



CHAPTER 1

Understand the PRAPARE Project

This chapter provides an overview of the PRAPARE project in regards to its history, its importance, and its future. It also contains a copy of the most recent version of the tool and answers to frequently asked questions.

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What Is PRAPARE and What Does It Help Me Do?

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect and apply the data they need to better understand their patients' social determinants of health. As providers are increasingly held accountable for reaching population health goals, they need tools and strategies to identify the upstream socioeconomic drivers of poor outcomes and higher costs. With this data, they can transform care with integrated services to meet the needs of their patients, address the social determinants of health, and demonstrate the value they bring to patients, communities, and payers.

PRAPARE is both a standardized patient social risk assessment tool consisting of a set of national core measures as well as a process for addressing the social determinants at both the patient and population levels. By using PRAPARE, providers can better target clinical and non-clinical care (often in partnership with other community-based organizations) to drive care transformation, delivery system integration, as well as improved health and cost reductions.

PRAPARE propels providers who serve underserved populations towards transformed, integrated care and the demonstration of value. Understanding patients' social determinants will allow providers to:



To accomplish these goals, it is important for all users of PRAPARE to collect data on ALL of the core measures of PRAPARE for data to reach critical mass and be strong enough to paint a full picture of the socioeconomic challenges that patients face across the nation.

What Does PRAPARE Measure?

The [PRAPARE tool](#) is both evidence-based and stakeholder driven. It was informed by research on social determinant of health domains that predict poor outcomes and high cost, the experience of existing social risk assessments, and the advice and feedback from key stakeholders including patients, providers, clinical leadership, non-clinical staff, and payers. It aligns with national initiatives prioritizing the social determinants of health (e.g., Institute of Medicine’s recommendations, Healthy People 2020 goals), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10 Z codes, and health centers’ current federal reporting requirements (i.e., Uniform Data System). PRAPARE emphasizes measures, listed below, that are actionable.

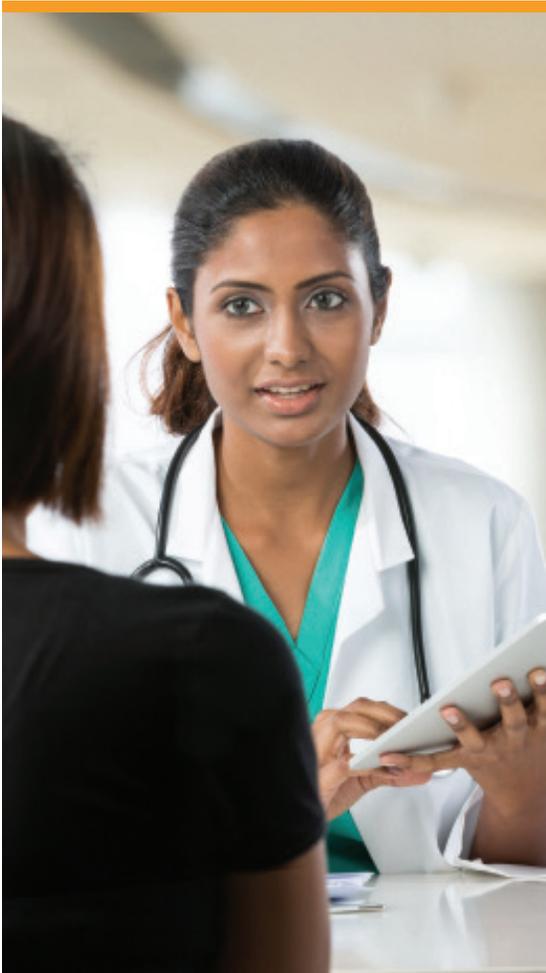
Core Measures in PRAPARE

	PERSONAL CHARACTERISTICS	<ul style="list-style-type: none"> • Race • Ethnicity • Farmworker Status 	<ul style="list-style-type: none"> • Language Preference • Veteran Status
	FAMILY AND HOME	<ul style="list-style-type: none"> • Housing Status and Stability • Neighborhood 	
	MONEY AND RESOURCES	<ul style="list-style-type: none"> • Education • Employment • Insurance Status 	<ul style="list-style-type: none"> • Income • Material Security • Transportation Needs
	SOCIAL AND EMOTIONAL HEALTH	<ul style="list-style-type: none"> • Social Integration and Support • Stress 	
	OTHER MEASURES IN PRAPARE	<ul style="list-style-type: none"> • Incarceration History • Refugee Status 	<ul style="list-style-type: none"> • Safety • Domestic Violence

PRAPARE measures are mapped to ICD-10 Z codes, LOINC codes, and SNOMED codes in our [PRAPARE Data Documentation and Codification file](#) to further standardize data for aggregation and analysis. Many of the PRAPARE EHR templates automatically map to the ICD-10 Z codes so that they can be easily added to the diagnostic/problem list.

Why Should I Use PRAPARE?

PRAPARE is being used by organizations in every state and even across the world. Organizations participating in the national PRAPARE movement include not only health centers and primary care associations but also hospitals, health systems, social service organizations, health plans, state Medicaid agencies, and others. PRAPARE questions have also been incorporated into various federal initiatives, including the Centers for Medicare and Medicaid's (CMS) Accountable Health Communities demonstration project along with the CMS Office of Minority Health's social needs screening efforts for long-term and post-acute care populations as part of the IMPACT Act.



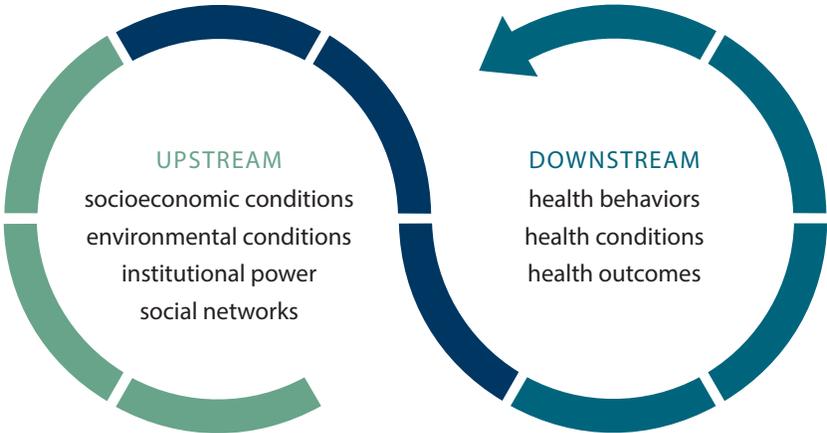
Interest in PRAPARE continues to grow by the day. Organizations like using PRAPARE for the following reasons:

- PRAPARE is evidence-based but has also been tested and vetted by staff and patients in the field
- PRAPARE is patient-centered
- PRAPARE is actionable
- PRAPARE can be adapted to fit within any workflow
- PRAPARE comes with free resources (described further below in the section on "[PRAPARE Resources](#)") to help implement PRAPARE with different populations and respond to needs identified, including:
 - PRAPARE EHR templates
 - Translated versions of PRAPARE
 - PRAPARE Readiness Assessment Tools
 - PRAPARE Implementation and Action Toolkit comprised of user stories, best practices, and lessons learned
 - PRAPARE Youtube Channel to highlight user stories and PRAPARE data findings

PRAPARE resources can be found at our website at www.nachc.org/prapare.

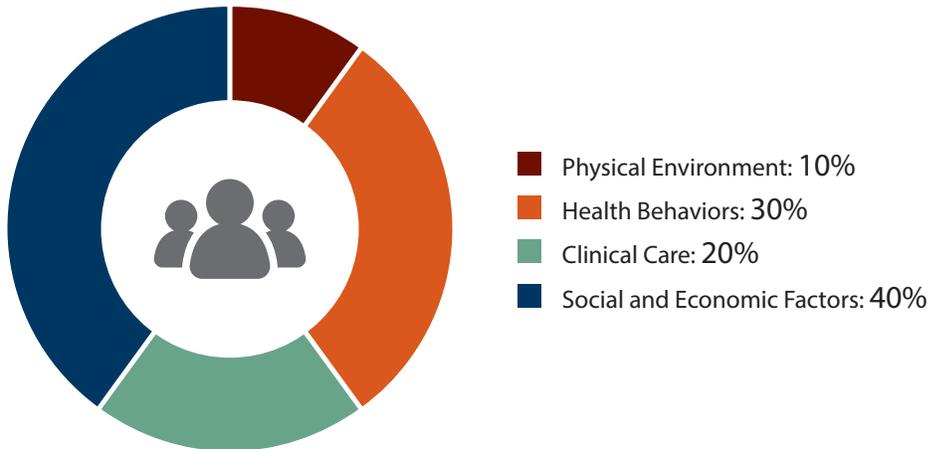
Why Is It Important to Address the Social Determinants of Health?

In today’s value-based care environment, organizations are accountable for improving health outcomes and lowering costs. To achieve these goals and succeed in such an environment, organizations need to better understand their patients and address the upstream socioeconomic factors that impact patients’ health behaviors, health outcomes, and health costs.



The social determinants of health (SDH) are the conditions in which people live, work, play, and age. They can encompass socioeconomic conditions, environmental conditions, institutional power, and social networks. These factors exist “upstream” in that they occur and inter-relate with each other to ultimately influence characteristics that manifest further “downstream,” such as health behaviors, health conditions, and health outcomes. Some social determinants of health are within an individual’s control; many lay outside an individual’s control but ultimately affect their health outcomes. The Robert Wood Johnson Foundation estimates that only 20% of health outcomes can be attributed to clinical care. Upstream social determinants of health account for the other 80%, including social and economic factors (40%), physical environment (10%), and health behaviors (30%) (FIGURE 1.1).

FIGURE 1.1. Social, Economic, and Environmental Factors Play a Large Role in Impacting Health Outcomes



Unfortunately, traditional ways of identifying complex patients is grounded in the “downstream” medical model in terms of number of chronic conditions, health outcomes, and hospital and emergency department utilization. Because the social determinants influence such downstream factors, they should be included in how providers identify and treat complex patients. Care teams must have an understanding of their patients’ complexity (both clinically and non-clinically) in order to make informed care decisions that are patient-centered and interventions that are more appropriately tailored.

Providing services to address the adverse social determinants of health will help organizations successfully participate in value-based pay arrangements and achieve the goals of the Quadruple Aim of better health, lower costs, and improved patient and staff experience. However, current payment systems do not adequately incentivize addressing the social determinants, ensure these services are sustainable, or cultivate community partnerships necessary for approaching health holistically and in an integrated fashion.

Documenting patient complexity using PRAPARE as well as the services and partnerships your organization provides to mitigate the social determinant risks can build the evidence base needed to advocate for sustainable payment systems to support holistic care that goes beyond the medical model and to advocate for policies that support upstream community change.



What Have We Learned After Using PRAPARE?



PRAPARE IMPLEMENTATION LESSONS LEARNED

- PRAPARE can be administered using various staff models and workflows
- PRAPARE data can be collected in Electronic Health Records
- PRAPARE is easy to administer
- Staff find PRAPARE helpful in assessing and addressing patients' needs
- Patients appreciate being asked and feel comfortable answering the questions
- PRAPARE implementation identifies new patient needs and facilitates collaboration with community partners to address socioeconomic needs
- PRAPARE implementation has led to positive changes at the individual patient-, organizational-, and community-levels



PRAPARE DATA FINDINGS

Based on our analyses, we have learned the following information. We are working on several peer review publications highlighting these results as well as conducting additional analyses to learn more about the impact of social determinants of health.

High risk populations experience a greater number of social determinant risks than general populations

- The general population of health center patients faces approximately 5 simultaneous and compounding social determinant risks
- More complex patients face upwards of 10 social determinant risks
- Uncontrolled diabetics experience a greater number of social determinant risks than controlled diabetics

The extent and type of social determinant risks are related to clinical outcomes

- There is a positive correlation between the number of social determinant risks a patient faces and having hypertension
- Patient's being able to afford medicine affects the likelihood of having diabetes control
- Stress levels affect the likelihood of having hypertension control

The most prevalent social determinant of health risks across 2015 - 2017 health center cohorts in 7 states were:

- Limited English Proficiency
- Less than high school education
- Lack of insurance
- Experiencing high to medium high stress
- Unemployment



PRAPARE IMPROVES INDIVIDUAL HEALTH AND LEADS TO COMMUNITY TRANSFORMATION

Organizations are using PRAPARE to develop interventions, form community partnerships, inform population health management, and advocate for upstream systemic change. Below are specific examples as to how PRAPARE has led to change at the individual-level, organizational-level, community-level, and macro-level for policy and payment.

Inform Care and Services:

- Prescribed more appropriate medications based on better understanding of patient's circumstances
- Improved care coordination services
- Cross-trained staff to better respond to social determinant needs
- Negotiated bulk discounts for taxi vouchers and bus tokens for patients in need of transportation
- Collaborated with local community partners (e.g., churches, food banks, daycare organizations, housing agencies, domestic violence programs, etc.) to provide needed services and resources
- Partnered with Uber, Lyft, and other ride-sharing services to provide discounted transportation services for patients in need
- Partnered with local farmers to bring farmers markets to organization for easy distribution of fresh, healthy food

Advocate for Community Change:

- Guided work of local foundations to invest in resources and services where PRAPARE data demonstrated need
- Advocated for regional transportation authorities to build new bus routes to areas in need based on PRAPARE data
- Used data to improve capacity for securing future grant funding

Inform Policy and Payment:

- Informed payment reform discussions at the state level around social determinants of health and their importance in cost savings with State Medicaid agencies and other key stakeholders
- Created more holistic risk score inclusive of clinical and non-clinical data to use for risk stratification and risk adjustment to predict patients with highest needs
- Strengthened relationships with managed care plans to explore different payment methodologies
- Negotiated with payers and Accountable Care Organizations to support intervention services, such as care management, job training, housing services, transportation services, etc.



PRAPARE USER STORY

PRAPARE directly impacts patient-provider relationships in a positive way. A patient from a health center in Ohio who was implementing PRAPARE walked 20 miles barefoot at night to escape a domestic violence situation because she knew the behavioral health nurse who had implemented PRAPARE with her and helped address some of her needs identified by PRAPARE would help her again.



PRAPARE RESOURCES

Available at www.nachc.org/prapare.

PRAPARE TOOL

The [PRAPARE tool](#) can be used as a paper handout to use for administration or to help educate and guide implementation.

FREE PRAPARE ELECTRONIC HEALTH RECORD TEMPLATES

We currently have free PRAPARE templates and configuration/implementation guides for the following EHRs:

- Athena
- Cerner
- Epic
- eClinicalWorks
- GE Centricity
- Greenway Intergy
- NextGen

To access these free PRAPARE Electronic Health Record templates, please go to Chapter 4 of our PRAPARE Implementation and Action Toolkit.

We are working with several other vendors to develop additional PRAPARE EHR templates. For those who use an EHR where a PRAPARE template doesn't currently exist, we also have an Excel file template that allows you to collect standardized PRAPARE data in Excel until a PRAPARE EHR template is developed.

- [PRAPARE Data Collection Excel Template](#)

TRANSLATED VERSIONS OF PRAPARE

We have translated PRAPARE into 26 different languages (available at www.nachc.org/prapare), including:

- Arabic
- Bengali
- Burmese
- Burmese
- Chinese (simplified and traditional)
- Chuukese
- French
- Farsi
- German
- Hindi
- Karen
- Karenni
- Khmer
- Korean
- Lao
- Marshallese
- Nepali
- Portuguese
- Russian
- Somali
- Spanish
- Swahili
- Tagalog and more!

PRAPARE READINESS ASSESSMENT TOOLS

PRAPARE Readiness Assessment Tools (available at www.nachc.org/prapare) can be used to help identify your organization's readiness to implement PRAPARE. The assessment can inform where your organization is at and help you decide where you want your organization to be as well as provide guidance on how to become "highly prepared."

We also have a PRAPARE Readiness Assessment Tool for organizations who are supporting their members with implementing PRAPARE to assess their readiness in providing training and technical assistance capacity.

PRAPARE IMPLEMENTATION AND ACTION TOOLKIT

The [PRAPARE Implementation and Action Toolkit](#) provides resources, best practices, and lessons learned to guide implementation, data collection, and responses to social determinant needs. It focuses on the major steps that are needed to implement a new data collection initiative on socioeconomic needs and circumstances based on the experiences, best practices, and lessons learned of our early adopting PRAPARE pioneers.

PRAPARE YOUTUBE CHANNEL

We have lots of webinars on our [PRAPARE Youtube Channel](#) that highlight functionalities of PRAPARE and the PRAPARE EHR templates, illustrate PRAPARE data findings, and showcase user stories, best practices, and lessons learned.

FREQUENTLY ASKED QUESTIONS ON PRAPARE

Peruse our Frequently Asked Questions document (available at www.nachc.org/prapare) for more information and for answers to commonly asked questions.