At RiverStone Health, patients (age 18 and older) are asked to complete PRAPARE on an annual basis upon check-in. Providers and the clinical staff work together to address positive screening responses to the questions regarding patients who either have high stress level responses, feel physically or emotionally unsafe, or do not have a support system. If the patient screens positive for any social risks, the patient will be connected with the Team Care Manager at the time of their appointment for assistance. All completed PRAPARE forms are entered into the patient's care plan into the Electronic Health Record by the Care Manager. This allows for data tracking and recording of the patients' socioeconomic concerns.

To have a more seamless workflow to respond to needs, RiverStone Health color-coded PRAPARE questions to alert staff implementing PRAPARE as to which staff are most appropriate to respond to certain needs. A positive screen indicated in the yellow section notifies the medical assistant that the Care Coordinator should see the patient after their visit to address those particular needs. A positive screen in the orange section, on the other hand, indicates that a clinical and/or behavioral health team member should be involved to help address risks related to stress, safety, and domestic violence, and social isolation.

RiverStone Health’s Incorporation of PRAPARE Data for Risk Stratification and Scoring

Located in Billings, Montana, RiverStone Health Clinic began PRAPARE implementation in November 2016. A multi-disciplinary team-based approach was utilized to plan the implementation of PRAPARE and to test, evaluate, and revise the clinical workflow that would be used by all sites.

To expand the utility of the standardized socioeconomic data collected via PRAPARE, they incorporated PRAPARE data with other clinical outcomes data to create a more holistic patient risk score to use for care management and transformation.
Responding to Socioeconomic Needs

RiverStone Health has maintained strong partnerships with several community organizations and has worked to identify new community partners available to assist patients with socioeconomic needs.

Creation of Windows One Note Program

The Care Management team created a system utilizing Windows One Note program to aggregate all the community resources available to patients to assist with social determinant needs. The Care Manager Coordinator updates the One Note system with any new resources on an on-going basis. The One Note program includes patient educational handouts and maps that can be printed and given to patients to further assist patients with getting connected to needed services.

Staff Educational Opportunities to Learn About Various Community Services

The Care Manager Supervisor coordinated educational opportunities for staff to learn more about the various community services in their area. For example, RiverStone Health invites social service agencies to speak at monthly staff meetings so that staff have the opportunity to learn more about the community assistance programs.
RiverStone Health followed the PRAPARE Risk Tally Score Methodology to assign each risk factor in PRAPARE a 1-point value. They used the PRAPARE risk score to create a distribution across their population to better identify high risk patients and low risk patients. For example, patients with a score of >36 were automatically offered care management services. They then integrated the PRAPARE risk scores into a risk stratification model inclusive of chronic disease scores, mental health scores, and cost scores to have a more comprehensive risk stratification model that focused on both clinical and non-clinical risks. The chronic diseases taken into account in the scoring algorithm were diabetes, hypertension, asthma, COPD and IVD. Mental health diagnoses ranged from depression all the way to schizophrenia.

RiverStone’s experience incorporating PRAPARE data into a risk stratification model have been considered in a 2019 Learning Collaborative hosted by the PRAPARE team to develop a common national risk stratification model that includes both clinical and non-clinical risk data from PRAPARE.

**Reports have been developed to track responses on the PRAPARE form as well as the overall number of patients that have completed the screening tool. In 2018, 5,511 patients at RiverStone Clinic completed the PRAPARE form. The highest-ranking social drivers of health reported in 2018 were as follows:**

- Stress
- Medicine/Healthcare Insecurity
- Food Insecurity
- Social Isolation
- Transportation to Medical Appointments
- Afraid of Partner/Ex-Partner

**Next Steps**

RiverStone plans to do further analyses on their PRAPARE data and risk stratification results to better:

- Identify and manage high-risk populations with goal to improve population health measures, such as preventive health screenings and chronic disease management
- Assess whether community resources have been identified to assist patients in areas of need
- Update RiverStone’s resource library
- Build and expand more community partnerships to fill the care gaps identified
- Determine the overall impact of social determinants of health and care management intervention on chronic disease management. RiverStone has already noticed that patients who had documented care plans had improved HbA1c levels compared to high risk patients who did not receive a care plan due to various reasons. RiverStone would like to explore this further.

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