FAQ Contents

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Tool Development

- What were the top criteria that were prioritized by stakeholders when PRAPARE was developed?
    - Here are some example criteria provided by NCHPH: domains, length of assessment, reading level, languages available, cost, integration into EHRs, flexibility, resources needed to implement screening tool, rating or ranking

- Regarding the housing status PRAPARE question, how did stakeholders decide to word/phrase that question?
    - There is an interest on how phrasing affects patient sensitivity. NHCHC was involved as a stakeholder and can provide more details on the question.

- What differentiates PRAPARE from homegrown SDOH questionnaires that are already built into our EHR products?
    - PRAPARE is an evidence based and stakeholder driven tool that is actionable, widely used and patient centered. PRAPRE has also been designed to accelerate systemic change. For more information on PRAPRARE please see the What is PRAPARE Infographic and the FAQs.

- Is PRAPARE and SDOH screening the same thing?
    - PRAPARE is national standardized patient risk assessment protocol built into the EHR designed to engage patients in assessing and addressing social determinants of health.
    - PRAPARE stands for the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences

- How were the PRAPARE questions developed?
    - A meta-analysis was conducted of the existing evidence base and risk assessment tools which resulted in a core list of domains and questions as candidates for inclusion in PRAPARE. An iterative process using expert panels, subject matter experts and users in the field resulted in the draft tool that was piloted for both cognitive testing (do people understand the question and answer them in the way intended) and for ease of administration.

- Is there a short version of the tool?
    - Not currently. Although much work has been undertaken in health care to better understand social determinants of health, there is not enough evidence to point to the seminal questions of greatest utility.

- Is there a reason why many of the PRAPARE questions are UDS data elements?
    - A design feature of PRAPARE was to minimize the burden of reporting for health centers. Many of the PRAPARE questions are in data elements used to produce health

center UDS measures. For those with an electronic health record that has PRAPARE embedded those fields are auto populated.

- Will PRAPARE change over time?
  - PRAPARE was developed to be as broad as possible to avoid the need for constant revision. PRAPARE will be updated as the field evolves and where changes are deemed necessary for alignment with the external environment such as CMS and UDS.

- What patients are typically targeted for PRAPARE?
  - PRAPARE is developed to be administered at a population level to help health centers better understand their populations' SDOH factors.
  - Note: Some health centres have chosen to focus only on high cost users due to limited staffing capacity or for a specific program need.

- How long was the process to develop the PRAPARE tool?
  - The process to develop the tool took two years including one year of piloting.

- What languages has PRAPARE been translated into?
  - PRAPARE has been translated into 26 languages. The PRAPARE team worked with a qualified translation vendor to translate PRAPARE. Health centres were engaged to validate and test the translations to ensure that they were accurate and culturally appropriate. To access PRAPARE translations: https://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/

- Were any rural health clinics involved in the PRAPARE pilot? And if so, were there any considerations or implications for SDOH and related interventions in rural areas that differed from urban CHCs?
  - Yes- the pilot teams included both urban and rural centers. The pilot data demonstrated that needs differed depending on the local community context. For example, transportation and social isolation tended to be a larger need in rural areas as opposed to urban areas. The pilot teams located in the rural areas focused on developing innovated interventions to meet these needs. Examples:
    - Iowa: Focused on engaging and developing a relationship with the local transportation authority. From active engagements, the health center was able to negotiate bulk discounts for taxi vouchers and bus tokens. They also geo-mapped their data to highlight areas experiencing the highest transportation need, which will be used to advocate for new bus routes to those areas.
    - Hawaii: Discovered that many of their diabetic patients felt socially isolated. After learning this, they teamed up with local churches and the American Diabetes Association to offer peer support groups for diabetes management in the local churches to provide health care and health education in a supportive environment.

- How have social service agencies been involved in the creation of the PRAPARE tool?
  - No social service agencies were directly involved in the creation of the PRAPARE tool. The question set was derived from the current evidence-based literature which social service agencies contributed input.

- What was the criteria for selecting the final 15 domains?
  - We included six weighted criteria to objectively narrow down our list of SDOH domains to a "core" set for standardized data collection and an "optional" set for local community circumstances and populations. The criteria included:
    1. Actionability for individual patient management
    2. Alignment with national initiatives
    3. Evidence in the literature that links the SDOH domain to higher healthcare costs,
    4. Stakeholder feedback
    5. Additional burden of data collection
    6. Sensitivity for disclosing this information.

Tool Implementation

- Can multi-disciplinary providers use your tool at their agency?
  - Yes
- How often should a PRAPARE form be asked?
  - Recommendations are provided in Chapter 5 in the PRAPARE Implementation and Action Toolkit. However, there is no one standard model- health centers make difference choices based on staffing and data infrastructure.
- What is the starting point to begin implementing PRAPARE?
  - Tips for getting started:
    1. Assess your organization's readiness to implement PRAPARE. The PRAPARE Readiness Assessment Tool can be used to help identify your organization's readiness to implement PRAPARE.
    2. Ensure PRAPARE team, staff, and leadership are all on the same page regarding organizational goals with SDH data collection
    3. Ensure have appropriate staff on PRAPARE team and/or regularly updated
    4. Have internal meetings with PRAPARE team to discuss what's going well, what's not going well
    5. Start small and use PDSA!

- Do all PRAPARE questions need to be answered for the assessment to be completed?
  - It is encouraged to ask full set of core questions as the collection of data becomes a pathway to address community issues

- How can you acknowledge GED as an accomplishment in the education question?
  - The current PRAPARE screening tool has the option to select: High school diploma or GED.

- Is there a PRAPARE that is geared towards pediatrics/adolescents?
  - Currently there is no PARAPARE version that is geared towards pediatrics/adolescents. NACHC is hoping to focus on creating protocols to help organizations implement PRAPARE for pediatric and adolescent populations. There are health centers who use PRAPARE to screen pediatric and adolescent populations, however the way in which they screen will vary based on their staffing model and engagement of family members.
  - Case study Compass Community Health's Implementation of PRAPARE with Pediatric and Adolescent Patients and Their Families that you might find useful.

- Is the use of PRAPARE limited to health centers only, or is there a plan to expand at some point, such as in social services CBOs?
  - The use of PRAPARE is not limited to CHCs and could be used by community-based organizations and other social service organizations.

- Should we begin to collect PRAPARE data now or wait until the pilot is over and the implementation packet is ready?
    - Anyone can start using PRAPARE now! Michigan has a Community Health Worker program underway with many health centers that are using the tool to help guide their work. In Oregon, the clinics in the Alternative Payment Methodology are using the tool as well.

- Addressing social determinants of health can take multiple years to influence the environment and to see the results. Payers typically focus on wanting results in a very short period of time- How does one justify the use of the tool in that sort term results oriented environment?
    - There is no question that some interventions will take multiple years to fully address in the community and more than likely will require partnerships to address. That said, we are increasingly finding that there are interventions that can be done in the short term that can influence utilization or cost. For example, a cohort of patients from a particular zip code could be high cost utilizers and frequent users of an emergency room. One organization found these patients were often no shows in the clinic and by working with the City, a bus route was established that provided access to that community. By gaining access to care in the health center it can avoid the more costly emergency room admissions while decreasing no show rates for the health center. One team in Hawaii discovered that many of their diabetic patients felt socially isolated. After learning this, they teamed up with local churches and the American Diabetes Association to offer peer support groups for diabetes management in the local churches to provide health care and health education in a supportive environment.

- How do you implement PRAPARE to the pediatric/adolescent populations?
    - There are health centers who use PRAPARE to screen pediatric and adolescent populations, however the way in which they screen will vary based on their engagement of family members.
    - NACHC is hoping to focus on creating protocols to help organizations implement PRAPARE for pediatric and adolescent populations
    - Case study Compass Community Health's Implementation of PRAPARE with Pediatric and Adolescent Patients and Their Families that you might find useful.

Cost

- How much does PRAPARE cost?
    - PRAPARE is available for free to end users such as community health centers. Electronic health record (EHR) vendors may charge for technical support if you are unable to configure your system within the resources and expertise of your organization. Some vendors also charge extra for custom reports if you do not have an ad hoc reporting tool capacity with your EHR. For vendors and software companies looking to integrate PRAPARE into their products, please email us at prapare@nachc.org for additional information on licensing agreements.

- Is technical assistance available for non-funded CHCs that are interested in implementing PRAPARE?
    - There is currently no funding available for technical assistance. However, state-based dissemination strategy is being pursued where local coaching and technical assistance can be made available through state based primary care associations and health center-controlled networks.

License Agreements

- What types of License Agreements are there for PRAPARE?
    -
- Can an end user integrate PRAPARE into their own electronic tracking- Such as using Monday.com or Salesforce? Or is a license agreement needed?
    - A Royalty Free end user license agreement is required.

EHR

- How does PRAPARE integrate into an EHR product exactly? What is the effort for EHR developers to support this integration?
    - Each EHR has their own way of integrating PRAPARE into their system. This could potentially be an opportunity for All Scripts to engage with health centers and other stakeholders who use your system to get a better understanding of how they would like PRAPARE integrated. NACHC currently hosts a forum called the PRAPARE Tiger Team that meets bi-weekly to discuss the functionality of PRAPARE in EHR systems. We do have multiple stakeholders who attend/participate in the meetings who use All Scripts. Please feel free to join!
      For more information on the PRAPARE Tiger Team visit:
      https://confluence.nachc.org/x/i4aO

- How do you use the PRAPARE assessment tool with an EHR system?
    - All PRAPARE EHR templates are paired with a configuration and implementation guide to help users incorporate the templates into their EHR and use them in workflow. We also have demo videos on our PRAPARE Youtube Channel that highlight the functionalities of each PRAPARE EHR template and how they can be used in workflow.
    - Most of the PRAPARE EHR templates automatically map PRAPARE responses to ICD-10 Z codes so that staff can easily add ICD-10 Z codes to the problem or diagnostic list. Some of the PRAPARE EHR templates also incorporate our PRAPARE risk tally methodology so that organizations can better understand how many socioeconomic risks their patients are facing and use it for risk stratification. For more information on the PRAPARE risk tally methodology, please read Chapter 6: Develop a Data Strategy.
    - A licensing agreement is needed for an EHR system. If the EHR system you use doesn't have PRAPARE built into the platform, please submit a request to your Account Representative and also email our team at: prapare@nachc.org.

- Are there resources and tools on incorporating SDOH data into treatment plans, documenting referrals and measuring improvement?
    - In terms of incorporating SDOH data into treatment plans, there are several factors that impact feasibility. First, does the EMR have PRAPARE built into it's software. If so, then the next question is if the information collected using PRAPARE is then "pulled" over into treatment plans. This is more of a data infrastructure factor. The same can be said about electronic referral platforms, which may have the capacity to do this. Please keep in mind that this level of interoperability is a work in progress.
    - The larger question about collecting SDOH data is not only who on the care team is collecting the information, but then who has access to see the data and then act on it. It is important to engage the care team and test what strategies work best for collecting SDOH needs and then how that would be used in treatment plans and referrals.

- What have clinics experienced as a barrier of building the PRAPARE assessment tool into their EHR?
    - Barriers to keep in mind include:
        - License Agreement is needed for an EHR system to use PRAPARE (It should be noted that end-users can use PRAPARE for FREE).
        - Working with the EHR vendor to make sure that PRAPARE is implemented into the system in a user-friendly way.

- Is PRAPARE a paper-based tool or available electronically?
    - PRAPARE is available in a paper format and can be built as a template for electronic health record (EHR) systems.

- Is PRAPARE a web-based tool that is offered as a software service?
    - No, the electronic versions are imbedded in electronic health records.

- Is PRAPARE available in all electronic health record solutions?
    - PRAPARE is currently available in the following EHRs:
        - EPIC
        - NEXT GEN
        - eClinicalWorks
        - GE Centricity
        - Athena
    - EHR vendors may choose to add PRAPARE as a new feature if there is enough demand from the market. Ask you vendor to add PRAPARE as a new tool set.

Referral Platforms

- How do centers best use the information they receive on the PRAPARE tool to connect people in need to services in their community?
    - Community Resource Platforms such as 211, Aunt Bertha, Healthify, NowPow, OneDegree, UniteUs. Each has different features and tradeoffs to consider.

  - Build off of PCMH requirements and use data for PCMH re-recognition
  - Participate in local collaboratives with other health, human service, and social service organizations
  - Think about staffing needs and further community partnerships needed to connect patients to necessary interventions
  - Engage in your community and work to develop cross-sector partnerships
  - Start with most common SDOH needs (i.e. food, housing and transportation)

- How do referral platforms use PRAPARE?
  - Health Centers and other providers do use a variety of resources and referral platforms to implement PRAPARE. Aunt Bertha is one of the referral platforms options.

Workflow

- When do you graduate a patient from case management program?
  - In terms of how to keep a patient active within case management, it depends on the acuity of both their medical and social needs. If their physical health is stable but they have a persistent social need, it's best to keep them engaged and support them. As you stated, complete the PRAPARE screening annually (some questions don't need to be asked again) to determine if the situation has changed. It's great the clinic is using PRAPARE to identify social needs and many times, these are the barriers that most impact a person's health and their journey to being healthy.

- How long does the staff continue to engage with patient when they're focused on other priorities?
  - In terms of patient engagement, it's best to partner with them to see what is their priority in terms of their health and strategies to be healthy. If patients have too many social needs or stressors, they may not prioritize their health and care plan. Partner with them to see where they're at, what challenges or worries are top of mind, and then work with them. Co-create the care plan with the patient and/or caregivers to capture their insights and give them permission to say no or to prioritize something else. The Stages of Change (Transtheoretical Model) is a wonderful resource to remind us that people are in different stages when it comes to personal change. Typically, if a patient is prioritizing other aspects of their lives and not focusing on their health, you may need to dig a little deeper. This is where Motivational Interviewing can be really helpful in working with patients and unearthing their thoughts and challenges. Based on what you learn, you can adjust your approach.

- How do providers / patients interact with PRAPARE?

- This will vary on the ground with end-users and it will depend on the health center or facility workflow. Some sites complete the PRAPARE screening face to face with a member of the care team- (clinical or non-clinical), others have implemented IT enabled strategies such as the use of Ipads in the waiting room. For more information on workflow examples please review the PRAPARE Implementation Toolkit.

- Can we make modifications to the questions?
  - Need to get approval from PRAPARE team prior to any modifications

- How do other agencies incorporate the screening tool into a primary care visit?
  - Use the Five Rights Framework (discussed in Chapter 3: Strategizing PRAPARE Implementation) to determine the best PRAPARE data collection and response workflow for your own setting.
  - Reference Chapter 5 "Workflow Implementation" for further tips on how to incorporate PRAPARE screening into a primary care visit.

- How do you motivate staff to find time to administer screening?
  - It is important to demonstrate how PRAPARE is making a difference in your organization and/or your community in order to sustain engagement and motivation. There are several ways to do this:
    - CELEBRATE SUCCESSES
      It is important to celebrate successes, no matter how small.
    - ENCOURAGE FRIENDLY COMPETITION
      Care teams can engage in friendly competition around meeting or surpassing milestones.
    - VISUALIZE THE DATA
      Results around the number of social determinants patients are facing, which social determinants are most prevalent in your community, and the percent of your community who are facing particular social determinant risks are key datapoints to share with your staff and community. Visualizing the data using dashboards, graphs, or infographics allows staff to better see and understand how the data can be used to inform care and population health efforts.
    - APPLY LESSONS LEARNED
      Based on their PRAPARE data, some organizations have decided to focus on a different social determinant of health each month or quarter so that they find or develop educational resources related to that social determinant of health.

- Can PRAPARE be used with additional screening tools such as SBIRT, PHQ2?
  - Yes. PRAPARE could be one of several tools you use to better understand your patients and better plan a treatment and care plan.

- If SDOH data is already being collected- does PRAPARE replace our questions or workflow?

  - Congratulations on your work! No- PRAPARE is not meant to replace your current questions or workflow. However, by including PRAPARE into your workflow will allow standardization of questions for benchmarking purposes. PRAPARE is quickly becoming adopted by health centers and various stakeholders and will have the ability to facilitate benchmarking across organizations and is intended to align with national accepted measures. The more aligned your questions are with the growing national consensus on measures that is reflected in the PRAPARE tool the better are your prospects from benefiting from the benchmarking and risk adjustment tools and resources that may evolve.

- Health centers already feel overwhelmed with data reporting requirements. How can we reduce burden?
  - The PRAPARE tool was designed to present minimum burden on staff. Total time to administer is less than nine minutes with many questions already being asked.

- What is the benefit of implementing the PRAPARE tool?
  - 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.
    - Provides a pathway to tackle many of the social determinant issues that staff traditionally have felt powerless to address
    - Positive impact with staff and patient relationship

- Is there any education required to administer PRAPARE or can any staff or "lay" person (volunteer) ask the questions and capture the data?
  - The tool is designed to be administered from all levels of staffing- educational level is not a factor in administration. A staff training guide is available that describes the importance of the tool and includes sensitivity training and examples of how the data can be collected.

- Can it be integrated into case management?
  - Yes, PRAPARE can be integrated into case management, specifically using the paper version of PRAPARE. In terms of the EHR- this would be a function of the vendor solution and would require configuration guidance.

- What is the total time to administer the PRAPARE tool questions?
  - Time to administer for the full question set is nine minutes or less.

- Some of the personal characteristic questions are duplicative of what we capture from our customers. Can we omit those questions from the tool for our customer population

  - Yes- if you are already collecting the data in another format you may omit those questions.

- How often should the PRAPARE questions be asked?
    - After the initial PRAPARE questionnaire has been administer, organizations can decide on the frequency of reassessing the questions. For example, race and ethnicity might be answered once and then revalidated annually. Or a health center might determine that a material security question is needed to be asked at each visit due to the local economic condition

Data, Research, and Evaluation

- What sort of standards are involved? For example, how does PRAPARE align with the work being done in the HL7 Gravity project?
    - NACHC is actively involved with Gravity- we sit on both the executive committee and technical committee.
      Data Dictionary

- Does PRAPARE support any sort of reporting functionality?
    - We are very interested in exploring reporting functionality but currently PRAPARE is a standardized social risk screening tool. We however aware that several systems are working on this aspect.

- What is the "output" of PRAPARE? Is it just a matter of providers being able to see the survey answers in patients' charts? Are there clinical recommendations provided based on the answers the patients provide?
    - PRAPARE identifies social risk patients and provides organizations with data at the population level to make changes at the organization level and community level. Organizations respond differently based on their own staffing models, community partners, and internal resources. Many also use referral platforms such as NowPow and Aunt Bertha in conjunction with the PRAPARE protocol.

- Are there further details on the source and validation of the 2 intimate partner violence questions on PRAPARE (#20&21)?
    - The safety and domestic violence questions were made optional in the final tool because some health centers felt it might be hard for their staff to ask these questions without being able to refer the patients to resources.
    - There is no validation for individual questions, but the PRAPARE tool is validated both in practice and with data as we stated in the validation fact sheet. The team conducted an environmental scan of 50+ existing screening tools, interviewed 28 screener developers, conducted a literature review on the health implications of social risks, and scanned national SDOH initiatives to identify the SDOH domains (including the two in question) to include in PRAPARE. The wording of PRAPARE was reviewed by a health literacy expert and measured it to be a 4.5 readability level or a 4th – 5th grade reading level.

- What are we supposed to do with someone who scores a 4 vs. someone who scores a 10? Are there guidelines for that - or are the interventions specific to each category? Or is each health center responsible for coming up with P&Ps when/if to address additional measures based on the risk tally score?
    - After completing the PRAPARE questionnaire and tally sheet, if a positive outcome is noted, that allows staff to identify potential resources that could assist the individual who noted an SDOH need. There is no bad scoring or weighted scoring associated with

PRAPARE. The PRAPARE Risk Tally Scoring Sheet can also be used as a population management tool- to look at how many of your patients have certain SDOH needs/ or number of needs.

- The optional questions are not included on the scoring guide. Are the optional questions scored similarly to the core set questions?
    - The scoring guide is a tally- and it is recommended to tally the score of each optional questions that identify a risk as a one (similar to how the core questions are tallied)

- Why do we need these social intervention codes if we can map PRAPARE need to SNOMED or CPT codes directly?
    - CPT and SNOMED are not all specific to PRAPARE needs nor are they comprehensive in the alignment with PRAPARE. Stakeholders have informed us they need a better system that fills these gaps that align with PRAPARE. As mentioned (supplementary documentation slide), we are also capturing a lot more than what is in SNOMED and CPT including capturing social intervention closed loop referral status.

- Movement in and out of clinical settings and therefore inability to follow-up is often a problem in a low-resourced patient population. How long do patients remain in the data set on average?
    - This is a great point. The vision is to have integrated systems (e.g. in partnership with other providers and social service organizations partners) so that we can better follow and coordinate patient care in low-resourced areas. The closed loop referral status documentation we are developing will be very helpful to ensure communication between organizations for this purpose.

- Is there any national advocacy toward including the ICD-10 codes related to SDoH in calculating a patient risk score in the electronic health record?
    - Yes, we have a PRAPARE Risk Stratification effort, where we developed an algorithm to calculating a patient's risk score based on clinical conditions (ICD-10 codes), behavioral/substance abuse conditions (ICD-10 codes), PRAPARE SDOH needs (ICD Z codes), and ER utilization/hospital stays. Accurate risk scores are important to managing care as well as managing your patient panel. This will also become increasingly important as more services are reimbursed under a value-based care model.
    - Social Data into Risk Stratification Models to Improve Health Equity and Demonstrate Value Webinar

- How is PRAPARE to achieving alignment with SDOH e-referral vendors and also Pathway HUB models?
    - As with PRAPARE, we recognize that national alignment and interoperability are very important. We are engaged with national partners (e.g. Gravity) and vendors to have this ongoing discussion for alignment. If you have any suggestions for those to ensure we engage with, please email me at rcweir@aapcho.org.

- Does the practice of risk adjustment inadvertently conceal health disparities? If so, how can PRAPARE bring those disparities to light?
    - Risk adjustment is not risk stratification.
        - **Risk Stratification:** Process or tool for identifying – and predicting – which patients are at high risk (or likely to be at high risk) and prioritizing the management of their care in order to prevent worse outcomes (care team, clinic level)
        - **Risk Adjustment:** is a method to offset the cost of providing health insurance for individuals who represent a relatively high risk to insurers (policy, payment level)
    - The PRAPARE risk stratification tool will need to undergo further testing
- Why Include SDOH Data in Risk Stratification Modeling?
    - Incorporating social and demographic factors into medical risk models enhances predictive power and provides a more complete picture of the patient.
- How/ what does the PRAPRE Risk Assessment tool score?
    - Risk tally score" represents the cumulative number of distinct risks that are present vs absent for an individual patient. The social determinants of health (SDH) total score is calculated by summing the total number of present SDH risk responses as defined by literature for an individual patient completing the full PRAPARE assessment. For example, for the domain of housing status, "risk presence" would be defined as not having housing whereas "absence of risk" would be defined as having housing.
    - PRAPARE Risk Tally Scoring Methodology
    - Webinar
- Does the PRAPARE tool have published validity and reliability data?
    - The PRAPARE Validation Fact Sheet highlights how PRAPARE was developed and validated using the 8 "Gold Standard" Stages of Measure Development
- How does PRAPARE impact ICD-10 CM coding of the Z codes at hospitals?
    - PRAPARE is cross mapped to include ICD-10, LOINC, SNOMED and many of the PRAPARE EHR templates have used crosswalks to map PRAPARE measures to ICD-10 codes.
    - There are new proposed codes for PRAPARE in LOINC and ICD-10
    - PRAPARE Data Documentation available in Toolkit refer to our data dictionary with the cross walk to z codes
- How do you avoid double documentation?
    - Crosswalk your data/documentation by:
        - Review your intake forms
        - Are there areas where you already collect information that is also in PRAPARE?
            - Income verification forms

        - Self-management forms
    - Many PRAPARE EHR templates automatically map to practice management system and/or demographics section and auto-populate that into PRAPARE template

- Why is it important to have a standardized tool?
    - Standardized data will enable cross-setting data collection, outcome comparison, exchangeability of data, and comparison of quality within and across CHC settings. In addition, standardized data has the potential to improve patient outcomes by improving coordination of care and planning.

- Why is it important to collect social determinate of health (SDOH) data?
    - Health Centers have understood the importance of social determinants of health since the inception of the health center movement. This includes a recognition that patients with social determinants of health may require more resources to support their needs.
    - By systematically collecting standardized questions on SDOH enables CHCs to gain better insight on their population of patients being served. This data can demonstrate the value CHCs add, compared to other community providers and help to target resources to those who might benefit the most.

- What is the link between patient level data in PRAPARE and community level data thru GIS/CHNA?
    - A health center is accountable for a panel of assigned patients regardless of whether they come to you for care or not. Ideally, an organization would have a data strategy that enables information from various sources to be integrated and turned into actionable information for patient care delivery and population health planning. PRAPARE could be one of several tools you use to better understand your patients and plan care.

- Why do we need to calculate a patient's overall risk score?
    - By assessing individual risk enables you to focus your care management resources. For example, changes in a person's life resulting from several social determinants of health might quickly lead that person to become a high cost utilizer. By understanding the issues and intervening in real time, one might help that person in crisis while avoiding near and long-term costs and demand for services.
    - Furthermore, as we systematically collect at an individual level and then roll up the data to see at a population level it enables an organization to focus energies on those SDOH most influencing their patient population.

- How do you counter the argument that risk adjustment masks disparities?
    - Risk adjustment is not a solution but rather a tool that can be used to unmask disparities to help better understand the role disparities play in driving patient complexity and cost.

- Why do we need to collect both patient-level SDOH and ES data?
    - Enabling Service Accountability Project (ESAP) is a standardized data collection system to track and document the different nonclinical strategies and interventions used to address SDOH.

- Do others already collect this data such as health plans, ACOs, & Medicaid?
    - Historically there have been few standardized measures or tools available to collect SDOH. The Institute of Medicine in 2015, recommended systematic data collection of
    - SDOH and proposed domains and measures to better understand which SDOH have the greatest impact on the needs of an individual or a population. Those who are responsible for the cost of populations of patients such as Medicaid or an ACO have acknowledged that many of the root causes driving utilization and cost are related to social determinants of health such as transportation, homelessness, etc.

- How are PRAPARE data collected by health centers?
    - Health Centers that use PRAPARE develop individualized workflows based on their local care team and staffing models. A concept of "no wrong door" can be implemented, where any staff member can administer the questions based on the center workflow and staffing resources available. Examples of workflow include:
        - Administering the questions in advance of the visit while waiting to be roomed
        - Administering the questions during rooming
        - Administering the questions to only high-risk patients

- Why were some measures listed as optional or not included?
    - In order to reduce the burden of collection, the current PRAPARE version focuses on a minimal data set while offering the greatest utility and potential for impact. As patients respond to core questions, it might trigger the need to drill down and ask other questions in a specific domain.
    - As a national learning community evolves, additional questions may be added to a library that health centers can choose to add to their workflow based on local need.

Policy and Advocacy

- CMS has launched an Accountable Community program and it appears there will be questions endorsed by CMS on SDOH. Do they conflict with PRAPARE?
    - The PRAPARE project team worked closely with many national organizations including CMS in order to facilitate alignment of how SDOH are measured. The CMS questions have yet to be announced but once they are made available an effort will be made to align PRAPARE where possible.

- How do you convince payers to take homegrown PRAPARE data?
    - PRAPARE is aligned with Meaningful Use 3 and with ICD-10 which payers use to meet their billing and compliance needs. Payers are using their own risk adjustment tools which have historically been developed from encounter data and have not factored in SDOH.
    - PRAPARE offers payers the opportunity to develop an even greater understanding of their member population and can be the foundation for working with health centers to address the issues which are driving cost and utilization.

- How could social service organizations that serve many of the clients served by the health centers take advantage of the alternative payment method? Social service organizations address many of the social determinants of health.
    - Systematic collection of data on the needs of the population could be used by social service organizations to advocate to their funding sources. Social service organizations are encouraged to join the national learning community as it evolves and benefit from the opportunities to share insights and best practices.

Communications

- Can you describe the linkages between health centers and their states?
    - Partnerships between health centers and their states vary and is based on several factors. It's always good to include Primary Care Associations as they may have partnerships with statewide agencies (either developed or in the works). The next entity to check with is with local and state health departments.

- How are clinicians and staff identifying actionable outcomes from the screeners to ensure that this is not a data-extractive process, but rather a patient-centered tool for care planning?
    - Focus is on building relationships with your patients
    - Shift mindset from "collecting data" to getting to know your population one person at a time
    - Keep in mind that one person's data is another person's difficult life experiences, so important to emphasize sensitivity, compassion, strengths, autonomy, privacy, etc.
    - More information and resources on patient-centered approaches including, empathic inquiry, cultural humility, motivational interviewing can be found in Chapter 2 and Chapter 5 in our PRAPARE Implementation and Action Toolkit

- How do you counter the question/argument, why should you risk adjust if all patients have Medicaid (and therefore the same income levels)?
    - The fact people are on Medicaid only addresses part of the poverty issue. Material security goes beyond whether you can afford health insurance. One must understand issues such as food insecurity, access to medications or transportation to care delivery resources, and homelessness among other factors. In CHCs, the patients are likely to have more co-morbid conditions and confounding social determinants of health issues underpinning their health status. Risk adjusting enables one to understand how to concentrate resources for care delivery within your panel of patients but also presents the opportunity to better educate payers in order to explore reimbursement approaches that address the resources needed by health centers to address SDOH.

- What if patients are reluctant to answer the questions or if they feel some questions are irrelevant?
    - Part of the training in administration of the protocol includes addressing unanswered questions. There are no penalties for not answering a question. If a set of questions are routinely not being answered, the organization may want to explore the reasoning as it could point to deeper issues (i.e. limited health literacy).

- What if staff are reluctant to ask questions if they feel they do not have the ability to respond to the needs?
    - Encourage and train staff to ask all questions as the collection of data becomes a pathway to address community issues. Using the PRAPARE tool can unearth

interventions that staff can lead (e.g. referral to a foodbank for a food insecurity question). This can generate a sense of empowerment and increased job satisfaction.

Miscellaneous

- Why did CMS create the AHC Health-Related Social Needs Screening Tool when PRAPARE seems to have already been in existence.
    - PRAPARE is the most widely used screening tool amongst Health Centers and the CMS ACH tool is focused on 5 SDOH domains and was created for a demonstration project that is related to evaluation.

- PRAPARE sounds great but where do we go to find point of service interventions or approaches to community-based interventions?
    - A toolkit is accompanying PRAPARE that provides insights on how to develop a systematic program and examples of strategic approaches at both a patient and community level. In addition, a national Learning Action Network is being formed to provide a forum for sharing with peers and subject matter experts in order to accumulate best practices over time.

- Are there any clinic characteristics (e.g., workforce mix, patient volume, payer mix, etc.) that predict more robust enabling services and other SDOH interventions?
    - It is too early to draw any conclusion from the pilots due to the small sample size tested. This is an area for further research in Phase 2 of the project.

- What is the general reaction from patients when screened using the PRAPARE tool?
    - Patients have reported positive reactions to the questions as evidence that the health centers care about their patients beyond their clinical needs or complaints of the moment that brought them to the health center.

- Is this tool used internationally?
    - Not that we know of- PRAPARE is the most Dominant SDOH risk screening tool used by health centers and Medicaid managed care organizations. We also know that it is used throughout the US and territories.