data collection in health centers.

“At the clinic level, WACMHC seeks to support health centers in caring for their patient population through data-informed social interventions to improve clinical outcomes.” To continue the spread and use of PRAPARE, WACMHC is sharing the experiences and lessons learned gained from the PRAPARE Train the Trainer Academy with all state health centers to inform workflow choices, and increase awareness of the PRAPARE tool and available WACMHC implementation training and support efforts.

**WACMHC’s Training and Support Efforts**

WACMHC’s training and support efforts aim to accelerate changes at the health center level, spread PRAPARE or PRAPARE-aligned measures to more patients and health centers, and use SDH data with other state stakeholders. Specific results included:

- Environmental scan of health centers to determine SDH data collection procedures and data aggregating systems
- Support in developing, tracking, and maintaining referral resource in an in-house database list in a shared environment
- Development of a PRAPARE-aligned screening program implementation toolkit, specific to WA health centers
- Initiated exploration of the SDH efforts of state partners and payers

**Washington Health Centers’ Use of PRAPARE**

Participating health centers in Washington were able to determine the needed capacity to implement PRAPARE organization-wide, including staffing, funding, and IT support necessary for success. With the use of tools such as the 5 Rights Framework and WACMHC PRAPARE Crosswalk, health centers were able to better understand their capacity needs for implementing the PRAPARE survey.

**NeighborCare Health** has made significant progress in creating a community referral resources list as well as a Standard Operating Procedure for updating referrals within the list. Also, NeighborCare Health conducted a follow-up survey about the patients’ experiences with PRAPARE and found that patients were receptive to the survey, felt the “questions were important, appropriate and would positively affect their health care.”

**Next Steps in Using PRAPARE Data for State Transformation Efforts**

- Continue discussions with state organizations to align SDH measures
- Present PRAPARE Academy experiences and environmental scan data in a SDH Roundtable event, including FQHCs, state partners, and payors
- Create a transparent PCA data dashboard including SDH measures to support transformation
- Develop PCA capacity to support health centers in creating and sustaining community partnerships, including tracking referrals to resources
The Colorado Community Health Network (CCHN) partnered with Colorado Community Managed Care Network (CCMCN) to implement PRAPARE with three participating health centers. The team consisted of a staff member from CCHN’s quality and policy division and a data analyst and project manager of CCMCN. Staff spent a significant amount of time developing and delivering PRAPARE training curriculum for their health centers after attending PRAPARE Train the Trainer Academy learning sessions. CCHN and CCMCN then hosted an all-clinic PRAPARE discussion to encourage clinics to align behind one population of interest to more easily standardize and analyze PRAPARE data. Due to the alignment between different value-based payment arrangements and other quality initiatives, the group selected patients with uncontrolled diabetes (defined as patients with HcA1c scores greater than nine). CCHN’s future plans include possible statewide target population, particularly related to payment reform and the exploration of opportunities for a referral management system.

**Curriculum Planning**

CCMCN and CCHN met with participating health centers to understand and customize best PRAPARE implementation strategies for each health center. Implementation strategies included:

- Unique visits with care managers to ask the PRAPARE questions
- Potential use of tablets for PRAPARE screening
- Phone call PRAPARE screenings
- Administering PRAPARE during one-on-one visits with the patient during their regularly scheduled appointments

CCMCN and CCHN then spent time with each health center to develop detailed workflow plans to document how, when, and who is conducting PRAPARE screening using the strategies health centers identified.

**Next Steps: Supporting Health Centers in Data Collection to Further Discussions on Risk Stratification**

As these health centers progress, additional health centers will join the PRAPARE movement. The plan moving forward is for health centers to meet every three months to review PRAPARE social determinants data and refine the data collection process as they share lessons learned.

Additionally, CCHN is meeting with Regional Accountable Entities (RAEs-Medicaid regional contracts responsible for the management of the Medicaid behavioral health capititation and aspects of physical health) to share how health centers have applied their social determinants of health data to inform care and population health management. These discussions have been positive to show health center value and influence some REAs to consider PRAPARE as they draft plans for risk stratification of patients for care coordination.

**Key Takeaways**

- **Data Speaks Loudly:** Investing in a data reporting software and staff capacity to analyze data makes a great impact in engaging leaders and partners to invest in and respond to the social determinant needs found in their communities. CCHN found that visualizing the PRAPARE data collected by their health centers using a dashboard not only cemented the participating health centers’ interest and resolve in collecting this information, but it also really helped garner interest from other health centers not currently using PRAPARE. Visualizing the data helped clinic staff and leadership see just how complex their patients were and how the data could be applied to inform clinic care, population health management, and payment reform efforts.

- **Create clinic synergy:** Aligning behind a goal, metric, or population amplifies the collective impact and value of work across health centers and helps to facilitate shared learning across health centers.

**Successful Data Strategies**

CCMCN serves as the data warehouse for health centers and uses Tableau’s Business Intelligence (BI) platform for reporting. In this platform, data can be imported from various channels including text files and Excel spreadsheets. Tableau has the ability to display social determinants of health data collected by health centers in a manner that engages clinic leadership to have dynamic conversations regarding the impact of social determinants in their community, improvements for workflow implementation, and solutions to implementation challenges and barriers. This engagement created buy-in from both the executive level teams and the care management teams in understanding the importance of the PRAPARE tool.
Health Center-Level Changes as a Result of PRAPARE Implementation

- Pueblo Community Health Center is in a unique situation in Colorado as CCMCN hosts their EHR for them. This means that CCMCN has had access to their data since the beginning of the project and has been working to develop reporting mechanisms with Pueblo’s data. Several months into the Academy, CCMCN met with Pueblo staff, including the care managers responsible for completing the assessment, and showed them their data. CCMCN staff observed that reviewing the data during a formal meeting made care managers feel validated for the work they are doing and gave them a way to message the needs of patients. Additionally, Pueblo has launched a partnership with their county health department to utilize the data in future work together that will be further defined over time.

- Metro Community Provider Network (MCPN) has utilized PRAPARE as their initial screening tool by Patient Navigators as one of the ways to determine if a patient needs a referral for care coordination. The Patient Navigators are collocated with the care team and are able to utilize time before and after medical visits in the exam room to complete the screening tool with patients. Based on the results of the screen, they can provide resources that day as needed, and also identify if the patient is in need of more intensive services and assistance, which can be provided by the care coordinators. Additionally, MCPN is working to develop an internal risk-stratification model to identify patients for care coordination. To ensure the stratification accounts for the whole person, they are equally weighing medical diagnosis, behavioral health diagnosis, and social determinants in the stratification model.

Demographic Map of Patients Who Completed Assessment

Graphics from CCMCN’s Tableau demo to visualize their social determinants data collected by Colorado health centers
Massachusetts League of Community Health Centers Supporting PRAPARE Data Reporting, Aggregation and Analysis

Massachusetts League of Community Health Centers (Mass League) worked with both their health centered controlled network (HCCN) and Azara Healthcare to emphasize the need to visualize social determinants of health (SDH) data from PRAPARE at a population level. The HCCN worked with the health centers to map their data into the Azara reporting tool, covered the cost of this mapping, and facilitated the meetings between health centers and Azara. This ensured that developed registries were organized effectively and the most useful information was contained for clinical utility. The team also collaborated to add PRAPARE social determinant information to patient visit planning reports to help staff prepare for visits. Once these tools were developed and used, the Massachusetts PRAPARE team set up various meetings to promote this work by displaying the visualized PRAPARE data and demonstrating how its use could inform care and population health management. Using the aggregated data, Mass League is planning to build a partnership with their Department of Public Health for future funding opportunities.

**Successes**

- **Health center buy-in and increased motivation:** The health centers in Massachusetts were already enthusiastic about collecting PRAPARE data, partly because Massachusetts went live with its first Medicaid Accountable Care Organization (ACO) on March 1, 2018. In this environment, the community health centers (CHC) recognized the importance of understanding the needs of their population and PRAPARE provided an opportunity for them to better manage those needs. Interest in collecting PRAPARE data only increased across health centers as Mass League was able to visualize PRAPARE data and demonstrate how it could be used. UMass Medical School also collaborated and provided funding to three health centers to learn more about their specific challenges and successes of implementation.

Approximately 10,000 patients have been screened using a modified version of the PRAPARE tool from two health center partners and Mass League is continuing to work with several other centers to implement PRAPARE. Mass League’s future goals are to implement PRAPARE in six other CHCs over the coming year and then more every year.

**Strategies for Aggregating, Reporting, and Using PRAPARE Data from Your Health Centers**

- **Mapping of the data elements into the Azara DRVS reporting tool:** Working with the Azara DRVS tool, the team used the data in several actionable ways, such as developing registries and patient visit planning tools. The team was also able to aggregate the data using DRVS and determine the portion of the population that are affected by the SDH elements in PRAPARE. By having the data elements available, DRVS also allowed the PCA to look at the data in different ways, such as seeing the relationship between specific diagnoses with specific SDH. For example, what proportion of patients with a diabetes diagnosis also indicated that they have food insecurity needs? These kinds of analyses can help target the enabling services to maximally benefit the patient. In the previous example, a health center could assign a nutrition counselor to work with the food bank and the patient to address their specific diabetic dietary needs.

1. **Development of an Excel based template when the PRAPARE data was not available in DRVS:** One Massachusetts health center administered the PRAPARE paper tool in an electronic library to people that may or may not become health center patients. This was due to the rural location of the health center. They did not want to include these people in their EHR because if they were not patients, it would be problematic for the clinical quality measures if they were listed in the EHR.

In terms of value-add, having the training to implement the PRAPARE tool to each health center in Massachusetts was very valuable. Based on the numbers of health centers in the HCCN, it was estimated to a cost of about $292 per health center for the HCCN to be trained on PRAPARE. The cost per health center also could include mapping reimbursement and the administrative time to coordinate calls, go for in-person visits, etc.
The Mass League HCCN developed an Excel-based tool, which allowed the health center to continue administering the tool at the local library as part of their partnership with a community based organization and still obtain aggregate data. If the people later became patients at the health center, there was a function to look up their PRAPARE questionnaire in the Excel tool and then bring the information over to the EHR.

**Challenges and Solutions**

- **Additional questions to ask the patients:** Many screening questions are asked of patients, such as the PHQ-9, tobacco use, falls risk, etc. The intake process is long and many health centers are wary of asking more questions. Getting them to try it on specific small pockets of the patient populations was the best practice. For example, in one health center, the PCA began by having them administer the PRAPARE questionnaire for new patient physicals at their new location. Once the clinic saw that it was not as bad as they feared, they expanded the group of patients. The eventual goal is now to administer it to all patients annually. Aggregating the data is easy for patients who have the DRVS reporting tool.

**Key Takeaways**

- **Emphasize the importance of gathering the data, even if you cannot immediately act upon the needs identified.** Obtaining the aggregate population level data is very valuable for prioritizing the SDH needs of all of the patients at the health center in an analytic fashion, rather than only having anecdotal stories to determine where advocacy efforts are needed. Using evidence-based analysis will empower health center staff to target meaningful interventions to have maximal impact on their patients. This is especially true when some of the SDHs may be more subtle or less vocalized at appointments and therefore more likely to be overlooked. Having the actual data that points to a SDH that may have otherwise gone undetected will benefit both the patients and the health center in the long run.

- **Think outside the box.** Administer the PRAPARE tool even when there is no EHR template that can incorporate the answers into your EHR. Using the Excel based tool will allow the health center to obtain aggregate level data and be able to begin to understand the SDH factors at the health center. While less optimal than having the EHR template, it is still better to have an option to aggregate data than not having that option at all. In addition, thinking outside the box opens the door to more options, such as implementing PRAPARE in the dental clinic and at outreach sites.

- **Think about combining the SDH data with referral registries.** One health center that Mass League is working with is combining SDH data elements with their referral registries to see if their referrals are appropriately addressing patient needs. For example, if the patient indicates they have food insecurity needs, the referral registry should show a food bank referral. This is an additional “checks and balances” step in the process, so that caseworkers can double check that appropriate referrals were actually generated in the EHR and can track if the patient completed the referral. Having this extra step of connecting the SDH to the referral type closes the loop of addressing patient needs.
Beginning in 2017, the Indiana Primary Health Care Association (IPHCA) supported three Indiana health centers during the PRAPARE Train the Trainer Academy by providing training and technical assistance, developing materials, and closely monitoring and tracking progress with PRAPARE implementation. Although it required significant staff time early in the implementation process to plan a training curriculum and conduct trainings with their health centers, IPHCA considers this time spent to be valuable due to the long-term impact social determinant of health screening will have on alternate payment models and reimbursements to come in the future. Because of its PRAPARE work, IPHCA is now a leader in its state in regards to social determinants of health and have been able to inform and advance other state social determinant work.

IPHCA’s overall goal with PRAPARE is to demonstrate the value and return on investment of social determinants screening to health center leadership to increase health center capacity to collect and analyze social determinants of health data. To achieve this, IPHCA will continue their efforts in working in partnership with payers in Indiana (specifically Medicaid managed care) to incorporate social determinants of health into performance metrics and reimbursement methods. By working closely with the Indiana Quality Improvement Network (IQIN) and other external stakeholders, IPCA will continue to update key PCA staff during meetings with PRAPARE findings and discuss how PRAPARE informs the work of other departments, such as finance and operations, outreach, clinical quality, and policy and advocacy.

**Successes and Lessons Learned**

- Having an in-person kick off for each health center and traveling to the sites to decrease travel time for the health centers
- Continuous planning and strategizing with small PDSAs
- One-on-one team meetings with different levels of staff
- Completion of the readiness assessments to provide baseline data for PCA to revise health center’s workflow implementation timeline
- Shared learning opportunities for health centers by providing peer-to-peer mentoring by matching experienced health centers using PRAPARE to non-experienced health centers
- Workflow mapping exercise with each health center

**Spreading PRAPARE and Leveraging Data**

IPHCA has engaged with many state partners and payers to encourage a statewide approach to social determinant screening. Examples of these efforts include

- Engaging health centers to map social determinants data from their EHRs into Azara DRVS
- Hiring a Quality Improvement Coordinator to support the spread of PRAPARE
- Collaborating with Family Social Services Administration’s Office of Health Equity, which plans to utilize PRAPARE as standard questions for other social service agencies in Indiana
- Advising the Indiana State Department of Health and the State Health Commissioner on the value of PRAPARE
- Invited the Indiana Minority Health Coalition to attend the IPHCA Annual Conference’s PRAPARE session

**2-1-1 Partnership and Statewide Dissemination**

IPHCA collaborates with the Indiana 211 Partnership, Inc. and the Michiana Health Information Network (MHIN) with the goal of screening and referring health center patients using PRAPARE to local 2-1-1 affiliates. The 2-1-1 affiliate will share referral information back to the health centers to close the referral loop. In return, MHIN will also aggregate data to share with local communities in assessing needs and allocating resources to organizations such as other health centers to address social determinants of health.

“Be the influence by leading. As early adopters, PCAs have the opportunity to lead and innovate with social determinants of health data in your respective state, which is an impactful way to influence payers and health systems in a direction that supports community health centers and improved health outcomes for patients.” - IPHCA Team
IPCA's PRAPARE workflow mapping and PDSA exercises with each of their participating health centers.
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.**
Maine Primary Care Association’s Specialized Approach to Training and Technical Assistance and Identifying Community Partnerships

The Maine Primary Care Association (MPCA) began working with four health centers to incorporate PRAPARE into the work they were already doing to ensure the health centers would recognize its connection to what they do. MPCA hopes this work will drive conversations about the impact of social determinants of health on care coordination strategies, outcomes and evaluation strategies to position the health centers for payment models that reflect social need. Based on feedback from the health centers, the MPCA made the decision to provide each health center with a specialized and individualized approach with PRAPARE implementation. The health centers in Maine valued sharing their PRAPARE project planning guides and identified next steps with MPCA, while receiving direct support and insight to push forward their health center’s agenda.

While it does require dedicated internal staff time to support health centers with PRAPARE implementation, MPCA realistically evaluated their internal capacities and resources before they began working closely with their health centers in strategically planning training models and workflow integration. To continue and spread the work of the health centers, MPCA will provide ongoing 1:1 support to all health centers and continue deepening relationships with community partners.

PRAPARE Training & Technical Assistance Approach

MPCA provided three types of training and technical assistance based on health center feedback and time available:

1) In-person kick-off meeting
2) Monthly 30-minute group calls for shared learning
3) Onsite individualized technical assistance

The kick-off meeting focused on developing health center work plans. The 30-minute group calls were a chance to provide updates PRAPARE implementation at health centers and what they learned. Individualized onsite technical assistance in-between the group calls proved critical to troubleshoot challenges and address issues as they arose.

Training Success:

- Resources provided by the national PRAPARE team linking PRAPARE questions to ICD-10 codes were helpful for health center data collection
- Health centers appreciated one-on-one time with the PCA to work through implementation issues
- Troubleshoot implementation challenges early-on
- Involve multiple staff from the PCA to help with this work to ensure the work can easily be sustained even if staffing changes. PRAPARE dovetails with their role and adds value to their work with many staff

Next Steps: Building Community Connections around Identified Transportation Needs

MPCA and several other health organizations started a transportation coalition, which has grown to the point where they are organizing a mobility management workshop for all interested state partners. MPCA is gathering a large group of people who care about transportation and are willing to dedicate time to work together and address state- and region-wide concerns. One MPCA staff person serves on a statewide transportation group coordinated by the Maine Department of Transportation to provide feedback and support on health care related transportation issues.

Key Takeaways

- **Find Other Partners to Help Advance Social Determinants Work:** While there are many things that health centers and PCAs can do to address social determinants needs, it is important to identify other organizations who can help carry out the work. This way, the burden of addressing social determinants doesn’t solely fall on the PCA or health centers. The Maine PCA found it extremely helpful to participate in the statewide transportation coalitions focused so that they could collaborate with others rather than trying to address transportation needs on their own.
- **Value of One-on-One Technical Assistance:** Health centers appreciate one-on-one time with the PCA to work through issues and insight in regards to identifying next steps, either via phone or onsite.

Lessons Learned:

- Health centers had a lot to share on the monthly group calls such that 30 minutes was not enough time to share
- Plan onsite visits earlier in the rollout to

“With other initiatives and efforts happening at MPCA, it was hard to dedicate staff time to advance the work. Being part of the Train the Trainer learning collaborative helped jump-start these social determinant of health efforts for us and provided the opportunity to network and partner with national and state organizations to keep the work moving forward.” - MPCA team