PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

FAQ Contents

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Tool Development

- How up to date is the PRAPARE® form? *(2022)*
    - The PRAPARE® tool was copyrighted in 2016. Any public facing materials on the PRAPARE® website is always the most current one.

- Regarding the "Refugee" question- what is the official definition that is used for the PRAPARE® question- Do you use the term "refugee" loosely or stick with the big R "Refugee" with rights and entitlements? *(2022)*
    - In general we try to keep the definition broad so that we are aligned with national coding for standardization purposes (including z codes). The PRAPARE® Team recently released a newer version of our data documentation that includes crosswalks to national codes including z codes (for refugees and all domains) .
    - Here is the Refugee definition we have used in our previous work (adapted from HHS) in case it's helpful:

      Refugee

      Refugees are people who were persecuted in their countries because of their race, religion, nationality, membership of a particular social group, or political opinion. Refugees are admitted to the U.S. for protection and have a pathway to citizenship. Refugees who are admitted to the United States meet the immigration status eligibility requirements for immediate access to Medicaid, the Children's Health Insurance Program (CHIP) and the health coverage options under the Affordable Care Act (ACA). Many other immigrant groups in the U.S. have to wait five years before they are eligible for public benefits like Medicaid. Knowing the difference can help you with your ACA outreach and enrollment activities. Adapted from HHS: https://www.acf.hhs.gov/sites/default/files/documents/orr/fact_sheet_refugees_and_the_affordable_care_act_508_8_27_13b_508.pdf

- Do you know if any of the tools mentioned below were used to develop the IPV questions in PRAPARE®? *(2022)*
    - Humiliation, Afraid, Rape, Kick (HARK)
    - Hurt, Insult, Threaten, Scream (HITS)
    - Extended–Hurt, Insult, Threaten, Scream (E-HITS)
    - Partner Violence Screen (PVS)
    - Woman Abuse Screening Tool (WAST)

    - The PRAPARE® questions were adapted from HARK as we emphasized alignment with other tools. However, it is not exactly the same as it was changed slightly as a result of our Advisory Committee feedback and piloting that took place in 2015-2017.
    - As we delve into PRAPARE® 2.0, we are revising it with feedback from Futures Without Violence and additional Advisory Committee feedback.

- When will PRAPARE® 2.0 be available? *(2022)*
    - In terms of PRAPARE® 2.0, it is currently being piloted which began in March 2022 and will continue until March 2023. Based on the findings and feedback from the pilot team, the National PRAPARE® Team at NACHC and AAPCHO will work with the PRAPARE® 2.0 Advisory Committee to determine next steps. At the earliest it would be 2024 but we're not sure at this point. Since only one team is piloting the updated version, we may have a 2nd phase of the pilot with multiple sites (5-7) in geographically diverse areas as well as diverse patient populations.

- What is the logic behind each question, specifically the one that asks for Education level? *(2021)*
    - When PRAPARE® was initially developed, a literature review helped identify key measures of social determinants of health needs that should be assessed to inform patient care and population health efforts. When piloted by community health centers and participating staff members it was reported that the questions used in PRAPARE® to identify social needs were helpful in identifying referrals and resources for patients, which ultimately led to improved outcomes. Health center staff reported that using PRAPARE® also helped them build relationships with patients and they learned more about ways to improve care. For example, for patients with low literacy levels, they were referred to community health workers that could provide individual level education and coaching. Additionally, health center staff were mindful to provide information in a simple and understandable format. Chapter 1 in the PRAPARE® Implementation and Action Toolkit provides an overview of social determinants of health and why it is important to collect data related to social needs.

- Is there an algorithm or best practice to use for how patients respond to the PRAPARE® questions? For example, if a patient indicated having less than a high school degree, is there a specific referral route you take the patient? *(2021)*
    - In the PRAPARE® Implementation and Action Toolkit, Chapter 9 provides an overview of why each domain in PRAPARE® is important and what to do when a patient identifies a need. We encourage you to also look at Chapter 8 to learn more about developing partnerships to address patient-level social needs as well as ways to use PRAPARE® data for advocacy efforts.

- What were the top criteria that were prioritized by stakeholders when PRAPARE® was developed? *(2021)*
    - Top criteria included: domains, length of assessment, reading level, languages available, cost, integration into EHRs, flexibility, and resources needed to implement the PRAPARE® screening tool.

- Regarding the PRAPARE® housing status question, how did stakeholders decide to word/phrase that question? *(2021)*
    - 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 EHR products? *(2021)*
    - PRAPARE® is an evidence based and stakeholder driven tool that is actionable, widely used and patient centered. PRAPARE® has also been designed to accelerate systemic change. For more information on PRAPARE® please see the What is PRAPARE® Infographic and the FAQs.

- Is PRAPARE® and SDOH screening the same thing? *(2021)*
    - PRAPARE® (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences) is a national standardized patient risk assessment screening tool designed to engage patients in assessing and addressing social determinants of health.

- How were the PRAPARE® questions developed? *(2021)*
    - 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 reason why many of the PRAPARE® questions are UDS data elements? *(2021)*
    - 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? *(2021)*
    - 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® ? *(2021)*
    - PRAPARE® is developed to be administered at a population level to help health centers better understand their populations' SDOH factors.
    - Note: Some health centers 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? *(2021)*
    - The process to develop the tool took two years including one year of piloting.

- What languages has PRAPARE® been translated into? *(2021)*
    - PRAPARE® has been translated into over 25 languages. The PRAPARE® team worked with a qualified translation vendor to translate PRAPARE®. Health centers were engaged to validate and test the translations to ensure that they were accurate and culturally appropriate.

- 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? *(2021)*
    - 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 innovative 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? *(2021)*
    - 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? *(2021)*
    - 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

- Is there any condensed version of PRAPARE® ? *(2021)*
- Is there a shorter version of the tool? *(2021)*
    - There is no condensed version of PRAPARE® . You may decide that some questions may need to be only asked once/annually such as race and ethnicity. If you are looking to modify any of the questions- you will need to get approval from the PRAPARE® team prior to any modifications.
    - 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.

- Do you have to use every question in PRAPARE® or are there elements such as the non-social needs that we can exclude? *(2021)*
    - It is encouraged to ask the full set of core questions as the collection of data becomes a pathway to address community issues- but you may decide to exclude questions from PRAPARE® to best suit your population and data needs.

- Do all PRAPARE® questions need to be answered for the assessment to be completed? *(2021)*
    - It is encouraged to ask full set of core questions as the collection of data becomes a pathway to address community issues

- Can multi-disciplinary providers use your tool at their agency? *(2021)*
    - Yes

- How often should a PRAPARE® form be asked? *(2021)*
    - Recommendations are provided in Chapter 5 in the PRAPARE® Implementation and Action Toolkit. However, there is no one standard model- health centers make different choices based on staffing and data infrastructure.

- What is the starting point to begin implementing PRAPARE® ? *(2021)*
    - 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!

- How can you acknowledge GED as an accomplishment in the education question? *(2021)*
    - The current PRAPARE® screening tool has the option to select: High school diploma or GED.

- Is there a PRAPARE® version that is geared towards pediatrics/adolescents? *(2021)*
- How do you implement PRAPARE® to the pediatric/adolescent populations? *(2021)*
    - 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? *(2021)*
    - The use of PRAPARE® is not limited to CHCs and could be used by community-based organizations and other social service organizations.

- 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 short period of time- How does one justify the use of the tool in that short term results-oriented environment? *(2021)*
    - 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.

Cost

- How much does PRAPARE® cost? *(2021)*
    - 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® ? *(2021)*
  - 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.
  - NACHC offers a fee for service TTA that can assist with implementing PRAPARE® . To inquire contact the PRAPARE® team at prapare@nachc.org

License Agreements

- What types of License Agreements are there for PRAPARE® ? *(2021)*
  - There are several types of license agreements.
    - End User License Agreement
    - Provider Network License Agreement
    - PRAPARE® Amalgamated License Agreement
    - Royalty Free License Agreement
    - Regular License Agreement
    - Enterprise License Agreement
  - For more information on license agreements or to better understand which license agreement is the most appropriate for you- contact the PRAPARE® team at prapare@nachc.org

- Can an end user integrate PRAPARE® into their own electronic tracking- Such as using Monday.com or Salesforce? Or is a license agreement needed? *(2021)*
  - A Royalty Free end user license agreement is required. Contact the PRAPARE® team at prapare@nachc.org.

EHR

- How do we know if our EHR system has access to PRAPARE® ? *(2022)*
  - There are several EHRs that have active license agreements. If you are not sure if your EHR vendor has an active license agreement or if EHR Vendor is interested in building the PRAPARE® screening tool onto the platform, please send us an email at prapare@nachc.org and we can follow up.

- How do we better access patient needs in the EHR with using PRAPARE® ? *(2022)*
  - We recommend sharing the reports internally with each other that could be part of regular meetings. This will allow the care team to share the data with each other. By having these conversations, the care team members can review the results of the documentation and identify patients with the highest needs.
  - It is important to empower your staff to be able to use the data that they collect and encourage them to keep collecting and reviewing the data to further patient improvement.

- Once we collect the PRAPARE® data in our EMR, and document it - Where should we collect and compile this information at? *(2022)*
    - This will vary from one CHC or organization to another. Some may have a common platform that is used in order to share data with each other and others may have different methods to compile the data. Currently there is no central data hub for PRAPARE® data that is collected.

- Are the examples to when a referral for a positive PRAPARE® screening was sent to a community-based organization using a "direct connect messaging" referral from the EMR? Is it always necessary to buy a third party software like NowPow to receive and send referrals related to PRAPARE® items? *(2021)*
    - We do not know of any specific examples however between EHRs and the third-party platforms, the critical piece is an API that will allow for that bi-directional communication. At this time, we have not heard of CBO's having an API that will interface with an EHR which is why most use a platform such as NowPow or Aunt Bertha.

- Do you suggest using the PRAPARE® tool directly through EHR or with one of the referral platforms? *(2021)*
    - Choosing the most meaningful workflow for using PRAPARE® is dependent on staffing models at the health center, the EHR platform that is used, and the referral platforms that are available in your community. We recommend doing short term PDSA's to test which models work best for health centers. PDSA's are helpful to track the proposed changes and the impact of changes that were incorporated. There are efforts from EHR vendors to improve interoperability with community referral platforms. It is worth noting that it might be best to document directly in the EHR and then integrate the use of community platforms once EHR platforms have made changes to allow for bidirectional communication. For more information, please read Chapters 3 and 8 of the PRAPARE® Implementation and Action Toolkit.

- Have you found an EHR tool that is proficient with data gathering using the PRAPARE® tool? *(2021)*
    - There are several EHR platforms that have an active license agreement in place to integrate PRAPARE® within their platform and that is available to their respective users. Email prapage@nachc.org to check if your EHR system has an active PRAPARE® license agreement.

- Where can I find the template for the PRAPARE® tool to then connect it to our EHR? *(2021)*
    - The most current version of the PRAPARE® tool (dated September 2016) is available for download on the website. If the EHR Vendor is interested in building the PRAPARE® screening tool onto the platform, please send us an email at prapare@nachc.org so we can review the license agreement process with the vendor.

- How does PRAPARE® integrate into an EHR product exactly? What is the effort for EHR developers to support this integration? *(2021)*
- How do you use the PRAPARE® assessment tool with an EHR system? *(2021)*
    - Each EHR has their own way of integrating PRAPARE® onto their system. It is recommended that the EHR vendor engage with their clients to better understand how they would like PRAPARE® to be integrated.
    - Prior to implementing PRAPARE® onto the EHR system an active license agreement is required (between NACHC and EHR vendor).
    - 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 a 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.

- Are there resources and tools on incorporating SDOH data into treatment plans, documenting referrals and measuring improvement? *(2021)*
    - In terms of incorporating SDOH data into treatment plans, there are several factors that impact feasibility. First, does the EMR have PRAPARE® built into its 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? *(2021)*
    - 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? *(2021)*
    - 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? *(2021)*
    - No, the electronic versions are embedded in electronic health records.

Referral Platforms

- Are you aware of what software is being used by CHCs on the back end for community documentation? *(2021)*
    - There are several online platforms that health centers use to identify community resources and document efforts to meet the social needs of their patients. This comprehensive guide from the Community Health Care Association of New York State provides an overview of each platform, features, and contact information for key individuals:
        - https://www.chcanys.org/sites/default/files/2021-07/CHCANYS%20SDOH%20Vendor%20Guide%202021.pdf

- How do centers best use the information they receive on the PRAPARE® tool to connect people in need to services in their community? *(2021)*
    - Community Resource Platforms such as 211, Aunt Bertha, Healthify, NowPow, OneDegree, UniteUs. Each has distinctive 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)

Workflow

- How can we better access patient needs through the use of PRAPARE® ? *(2022)*
    - The Full PRAPARE® tool allows you to get a comprehensive view of your patient needs. We understand that different facilities will have different challenges that may serve as limitations. It is okay to prioritize some questions over others – we have heard of health centers that are able to take a phased approach.
    - PRAPARE® is a great conversation starter and it's a great way to learn more about your patients. Do not think of PRAPARE® as a transactional occurrence but rather a method to inform your care teams and to identify the resources your patient needs.

- Do non-FQHCs also use PRAPARE® ? *(2022)*
    - Any organization can use PRAPARE® . Outside of FQHCs, it is the most widely used SDOH screening tool amongst FQHCs and Medicaid Managed Care Organizations. There are several health systems and community-based organizations that are also using PRAPARE®.

- Can PRAPARE® be self-administered? *(2022)*
    - Yes, PRAPARE® can be self-administered

- What is best practice for the frequency this is completed by our patients? *(2022)*
    - Some questions may only need to be asked on an annual basis such as race or ethnicity. We recommend following up with patients during each visit if there is a positive screen for an SDOH need- as things may have changed between visits.

- Is it important to use the questions word for word in the PRAPARE® assessment with patients? *(2021)*
    - No, PRAPARE® is unique in that it emphasizes standardization of the risk or need rather than the question. Some health centers have re-worded the questions to be more community- and culturally-sensitive depending on the situation, used patient-centered empathic inquiry and talk story approaches, and/or explained the question in further detail as needed.
    - We recommend conducting cognitive interviewing techniques to better understand how to approach this for your specific communities. For example, Oregon PCA had initial discussions with patients on what is most important for learning about patients before they finalized the wording of the questions

- When racial/ethnic groups are so diverse culturally and linguistically, what outreach approaches should be part of the healthcare system? *(2021)*
    - When working with diverse populations, there are several approaches to consider.
    - First, it is important to build relationships and trust with diverse communities. Take time to build trust and relationship with communities as this is a critical step that cannot be rushed. Engage with stakeholders and leaders that are trusted by diverse communities, such as places of worship, cultural groups, schools, and local businesses. It is always a great idea to attend cultural events in the community. Be specific to ask stakeholders on how your health center can customize care for the target population as well as strategies to increase trust and create a welcoming environment at the health center.
    - Second, invite members from diverse communities to fill job vacancies or leadership roles, such as advisory committees, board of directors. For example, community health workers, hired from the communities served, have proven to be an effective approach to outreach.
    - It is important to actively listen to members of diverse communities, state what actions your health center will take, and update community members on the outcomes of action steps.
    - Finally, have an open mind that while there are similar characteristics across cultural groups, there will be differences and to approach each person as an individual.

- How do you manage/ work with individuals that are homeless and don't have a way to contact them? *(2021)*
    - Working with individuals that are experiencing homelessness requires flexibility and creativity in caring for them. There are several strategies that can be helpful.
    - First, ask the individual if they regularly communicate with a family, friend, or associate and if they feel comfortable sharing their contact information once they've received permission from their point of contact. This strategy may be used when a person has stable housing but uses a shared telephone or cell phone.
    - Second, ask them if there are places that they frequent, such as parks, shelters, food banks, churches, or places of employment and if they are comfortable with you visiting those places in case you can't contact them. Reassure them that your priority is to care for them and that being able to communicate allows you to support them.
    - Finally, when scheduling a meeting or check-in, identify a location that is most convenient for the person and if resources are available, ask the person if they'd like for you to bring them a meal or items they need (hygiene, clothing, shoes, etc.) We recommend visiting the website for the National Health Care for the Homeless Council for additional resources: https://nhchc.org/

- When do you graduate a patient from case management program? *(2021)*
    - 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. Complete the PRAPARE® screening at least annually (some questions don't need to be asked again) and consider revisiting PRAPARE® questions that are related to the identified social need (3-6months) to determine if the situation has changed.

- Is it appropriate for use as patient-administered in the PCP office? *(2021)*
    - Yes

- How long does the staff continue to engage with patients when they're focused on other priorities? *(2021)*
    - In terms of patient engagement, it's best to partner with them to see what their priority in terms of their health and strategies is 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 resource to help 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® ? *(2021)*
    - 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 iPad in the waiting room. For more information on workflow examples please review the PRAPARE® Implementation Toolkit.

- Can we make modifications to the questions? *(2021)*
    - In order to make any modifications, approval from the PRAPARE® team is required.

- How do other agencies incorporate the screening tool into a primary care visit? *(2021)*
    - 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.
    - Review 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? *(2021)*
    - 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? *(2021)*
    - 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? *(2021)*
    - 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? *(2021)*
    - 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? *(2021)*
    - 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? *(2021)*
    - The tool is designed to be administered from all levels of staffing. Educational level is not a factor in administration. Review the PRAPARE® Action and Implementation Toolkit for more information on the importance of the tool and sensitivity training and examples of how the data can be collected.

- Can the PRAPARE® screening tool be integrated into case management? *(2021)*
    - 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? *(2021)*
    - Time to administer 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 *(2021)?*
    - Yes- if you are already collecting the data in another format, you may omit those questions.

- How often should the PRAPARE® questions be asked? *(2021)*
    - 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

- Do you have any recommendations on data collection and reporting promising practices when using PRAPARE® ? *(2022)*
    - The PRAPARE® toolkit has a lot of great examples from the pilot teams, and we've continued, through the PRAPARE® tiger team, to collect additional promising practices. One promising practice is to always complete a data mapping exercise to see where in your EHR system you are collecting this information. This way you remove any duplication.
    - Another promising practice is to always engage the team that will be doing the data collection and screening. It is important that they are part of the process- this will increase buy-in and also an opportunity to hear their prescriptive/ideas on the data reporting and screening process.
    - We also recommend reaching out to your respective PCA or HCCNs to see what support they might be able to offer.

- Have you published a psychometric validation of the PRAPARE® ?*(2022)*
    - Please see our PRAPARE® validation fact sheet. Our paper that includes psychometric validation should be coming out later this year.

- How did you evaluate the Construct and Content Validity for the PRAPARE® assessment? *(2021)*
    - Several analyses were conducted on PRAPARE® data that demonstrated good to excellent validity using Greatest Lower bound (GLB) and Cronbach's Alpha.
    - Greatest Lower bound (GLB) result was 0.935 (excellent) and Cronbach's Alpha was 0.86 (good). PRAPARE® also has Known-Groups validity demonstrating significant differences between controlled and uncontrolled diabetics as well as controlled and uncontrolled hypertensive patients. A higher number of PRAPARE® risks was also associated with worse HbAlc and blood pressure values. This information is forthcoming in our publications.

- How do community-based or social organizations report their findings once the PRAPARE® Assessment Tool is completed? *(2021)*
    - This will vary from one community-based or social organization to another. Some may have a common platform that is used in order to share data with each other.

- Does NACHC have a data hub where these partners upload their findings? *(2021)*
    - No, not at this time

- Is the PRAPARE® Assessment covered by Medicare, Medicaid and/or Commercial Insurance plans? If so, what is the CPT Code that this Assessment would be properly billed under? *(2021)*
    - ICD10-Z codes are relevant for social needs, whereas CPT codes are more complex and are more related to the social intervention's component
      PRAPARE® ICD10 Z Codes – July 2021
    - This tool is a crosswalk between the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE®) tool and its corresponding ICD-10 Z codes in the electronic medical record system. To view the 2022 ICD-10-CM Release, please click here.
    - Social Determinants of Health data and suitable social intervention documentation is needed to demonstrate value to stewards and seek adequate financing to ensure interventions are sustainable while creating an integrated, value-driven delivery system to reduce total cost of care. The PRAPARE® Implementation Toolkit is available here.
    - https://www.cms.gov/files/document/zcodes-infographic.pdf

- Has there been studies to show that collecting SDOH has improved health outcomes and what has the research shown? *(2021)*
    - There have been several research studies that illustrate the role of collecting SDOH needs data and how it informs patient care and its impact on health outcomes. This literature review published in the Journal of the American Medical Informatics Association indicated that collecting SDOH data contributed to improvement in risk stratification, improvement in performance, increase in referrals to social workers, improvements medication adherence, and a decrease in risk of hospitalizations and 30-day rehospitalizations, to name a few. Please refer to the journal article for more details: https://academic.oup.com/jamia/article/27/11/1764/5959858?login=true
    - Furthermore, in Chapter 1, pages 5-8 of the PRAPARE® Implementation and Action Toolkit, the importance and impact of collecting SDOH data is highlighted along with findings from PRAPARE® pilot sites that detail improvements in patient-level care and informing community-level efforts.
    - For more examples of how PRAPARE® data has been used, please see PRAPARE® research fact sheets and recorded PRAPARE® research webinars at the PRAPARE® Trainings and Resources Page

- How does PRAPARE® align with the work being done in the HL7 Gravity project? *(2021)*
    - NACHC is actively involved with Gravity- we sit on both the executive committee and technical committee.

- Does PRAPARE® support any sort of reporting functionality? *(2021)*
    - The PRAPARE® team is extremely interested in exploring reporting functionality but currently PRAPARE® is a standardized social risk screening tool.

- 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? *(2021)*
    - 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®? *(2021)*
    - 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. *(2021)*

- Why do we need these social intervention codes if we can map PREPARE® to SNOMED or CPT codes directly? *(2021)*
    - CPT and SNOMED are not all specific to PREPARE® 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®. The PRAPARE screening tool also captures 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? *(2021)*
    - 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 immensely helpful to ensure communication between organizations for this purpose.

- How is PRAPARE® achieving alignment with SDOH e-referral vendors and also Pathway HUB models? *(2021)*
    - As with PRAPARE®, we recognize that national alignment and interoperability are especially 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.

- 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? *(2021)*
    - 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. *(2021)*
    - Social Data into Risk Stratification Models to Improve Health Equity and Demonstrate Value Webinar

- Does the PRAPARE®tool have published validity and reliability data? *(2021)*
    - The PRAPARE ®Validation Fact Sheet highlights how PRAPARE® was developed and validated using the 8 "Gold Standard" Stages of Measure Development.*(2021)*

- How does PRAPARE® impact ICD-10 CM coding of the Z codes at hospitals? *(2021)*
    - 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? *(2021)*
    - 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? *(2021)*
    - 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 determinants of health (SDOH) data? *(2021)*
    - 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? *(2021)*
    - 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 collect both patient-level SDOH and ES data? *(2021)*
    - 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? *(2021)*
    - 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? *(2021)*
  - 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? *(2021)*
  - 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.

Risk Stratification, Risk Scoring, Risk Adjustment

- Is there a reason we don't map to the 69490-1 code from PRAPARE®? There is no semantic difference.*(2022)*
    - Because 56051-6 is specific to PRAPARE® as the code representing the fact that it is 'asked' as a question, which is part of a survey/assessment instrument. Ideally, there would be a value set representing ethnicity, grouping together 56051-6 and 69490-1 (and others judged as semantically equivalent). In summary, if your EHR is to support one-to-many or many-to-one mapping, the PRAPARE® question on ethnicity should be bound to both 56051-6 and 69490-1.
      Use cases:
        1. SDoH researcher wants to query ethnicity only for patients who have PRAPARE® data, it would be 56051-6
           Queries for UDS aggregate reports to populate Ethnicity in Table 3B should not be limited to 56051-6, but should use 69490-1 to capture all patients regardless of PRAPARE® administration.

- Are we required to capture the "Question ID" LOINC code? Question ID: 56051-6 (Hispanic or Latino) 69854-8 (Hispanic or Latino or Spanish Origin)*(2022)*
    - Yes- use LOINC 56051-6 | https://loinc.org/56051-6/ | to represent the PRAPARE® question "Do you consider yourself Hispanic/Latino?"
      Using the standard Yes/No LOINC code bound to PRAPARE® https://loinc.org/LL5332-3/
        1. Yes = LA33-6
        2. No = LA32-8
        3. LA30122-8 = I choose not to answer this question

      A "Yes (LA33-6)" = answer for this question should be coded on LOINC or CDC race/ethnicity code system (whichever you support most, or both if possible) equal to "Hispanic or Latino" (LA6214-6 or 2135-2)

      A "No (LA32-8)" = answer for this question should be coded on LOINC or CDC race/ethnicity code system (whichever you support most, or both if possible) equal to "Not Hispanic or Latino" (LA19555-4 or 2186-5)

      Here are the details for why those codes are used for a Yes/No answer for 56051-6:
      To represent Ethnicity via LOINC as its own semantic concept not bound to a question, overall, regardless of questionnaire used, please us LOINC 69490-1 | https://loinc.org/69490-1/ | To align with OMB. If bound to PRAPARE®, use, again, 56051-6

      If you use LOINC to represent, please use https://loinc.org/LL2361-5/
        1. LA6214-6 = Hispanic or Latino
        2. LA19555-4 = Not Hispanic or Latino

If you support the "Race & Ethnicity – CDC" code system, use the following value set (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.837) to represent:

1. 2135-2 = Hispanic or Latino
2. 2186-5 = Not Hispanic or Latino

- In regards to the risk tally score for data analysis- when will the weighting analysis be completed? Do you have any recommendations for weighing the risk scores? *(2022)*
  - We did some exploration of weighting in our paper "Development of PRAPARE®Social Determinants of Health Clusters and Correlation with Diabetes and Hypertension Outcomes". However, we recommend further validation prior to announcing national weighting risk scores recommendations/
  - Link: https://www.jabfm.org/content/development-prapare-social-determinants-health-clusters-and-correlation-diabetes-and

- Has anyone analyzed the PRAPARE® codes?*(2022)*
  - As for the PRAPARE® codes, the National PRAPARE®Team developed them at the start in 2015 so that users had codes to use as needed. Since then, we have developed icd10, LOINC, and other codes that tend to get used for reimbursement purposes.
  - etc codes and people tend to use those for reimbursement purposes.

- We are currently implementing PRAPARE® at our organization and wanted to know if there was a scoring rubric for each of the questions that could be used to calculate a risk score? *(2022)*
  - The PRAPARE® risk tally score sheet which represents the cumulative number of distinct risks that are present vs absent for an individual patient. The social determinants of health (SDOH) total score are calculated by summing the total number of present SDOH 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

  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.

- In the cluster around insurance/employment - if a patient has Medicaid/Medicare, but is unemployed, should they be scored as a one? If there is a patent who has Medicare- 75 years of are and is unemployed, would the score be a one? *(2022)*
    - Below is our scoring recommendations. Your score would depend whether she is 1) unemployed and seeking work or 2) unemployed and not seeking work. For this example, she would score a 0 in the Insurance/Employment cluster assuming she is retired and #2 is her response.

Employment: What is your current work situation? (maximum of 1 tally)	
Unemployed and seeking work	1
Part-time work	1
Full-time work	0
Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary caregiver)	0
Insurance: What is your main insurance? (maximum of 1 tally)	
None/uninsured	1
Medicaid	0
CHIP Medicaid	0
Medicare	0
Other public insurance (Non-CHIP)	0
Other public insurance (CHIP)	0
Private insurance	0

- Regarding FPL, are we considering 100 or 200% of FPL?
    - FPL scoring of 1 is based on level up to 200% as indicated below.

Generate %Federal Poverty Level from income and household size responses (Maximum of 1 tally)	
100% or below	1
101-150%	1
151-200%	1
More than 200%	0
Unknown	0

- Is the PRAPARE® Risk Stratification Model being utilized by NACHC members? If so, to what extent? *(2021)*
    - Yes, by at least several health centers but it is still considered in the "pilot" stage. Some have incorporated in their population management vendor and are currently/planning to use, but it is still in its pilot phase. If you use it, please keep us informed of your experiences as we want to share those experiences with other members.

- Has the PRAPARE® Risk Stratification Model had any recent updates? *(2021)*
    - No- not at this time

- How will updates to the PRAPARE® Risk Stratification Model be disseminated? *(2021)*
    - All updates will be posted to the PRAPARE® website and announced in the monthly PRAPARE® E-news.

- What are we supposed to do with someone who scores a four 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 producing P&Ps when/if to address additional measures based on the risk tally score? *(2021)*
    - 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? *(2021)*
    - 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).

- Does the practice of risk adjustment inadvertently conceal health disparities? If so, how can PRAPARE® bring those disparities to light? *(2021)*
    - 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) *(2021)*
        - **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) *(2021)*
    - The PRAPARE® risk stratification tool will need to undergo further testing

- Why Include SDOH Data in Risk Stratification Modeling? *(2021)*
    - 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 PRAPARE® Risk Assessment tool score? *(2021)*
    - Risk tally score" represents the cumulative number of distinct risks that are present vs absent for an individual patient. The social determinants of health (SDOH) total score are calculated by summing the total number of present SDOH 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. *(2021)*
    - PRAPARE® Risk Tally Scoring Methodology
    - Webinar *(2021)*

- Why do we need to calculate a patient's overall risk score? *(2021)*
    - 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? *(2021)*
    - 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

Policy and Advocacy

- Are you aware of any state funding, especially in states that have expanded Medicaid, to integrate software? *(2021)*
    - Currently, the following states have allocated funding to utilize software that collects SDOH data while identifying community resources. For example, North Carolina has implemented NC Care360: https://nccare360.org/. There is also CyncHealth in Nebraska, which is a health information exchange. If you would like more information on efforts, we encourage you to reach out to your statewide primary care association.

- Does the federal government gather SDOH data? *(2021)*
  - SDOH data is collected in two different ways: community-wide data (local, state, and national level data) and the individual-level data (health care settings and payers). In Chapter 1, page 4 of the PRAPARE®Implementation and Action Toolkit, an overview is provided in terms of how PRAPARE® aligns with national priorities to improve the SDOH across communities. There are growing requests for federal agencies to collect SDOH data given how critical this information is to improve the health of communities.
  - In terms of collecting individual-level data, the Office of the National Coordinator for Health Information Technology (ONC) announced in July 2021 that it is working on a list of data measures that EHR systems must collect, which includes patient-level SDOH needs and interventions. For more details, please refer to this article: https://www.pewtrusts.org/en/research-and-analysis/articles/2021/07/22/us-agency-prioritizes-sharing-data-on-social-determinants-of-health

- CMS has launched an Accountable Community program and it appears there will be questions endorsed by CMS on SDOH. Do they conflict with PRAPARE®? *(2021)*
  - The PRAPARE® project team worked closely with many national organizations including CMS 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? *(2021)*
  - 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. *(2021)*
  - 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? *(2021)*
    - Partnerships between health centers and their states vary and are based on several factors. It is 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? *(2021)*
    - 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 it is 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)? *(2021)*
    - 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? *(2021)*
    - 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? *(2021)*
    - 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

- How can Enabling Services best utilize SDOH data?*(2022)*
    - Enabling services aim to increase access to healthcare and improve health outcomes. Some of the best ways to utilize SDOH Data is by looking at the number of SDOH screens linked with social interventions and it can be by month, by category, by provider type, etc. The PRAPARE® team has developed a social interventions protocol (which is still in draft form) but with this protocol we want to be able to document not only what our patients' needs are, but also, which of these has have been addressed, and by which enabling services. By lining them up and documenting both you are then able to see what gaps in care you're still needing to address.
    - You can also look at the top five SDOH interventions provided based on your patients' needs: the mean number of SDOH interventions provided per patient, the number and proportion of patients that are still in need of addressing social interventions, especially those that have a greater number of social needs. From there you can sort those by the patients that have the most SDOH needs.

- Have you all developed specific tools to do a crosswalk from the PRAPARE® screening questions and prompting referral to medical legal partnerships? *(2021)*
    - We currently do not have specific materials for MLP screens/referrals using PRAPARE®, but it is something we will be exploring.

- How, if at all, do you overlap with Social Check – Intermountain's screener that is based on PRAPARE®? *(2021)*
    - If Social Check – Intermountain's screener that is based on PRAPARE® then they should have acknowledged the PRAPARE® questions appropriately within their screener.

- Why did CMS create the AHC Health-Related Social Needs Screening Tool when PRAPARE®seems to have already been in existence. *(2021)*
    - 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? *(2021)*
    - 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.

- Does NACHC have a screener to assess IPV and human trafficking? *(2021)*
    - We do have a lot of tools and recommendations on how to address IPV/HT in combination with PRAPARE® or other intake tools. Please check out our online toolkit https://ipvhealthpartners.org/ and our newly released website for the NTTAP Health Partners on IPV and Exploitation: https://healthpartnersipve.org/
    - There are other screeners but what we recommend is our CUES approach – which stands for C: Disclosing limits of confidentiality, UE: Universal Education and Empowerment: and S: support. We recommend that prior to any screen or conversation about IPV/HT, providers offer brief basic information about IPV/HT and its impact on health and where to get help so that people have that information regardless of if they disclose on a screen. With IPV, even when screens are delivered empathetically we see disclosure rates that do not match prevalence rates of IPV/HT (for lots of reasons including fear of retaliation by the partner, fear of reporting etc.) so it is critical to offer information for all so patients have it even if they don't disclose and so that they can share this information with friends or family members who might need it. Then in terms of response – we focus on relational healing that helps providers work with the patient to develop a care plan that takes partner interference into consideration (i.e., medication interference, limiting access to health care etc.) Finally, the S stands for Support – which includes not just offering a referral number but rather a warm referral to CBOs for support including offering to put any patient who has disclosed abuse on the phone right then and there in the health center with a domestic violence advocate for support. The websites above have more info!
    - This approach can be done on its own without a screen or in combination with PRAPARE® or any other screen. None of the screening tools are perfect since really the key to an appropriate response to IPV/HT is a conversation but of the other screening tools, I like HARK tool.

- Are there any clinic characteristics (e.g., workforce mix, patient volume, payer mix, etc.) that predict more robust enabling services and other SDOH interventions? *(2021)*
    - 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? *(2021)*
    - 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? *(2021)*
    - 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.