PRAPARE

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

IMPLEMENTATION AND **ACTION** TOOLKIT

MARCH 2019

NATIONAL ASSOCIATION OF
Community Health Centers

AAPCHO
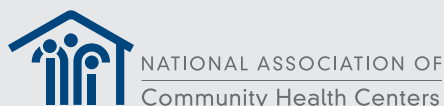Association of Asian Pacific Community Health Organizations

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Acknowledgements

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PRAPARE Implementation and Action Toolkit

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect and apply the data they need to better understand their patients' social determinants of health, transform care to meet the needs of their patients, and ultimately improve health and reduce costs. PRAPARE is both a standardized patient risk assessment tool as well as a process and collection of resources to identify and act on the social determinants of health.

The PRAPARE Implementation and Action Toolkit is designed to provide interested users with the resources, best practices, and lessons learned to guide implementation, data collection, and responses to social determinant needs.

This is a modulized toolkit. The Toolkit's chapters focus on the major steps that are needed to implement a new data collection initiative on socioeconomic needs and circumstances. New users are advised to go through the entire Toolkit. Other users may wish to focus on certain chapters to build or enhance capacity in certain areas.

This Toolkit is based on the experiences, best practices, and lessons learned of our early adopting and pioneering health centers. We thank them for sharing their innovations and lessons learned with us so that others can advance their own social determinants of health journey.

TABLE OF CONTENTS

Click on the chapters below to view resources and best practices on that implementation step. Building off of the roots of the PRAPARE name, chapters are organized based on whether they help users **"PREPARE"** for social determinants data collection, **"ASSESS"** social determinants of health data, or **"RESPOND"** to social determinants of health data. There will be webinars on each chapter to highlight examples from the field.

■ Preparing to Gather Data on the Social Determinants of Health

■ Collect and Assess Social Determinants of Health Data

■ Responding to Social Determinants of Health Data

CHAPTER 1
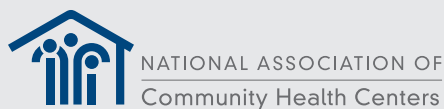## Understand the PRAPARE Project

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

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What Is PRAPARE and What Does It Help Me Do?

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

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

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

1	2	3	4
Define and document the increased complexity of patients	Better target clinical care, enabling services, and community partnerships to drive care transformation	Enable providers to demonstrate the value they bring to patients, communities, and payers	Advocate for change at the community and national levels

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

What Does PRAPARE Measure?

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

Core Measures in PRAPARE

PERSONAL CHARACTERISTICS
- Race
- Ethnicity
- Farmworker Status
- Language Preference
- Veteran Status

FAMILY AND HOME
- Housing Status and Stability
- Neighborhood

MONEY AND RESOURCES
- Education
- Employment
- Insurance Status
- Income
- Material Security
- Transportation Needs

SOCIAL AND EMOTIONAL HEALTH
- Social Integration and Support
- Stress

OTHER MEASURES IN PRAPARE
- Incarceration History
- Refugee Status
- Safety
- Domestic Violence

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

Why Should I Use PRAPARE?

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

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

- PRAPARE is evidence-based but has also been tested and vetted by staff and patients in the field

- PRAPARE is patient-centered

- PRAPARE is actionable

- PRAPARE can be adapted to fit within any workflow

- PRAPARE comes with free resources (described further below in the section on "PRAPARE Resources") to help implement PRAPARE with different populations and respond to needs identified, including:

  – PRAPARE EHR templates

  – Translated versions of PRAPARE

  – PRAPARE Readiness Assessment Tools

  – PRAPARE Implementation and Action Toolkit comprised of user stories, best practices, and lessons learned

  – PRAPARE Youtube Channel to highlight user stories and PRAPARE data findings

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

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

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

UPSTREAM
socioeconomic conditions
environmental conditions
institutional power
social networks

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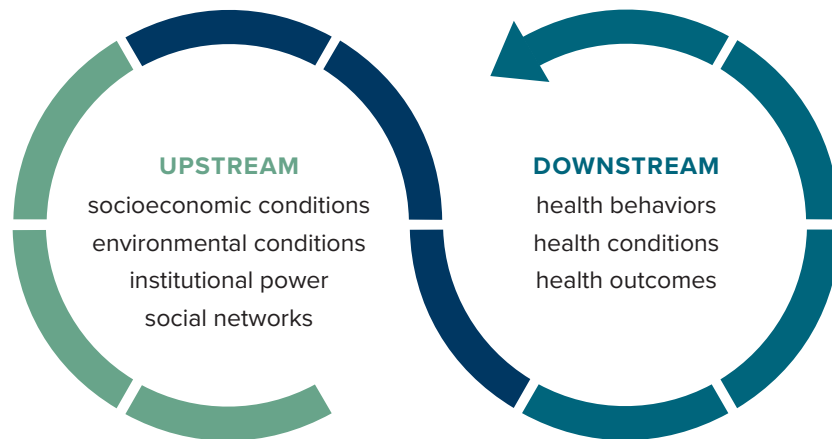
The social determinants of health (SDH) are the conditions in which people live, work, play, and age. They can encompass socioeconomic conditions, environmental conditions, institutional power, and social networks. These factors exist "upstream" in that they occur and inter-relate with each other to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

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

Physical Environment: **10%**
Health Behaviors: **30%**
Clinical Care: **20%**
Social and Economic Factors: **40%**
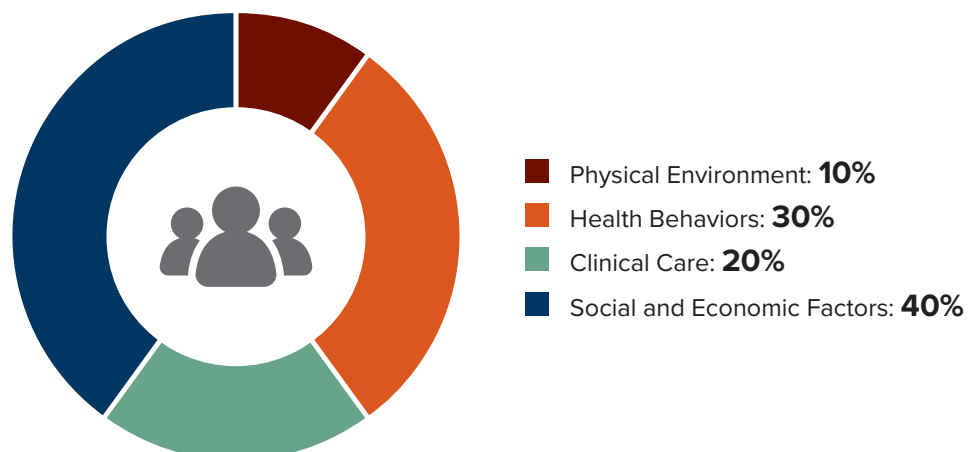
Unfortunately, traditional ways of identifying complex patients is grounded in the "downstream" medical model in terms of number of chronic conditions, health outcomes, and hospital and emergency department utilization. Because the social determinants influence such downstream factors, they should be included in how providers identify and treat complex patients. Care teams must have an understanding of their patients' complexity (both clinically and non-clinically) in order to make informed care decisions that are patient-centered and interventions that are more appropriately tailored.

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

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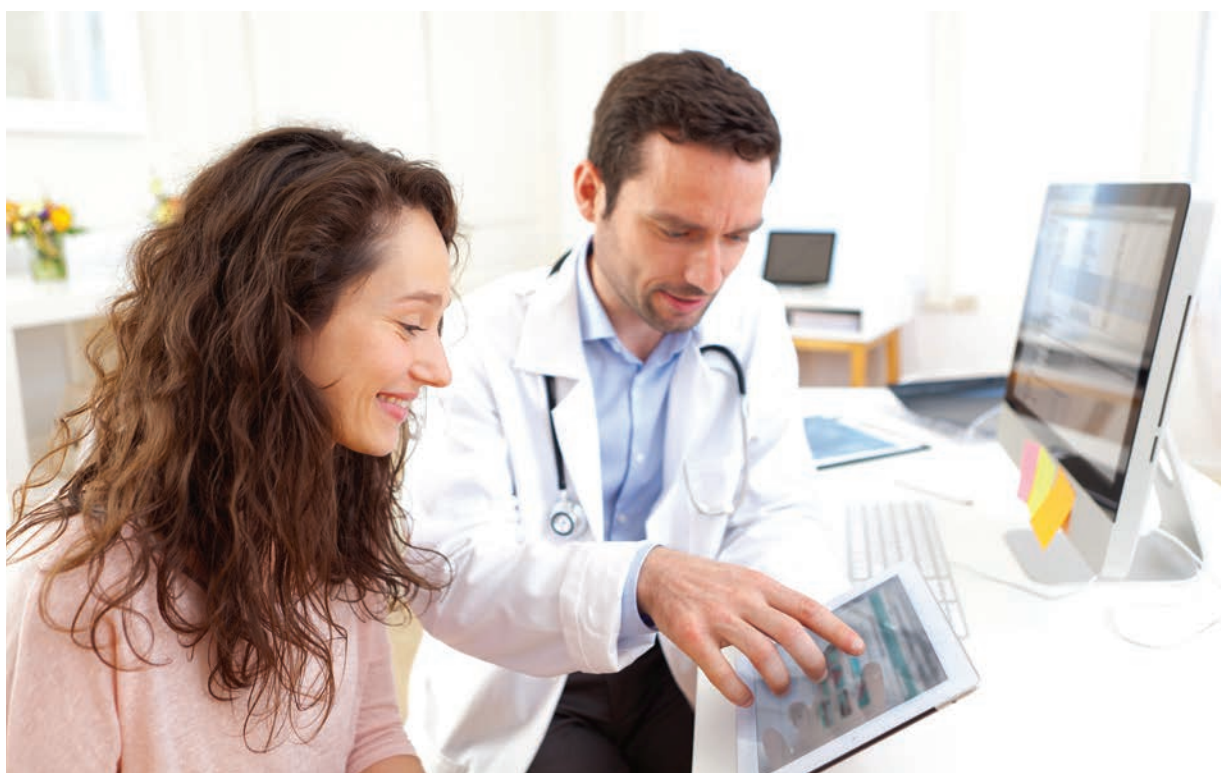
What Have We Learned After Using PRAPARE?

PRAPARE IMPLEMENTATION LESSONS LEARNED

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

PRAPARE DATA FINDINGS

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

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

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

The most prevalent social determinant of health risks across 2015 - 2017 health center cohorts in 7 states were:
- Limited English Proficiency
- Less than high school education
- Lack of insurance
- Experiencing high to medium high stress
- Unemployment

PRAPARE IMPROVES INDIVIDUAL HEALTH AND LEADS TO COMMUNITY TRANSFORMATION

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

Inform Care and Services:

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

Advocate for Community Change:

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

Inform Policy and Payment:

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

PRAPARE USER STORY

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

PRAPARE TOOL

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

FREE PRAPARE ELECTRONIC HEALTH RECORD TEMPLATES

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

- Cerner
- Epic
- eClinicalWorks
- GE Centricity
- NextGen

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

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

- PRAPARE Data Collection Excel Template

TRANSLATED VERSIONS OF PRAPARE

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

- Arabic
- Burmese
- Chinese (simplified and traditional)
- Korean
- Portuguese
- Spanish
- Somali
- Tagalog
- Vietnamese

As of 2019, we are working on an additional ten languages, including:

- Chuukese
- French
- Farsi
- German
- Hindi
- Khmer
- Laotian
- Marshallese
- Russian
- Tongan

PRAPARE READINESS ASSESSMENT TOOLS

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

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

PRAPARE IMPLEMENTATION AND ACTION TOOLKIT

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

PRAPARE YOUTUBE CHANNEL

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

FREQUENTLY ASKED QUESTIONS ON PRAPARE

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

CHAPTER 2
Engage Key Stakeholders

With any new initiative, it is important to engage stakeholders who have an interest in the success of the project. Involving people who will be impacted by the initiative can lead to strong support of the project and can strengthen the process and/or outcomes of the project. For example, engaging staff can lead to the development of more appropriate workflows to collect and act on the socioeconomic data; engaging patients can lead to more appropriate interventions or community partnerships.

There are many ways to engage stakeholders, ranging from education and consultation to direct involvement in the project process. Some stakeholders may desire and have the capability of engaging in a more active and direct way, such as helping to define priorities, collect the data, interpret the findings, act on the data, develop community advocacy plans, etc. Other stakeholders may desire or only have the capability of engaging in a more passive way (advise at meetings, providing feedback, etc.). What is important is engaging and educating stakeholders so that they can make an informed decision as to how they would like to be engaged.

This chapter includes messaging materials to help engage stakeholders and to address common questions and concerns. It also includes best practices in engaging stakeholders from both the PCA and health center levels.

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Messaging Materials for Staff and Patients on the Importance of Collecting Data on the Social Determinants of Health

Engaging stakeholders begins with messaging. Before asking staff, leadership, and patients to collect and provide personal and sensitive information, it is important to educate all stakeholders on the importance of collecting data on the social determinants of health and how that information will inform care and services. It is also important to emphasize how this work adds value to other work in which the organization is involved so that it does not come across as an isolated one-off project but one that fits into the organization's larger, overarching goals. Presented below are common questions and examples of messages health centers provided to address those concerns.

? **COMMON QUESTION**

Why Are We Asking Patients About Their Socioeconomic Situation?

✓ **MESSAGING SOLUTION**

The message should emphasize that collecting data on the social determinants of health will help the organization better understand their patients and their patients' needs to provide better care.

Example Message for the Patient:

"We would now like to ask you some non-medical questions to better understand you as a person and any needs you may have. We want to make sure that we provide the best care and services possible to meet your needs. This information will help us determine if we need to add new services or programs to better care for our patients.

This information will be kept private and secure. Only clinic staff will have access to this information. Your decision to answer or to refuse to answer will NOT impact your ability to receive care. In many cases, this information will help us determine if you are eligible for any additional benefits, programs, or services.

Please let us know if you have any questions, concerns, or suggestions."

How Do We Fit PRAPARE into Our Workflow Without Increasing Visit Time?

✔ MESSAGING SOLUTION #1

Utilize time when the patient is either waiting to be roomed in the waiting room, waiting for the provider in the exam room, or after the clinical visit, to administer PRAPARE so as not to disrupt the clinic visit.

✔ MESSAGING SOLUTION #2

Incorporate PRAPARE into other assessments (such as Health Risk Assessments, Depression Screenings, etc.) to encourage completion and to address similar needs or concerns raised by the assessments.

? **COMMON QUESTION**

How Do We Add Another New Initiative to Our Already Full Schedules and Responsibilities?

✔ MESSAGING SOLUTION #1

Don't market PRAPARE as a new big initiative but rather as a project that aligns with other work your organization is already doing (care management, enabling services, Accountable Care Organization (ACO) planning, etc.) and how PRAPARE adds value to that work.

✔ MESSAGING SOLUTION #2

Move the conversation on PRAPARE organically rather than forcing a new project. Be in the right place at the right time to make small changes and nudges as "People's attention is a commodity." Emphasize that collecting this information will help inform care, services, and community partnerships that will hopefully improve your patients' and organization's health outcomes.

? **COMMON QUESTION**

What If We Do Not Have the Resources or Services to Address the Social Determinant Needs Identified? What Do We Do?

✔ MESSAGING SOLUTION

Explain that "the organization has to start somewhere" and data collection is that first step. Collecting data on the social determinants of health will help the organization figure out which services it can provide in-house to which patients to hopefully improve outcomes by uncovering the root causes of health conditions and health behaviors. For services that the organization cannot provide in-house, this data will help inform which community organizations with which it should partner to provide needed services. Until then, the organization will do the best that it can to address the social determinants needs raised by PRAPARE with what it has.

Sample Action Steps to Engage Stakeholders

What follows are some example steps an organization can take to engage stakeholders, from staff to leadership to patients, based off of lessons learned from PRAPARE health center pilot sites.

STEP 1	EDUCATE STAFF, BOARD, AND PATIENTS AND GATHER FEEDBACK

Staff

It is important to educate staff informally through conversations and internal meetings to gather support and feedback. Make sure that you allow staff to ask questions and to participate in the planning process. Their engagement will likely lead to more effective workflow models to collect and respond to social determinants data. Engaging different types of staff early-on in the planning process may also highlight potential implementation challenges and ways to overcome those challenges.

BEST PRACTICE

When speaking about PRAPARE, do not use the word "project" as that is something that ends. It is better to frame PRAPARE and social determinants of health work as a way to achieve your mission of improving health.

Leadership and Board

It is also important to have support from leadership. Give presentations to executive leadership and the board to highlight the ways PRAPARE aligns with existing organizational priorities and how data on the social determinants of health will add value to other organizational initiatives.

RESOURCES

Our PRAPARE 101 webinar provides information that could be helpful in these kinds of engagement and educational conversations, such as what PRAPARE is, how it was developed in an evidence-based and stakeholder-driven process, how it can be used, and how PRAPARE data can add value to what the organization is already doing.

Patients and Community

It is equally important to engage community leaders to understand patients' and the community's attitudes towards discussing their socioeconomic circumstances. Actively listen to community members' questions and work with them to address any concerns. Ensure that community leaders understand that gathering this information is meant to help the organization better understand its patients and to provide them with more appropriate services and care that are needed by the community. This kind of engagement will help build trusting relationships between your organization and the community.

Organizational Members Who Will Be Implementing PRAPARE

Similarly, if you are an organization that supports and/or manages other organizations (e.g., Primary Care Association, Health Center Controlled Network, Health System, Health Plan, Managed Care Organization, etc.), then it is important that you meet your organizational members where they are and that you do not assume familiarity or understanding of PRAPARE at the onset. When engaging your members, be realistic about timelines and respect the process as culture change or workflow adjustments take time but it leads to a greater good.

STEP 2	LAUNCH PRAPARE AT AN ALL-STAFF EVENT AND RECRUIT VOLUNTEERS

Once support has been secured from leadership, educate staff at all levels through a broad overview presentation at an all-staff meeting highlighting the importance of this work and how it aligns with the organization's larger goals. It is important that everyone understands the benefits of PRAPARE.

Ask for volunteers at this meeting--advocating for a "no wrong door" approach in which each and every staff can play a part in helping to "paint a fuller picture of the patient".

Accept all volunteers, even if they are not members of the staff group initially intended to collect data (e.g., case managers, social workers, etc.) as they may become some of the most successful data collection and response staff due to their personal motivation or connection to this issue.

PRAPARE USER STORY

At one of the PRAPARE pilot sites, one outreach and enrollment coordinator collected data on over 300 patients in just three weeks due to her ability to build trusting relationships with the patients and noticing when they would be waiting to be roomed or waiting to see the provider.

Provide detailed training and education for all volunteer and assigned PRAPARE data collection and response staff. (For sample training curriculums, see Chapter 5: Workflow Implementation.)

Identify project champions to help keep the health center motivated based on their passion for the social determinants of health. Champions can be any staff but usually are those that have good relationships with patients and other staff.

El Rio Health in Tucson, Arizona hosts a meeting with organizational staff and leadership to educate them on PRAPARE, to update everyone on their progress and lessons learned, and to share how they are applying PRAPARE data to inform care and partnerships with local community agencies.

Photo credit: El Rio Health in Tucson, AZ

PRAPARE HEALTH CENTER USER STORY

At one health center in North Carolina, several staff emerged as champions for PRAPARE implementation. The Clinical Operations Manager became a leader amongst staff, encouraging nursing staff who were implementing PRAPARE while also serving as a leading resource for identifying community resources. The Health Care Informatics Manager not only spearheaded much of the health center's PRAPARE efforts but is also leading social determinants of health work at the state level. Staff have felt empowered by their initial success with PRAPARE and have been excited to share results and lessons learned during peer learning calls with other clinic staff. These staff were already leaders at their health centers, but they have become champions for social needs screening and response programs.

CHAPTER 2: Engage Key Stakeholders and Answer Commonly Asked Questions

DESIGN WAYS TO ENGAGE PATIENTS IN THE PRAPARE PROCESS

It is important to engage and inform patients about why the organization is asking them to share social and economic information and how it will inform their care. Share that addressing social needs is necessary to improve health and reduce health disparities. Health care is crucial; however, it is only a small part of a person's overall health. Social and economic factors play a central role in the ability of an individual to adopt and maintain healthy behaviors.

BEST PRACTICE

In the opening message to patients (either written or spoken), do not call PRAPARE an "assessment" but rather a "conversation" to invoke that these questions are meant to build better relationships between patients and staff and to inform the process to better care. Use empathic inquiry, talk story, or motivational interviewing techniques to talk compassionately and reflectively with patients. For more information on these data collection techniques, see the next section on Empathic Inquiry.

Patients can be involved in the PRAPARE process in the following ways:

Gather feedback from patients on this opening "script" message and PRAPARE in general to see if they have any remaining concerns or input on how to tailor the message to different communities. See the next section on Empathic Inquiry for ways to ensure that messaging materials are patient-centered.	Ask patients to participate in the "PRAPARE Huddle" meetings (see Step 5 below) to see if the results of the data collected resonate with them, to advise on overcoming data collection challenges, and to provide suggestions on how to address the needs identified.	Engage patients in enhancing the community resource guide to ensure that it contains the most relevant, trusted, and helpful resources.	Visit homes and neighborhoods of patients to witness how the social determinants of health affect the community.	Engage patients in community advocacy for change.

PLAN OPPORTUNITIES FOR SHARED LEARNING

Plan mechanisms, such as weekly "PRAPARE Huddle" meetings, to allow data collection staff to regularly share their progress, celebrate successes, and troubleshoot challenges in collecting data. These meetings also provide an opportunity to discuss the socioeconomic needs that have been identified and whether the organization has the resources or capabilities of addressing those needs in-house or if it should examine partnerships with other community organizations.

These regular meetings are also a good opportunity to have patients describe their experiences with PRAPARE and to discuss ways to improve the data collection and response process.

STEP 6 — DEVELOP RESOURCES WITH STAFF AND PATIENT INPUT

There are several different resources that your organization can develop with staff and patients that have a lot of value-add.

Script to Introduce PRAPARE

Develop a script for introducing PRAPARE to patients with patient and staff input as to the language and tone used. Below are some sample scripts, as well as in the last section on "Sample Scripts for Introducing PRAPARE to Patients".

- Email message to patients to complete PRAPARE online and be connected to resources: Developed by Lone Star Circle of Care in Texas
- Script for staff to use when conversing with patients: Developed by Venice Clinic in California
- Guide to Creating an Empathic Inquiry Conversation around Social Determinants of Health Screening: Developed by the Oregon Primary Care Association

Community Resource Guide

Create or enhance a list of resources or "Community Resource Guide" that maps to PRAPARE-identified assets, risks, and experiences. Engage a wide variety of staff and patients in developing this resource as they may be knowledgeable about resources available in the community. If local resources do not exist, provide resources in the next closest city and/or national resources or online links.

Some health centers created one-page resource lists for community services in both English and Spanish to include in all patient registration packets. To learn more about what worked well for California health centers in developing messaging and resources for their staff and patients, read our series of California health center case studies.

BEST PRACTICE

For rural areas or small towns where resources may be scarce, it is always worth reaching out to social service organizations in the next closest city to see if they would be willing to serve your community. A health center in rural Massachusetts discovered that they had high food insecurity amongst their patients after administering PRAPARE. Their town did not have a food bank, but they called a food bank in Boston 70 miles away to see if they could help. Because the health center had data to demonstrate their need, the Boston food bank was happy to form a partnership where the Boston food bank delivers a truckload of food (both fresh and non-perishable) every week to the health center.

Education Flyers

Flyers are a great way to educate patients and the community on the purpose of PRAPARE and how data will be used to inform care and services at your organization that can be placed throughout your organization for patients to see. La Clinica de la Raza in California developed PRAPARE flyers in English and Spanish to communicate with their community.

Website

For organizations that are supporting members in implementing PRAPARE, consider building a website to house resources and training materials, host a shared calendar of events, share results and lessons learned, and to engage in discussion. The Minnesota Association of Community Health Centers developed a website for their members that helped facilitate engagement and shared learning.

Developed by La Clinica de la Raza (Oakland, California)

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. The PRAPARE team or the organization as a whole can celebrate with lunch or a party once a certain goal or milestone is met or when their work had a positive impact for their patients.

ENCOURAGE FRIENDLY COMPETITION

Care teams can engage in friendly competition around meeting or surpassing milestones. Alternatively, individuals who reach certain milestones could be placed in a raffle for a gift to encourage individual motivation.

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. This is also a great way to engage other staff or organizations because they can better appreciate the value of having this kind of data to inform their work.

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 that they place throughout the organization for patients and staff to see, organize a health fair around that particular social determinant, centralize their newsletter on that particular social determinant, have meetings focused on that particular social determinant, and so on.

CASE STUDY

Read this case study on how a health center in Oregon engaged and educated their staff, leadership, and patients to jumpstart their PRAPARE implementation process.

CHAPTER 2: Engage Key Stakeholders and Answer Commonly Asked Questions

Importance of Empathic Inquiry Approaches to Collecting PRAPARE Data

Consider using the method of Empathic Inquiry: an approach to social needs screening that promotes partnership, affirmation, and patient engagement through synthesis and application of the concepts and methods of motivational interviewing and trauma-informed care, as well as input from patients and professionals. As health systems, the focus should not only be on the tool for social needs screening, but also on the communication style and skills that guide these interactions with patients.

It is critical to understand that one person's data is another person's difficult life experience. In order to create primary care environments that are patient-centered, we must not only learn to address social barriers to health, but that we do so in a way that emphasizes sensitivity, compassion, and patient empowerment.

For success, consider the following Patient-Centered Principles from the Oregon Primary Care Association Empathic Inquiry Curriculum:

1. Support autonomy and respect privacy.
2. Provide a clear explanation for conducting the screening, how information will be used and options for follow-up.
3. Share power by asking about patient priorities.
4. Account for the stigma associated with experiencing social needs, as well as personal assumptions about the experiences and capacities of patients.
5. Ask about strengths, interests, and assets.
6. Test screening workflows with patients before standardizing approach.
7. Ensure that information disclosed by patients through social determinants of health screening is shared with and acknowledged by all members of the care team.
8. Select a care team member with sufficient time to connect with patients about social determinants of health needs.
9. Minimize patient and staff distress and trauma.

FOR MORE INFORMATION AND RESOURCES ON EMPATHIC INQUIRY

- View this video developed by the Waianae Coast Comprehensive Health Center for a demonstration of the Empathic Inquiry method.
- Review the Patient-Centered Social Determinants of Health Screening Conversation Guide developed by the Oregon Primary Care Association for tips on how to develop an empathic conversation and script to use with patients.
- View Patient-Centered Principles for a more comprehensive explanation of patient-centered principles.

Sample Scripts to Introduce PRAPARE to Patients

What follows are sample scripts that PRAPARE users have developed to educate patients on the importance of collecting data on the social determinants of health and how that information will inform care and services.

- Email message to patients to complete PRAPARE online and be connected to resources: Developed by Lone Star Circle of Care in Texas
- Script for staff to use when conversing with patients: Developed by Venice Clinic in California
- Guide to Creating an Empathic Inquiry Conversation around Social Determinants of Health Screening: Developed by the Oregon Primary Care Association

CHAPTER 3
Strategize the Implementation Plan

After gaining an understanding of the project and engaging your stakeholders, it is important to think about how to strategize the PRAPARE data collection to fit within your overall organizational vision, workflow, and future strategy. This chapter provides a step-by-step companion guide to strategizing PRAPARE implementation at your organization. Implementation tools, such as suggested timelines, action steps, and readiness assessments, are provided that you can use and modify for your organizational needs as appropriate.

PRAPARE Readiness Assessment Tools

Before strategizing your PRAPARE implementation plan, you should first 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 related to the following categories:

The assessment can inform you where your organization is at and help you decide where you want your organization to be as well as provide guidance on how to become "highly prepared." These suggestions can help initiate conversations among staff about the plans that fit best for your organization and help secure strong buy-in from leadership and staff champions to ensure the implementation plan is carried out effectively.

Similarly, if you are an organization who provides support to your member organizations (such as Primary Care Associations), you can use the PRAPARE Readiness Assessment Tool for Primary Care Associations to assess your organization's readiness to support your member organizations in implementing PRAPARE and using PRAPARE data.

It is important to have strategic planning discussions with staff at multiple levels from executive to frontline staff (with organizational champions representing each level) to develop a workplan that is as realistic and feasible as possible. Tools such as the PRAPARE Readiness Assessment will help staff work through these decisions and needs for successful implementation.

Implementation Timelines

TABLE 3.1 showcases two different suggested implementation timelines with primary activity steps that you can use and modify for your organization's situation. One timeline is for organizations that may be more ready to implement PRAPARE and one may be more realistic for organizations that may need more time to engage and educate their teams.

> Please note that the timeframe is estimated based on experiences at a sample of health organizations, taking into consideration the organizational priorities undertaken by the majority of health organizations. Some activities can also take place simultaneously, decreasing the total time needed for implementation. The timeframe will inevitably vary based on the organization's priorities as well as readiness for data collection. Some organizations can implement PRAPARE in as little as one to two months, whereas other may take four months to a year.

TABLE 3.1. Suggested PRAPARE Implementation Timelines

ACTIVITY	QUICK IMPLEMENTATION TIMELINE	TIMELINE FOR ORGANIZATIONS WHO NEED MORE TIME
Strategic priority and needs assessment	~1 week	~ 1 week
Change management presentation to key staff	~1 week	~ 3 weeks
Develop/refine template as needed	~1 week	~ 3 weeks
Complete mapping, database and template	~1 week	~ 1 month
Develop workflow for data input	~1 week	~ 1 month
Train staff to collect data	~1 week – 1 month	~ 1 – 2 months
Train data analysts	~1 week	~ 3 weeks
Complete implementation readiness assessment	~3 days	~ 1 week
Implement initial pilot data collection	~1-3 months	~ 2 – 4 months
Evaluate implementation process	~1 week	~ 2 weeks
Data analysis and reporting	~1-2 weeks	~ 3 weeks
Sharing and dissemination	~1 week	~ 2 weeks
TOTAL APPROXIMATED TIMEFRAME	**3-4+ MONTHS**	**9 MONTHS – 1 YEAR**

The Five Rights Framework

The Five Rights of Clinical Decision Support (CDS) is a key health information technology framework that can help in planning PRAPARE workflow and implementation in your practice. Based on this framework, implementation must provide the following to improve targeted health outcomes, quality of care, efficiency, & cost-savings:

THE RIGHT INFORMATION	IN THE RIGHT FORMAT	WITH THE RIGHT PEOPLE	VIA THE RIGHT CHANNELS	AT THE RIGHT TIMES
WHAT sociodemographic information is already being collected that PRAPARE can align with rather than duplicate? How will intervention or resource information be organized so that it is readily available and standardized for all when needs are identified by PRAPARE?	**HOW** will the PRAPARE tool be administered to patients to ensure it accurately and respectfully captures the patients' social determinants of health?	**WHO** will collect the PRAPARE data and who will address the social determinant needs identified?	**WHERE** will PRAPARE data be collected and how will it be shared with the appropriate care team members to inform care appropriately and address needs identified?	**WHEN** in the patient visit does it make sense to administer the PRAPARE tool and when is the best time to address the identified needs?

By pre-defining the set of goals and objectives for implementation, your organization can determine the what (information), how (format), who (implementer and recipient), where (location), and when (workflow) for PRAPARE data collection to best fit your organizational needs. **TABLE 3.2** applies the Five Rights Framework to develop key questions to strategize PRAPARE implementation workflows to both collect and respond to PRAPARE data that best fit into your organization's setting and current workflow. You can read Chapter 5 of the PRAPARE Implementation and Action Toolkit on "Developing Workflow Models for PRAPARE Implementation" to view real life examples of different organizational workflow models and the tradeoffs associated with each.

TABLE 3.2. Using Five Rights Framework to Plan Workflow for PRAPARE Data Collection and Response

5 RIGHTS	WORKFLOW CONSIDERATIONS	RESPONSE WORKFLOW CONSIDERATIONS
Right Information: WHAT	**What information in PRAPARE do you already routinely collect?** • Part of registration • Part of other health assessments or initiatives	**What information and resources do you have to respond to social determinants data?** • Update your community resource guide and referral list with accurate information • Track referrals, interventions, and time spent
Right Format: HOW	**How are we collecting this information and in what manner are we collecting it?** • Self-Assessment? • In-person with staff?	**How will intervention and community resource information be stored for use and presented to patients?** • Searchable database of resources (in-house or via partner)? • Printed resource for patients to take with them? • Warm hand-off for referrals?
Right Person: WHO	**Who will collect the data? Who has access to the EHR? Who has contact with the population of focus? Who needs to see the information to inform care?** • Providers and other clinical staff? • Non-Clinical Staff?	**Who will respond to social determinants data?** • By a dedicated staff person? • By any staff person who administers PRAPARE with the patients? • By the provider?
Right Channel: WHERE	**Where are we collecting this information? Where do we need to share and display this information?** • In waiting room? In private office? • Share during team huddles? Provide care team dashboards?	**Where will referrals and/or resource provisions take place?** • In private office? • In the exam room?
Right Time: WHEN	**When is the right time to collect this information so as to not disrupt clinic workflow?** • Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?	**When will referrals take place?** • Immediately after need is identified? • After the patient sees the provider? • At the end of the visit?

RESOURCES

Chapter 5 of the PRAPARE Implementation and Action Toolkit on "Developing Workflow Models for PRAPARE Implementation" provides real life examples of different organizational workflow models and the tradeoffs associated with each.

Five Rights Worksheet Tool to help guide you through the workflow planning process.

PDSA Process

Once you have developed your workflows using the Five Rights Framework, you can test them using the PDSA process – a systematic series of steps that can be applied to understand needed improvements to optimize implementation for quality improvement. The framework will guide you in testing changes in real world practice settings by planning the change, testing the change, observing the results, and acting on what is learned. You first need to address three fundamental questions to help you set aims, establish measures, and select implementation changes.

After refining the changes through several PDSA cycles as needed, you can implement the changes on a broader scale (e.g., to larger populations or other departments in your organization).

1 What are the objectives that you are trying to accomplish and by when?
- Who is your population of focus?
- Be specific as possible including who will be involved, when it will be accomplished, where it will take place, and by when.

2 How will you know that a change is an improvement?
- Use objective, quantitative measures.

3 What change can you make that will result in improvement?
- Be sure to ask those most affected by the implementation.

After you set the aims, establish the specific measures, and select the changes, you can follow the PDSA cycle below to test the change to determine if the change was an improvement:

PLAN	**DO**	**STUDY**	**ACT**
List the tasks needed to set up the implementation	Describe what actually happened when you ran the implementation	Describe the measured results and how they compared to the predictions	Describe what modifications to the plan will be made for the next implementation cycle from what you learned.

CASE STUDY

Read this real-life example of an organization's use of the PDSA cycle on their PRAPARE implementation process.

Workplan and Progress Reports

After strategizing PRAPARE implementation, it is helpful to develop a workplan to document roles and responsibilities for team members involved. Keep your PRAPARE implementation goals for your organization front and center to remind your team about your overall objectives. Below are sample workplans developed by the PRAPARE team where team members can insert their progress, challenges, and solutions, as well as next steps. Keep these documents on your organization's shared drive where team members can track up-to-date information and status to understand ongoing needs.

RESOURCES

Workplan to strategize PRAPARE implementation strategy: Developed by the PRAPARE team

Workplan to document tasks, roles and responsibilities, and to report on progress: Developed by the PRAPARE team

BEST PRACTICE

Use these workplans to structure regular meetings where team members can huddle to share lessons learned, challenges, solutions, best practices, and additional helpful materials and tools. Meetings can also be a means to understand ongoing needs from various team members and a way to celebrate accomplishments. Consider leveraging existing similar meetings to reduce staff time to meet. For example, meetings can be incorporated into existing staff quality improvement meetings.

Tips for Getting Started

Start Small

Implementing PRAPARE can seem like a major undertaking but can be approached in ways that strategically "ease in" to implementation. Starting small allows you to work out any issues in workflow, dispel common myths or concerns, and use findings and lessons learned to educate others on how PRAPARE data can be used to encourage more buy-in.

The Oregon Primary Care Association piloted an approach known as the "3 by 10" approach whereby they asked their member health centers to choose just three questions from PRAPARE and ask those three questions with ten patients.

- New information that they did not know about their patients
- The ease and feasibility of gathering this information through conversations with patients
- Patient's comfort and willingness to discuss their socioeconomic situations
- The applicability of this information and how it could be used to inform the care they provided and how it could help them better manage their patient populations.

After implementing the "3 by 10" approach, staff were more comfortable in using the full PRAPARE tool to better understand their patients and how they could better care for them. Thus, starting small allowed staff to experience the feasibility of PRAPARE and the importance and potential use of collecting information on the social determinants of health.

Select a Population of Focus

While we believe it is important to have an understanding of all of your patient's socioeconomic needs and circumstances, starting with a population of focus is a strategic way to test PRAPARE workflows and share data findings and lessons learned for further engagement and buy-in.

Populations of focus may be determined by the organization's objectives, by staff availability and workflow alignment, or by project deliverables. Common populations of focus include:

ALL PATIENTS	ALL NEW PATIENTS (PRAPARE part of new-patient orientation)	PATIENTS WITH MULTIPLE CO-MORBIDITIES
PATIENTS WHO HAVE A CERTAIN TYPE OF VISIT (e.g., annual wellness visit, home health visit, etc.)	PATIENTS WHO SEE A CERTAIN STAFF OR PROVIDER (e.g., chronic disease management team, behavioral health provider, care coordinator, etc.)	PATIENTS WHO ATTEND CERTAIN CLASSES (e.g., prenatal classes, diabetes education classes, etc.)

CHAPTER 4
Technical Implementation with PRAPARE Electronic Health Record Templates

To help facilitate standardized PRAPARE data capture, we worked with Electronic Health Record (EHR) vendors and Health Center Controlled Networks to create PRAPARE EHR templates that are freely available to users.

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

- Cerner
- Epic
- eClinicalWorks
- GE Centricity
- NextGen

We are working with several other vendors to develop additional PRAPARE EHR templates. If you are interested in working with us to engage your vendor and develop a PRAPARE EHR template, please contact us at prapare@nachc.org.

NATIONAL ASSOCIATION OF Community Health Centers

AAPCHO
Association of Asian Pacific Community Health Organizations

OPCA
Oregon Primary Care Association

About the PRAPARE EHR Templates

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.
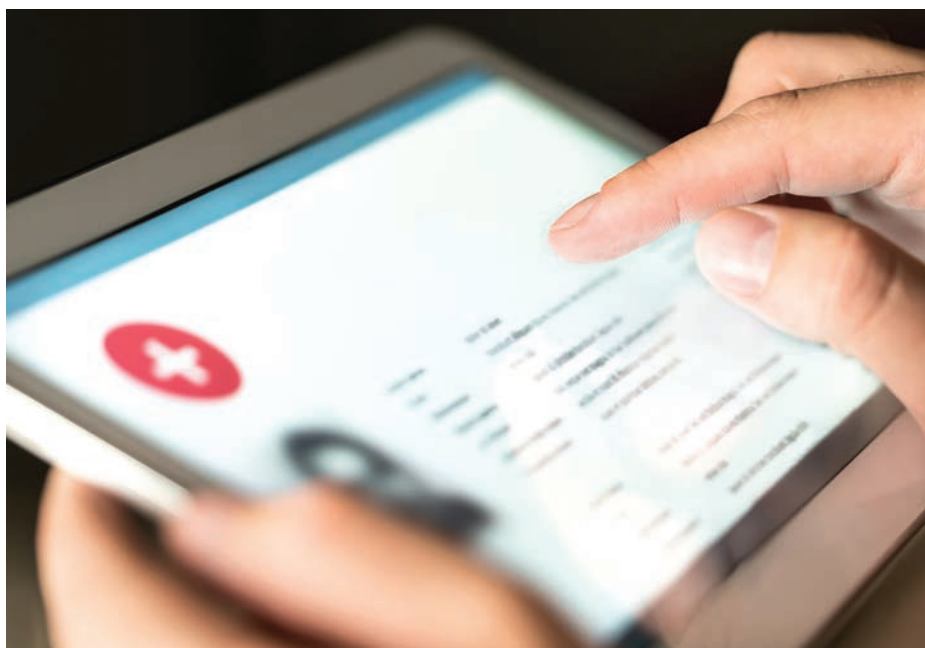
Accessing the PRAPARE EHR Templates

To access the free PRAPARE EHR templates, you must first sign an End User License Agreement. **By signing the End User License Agreement, you agree to not share these resources outside of your organization without permission from NACHC.**

Click here to sign an End User License Agreement to access free Electronic Health Record PRAPARE templates for Cerner, Epic, eClinicalWorks, GE Centricity, and NextGen.

Collecting PRAPARE Data Without an EHR Template

For those who use an EHR where a PRAPARE template doesn't currently exist, we also have an Excel file template that allows you to collect standardized PRAPARE data in Excel until a PRAPARE EHR template is developed.

- PRAPARE Data Collection Excel Template
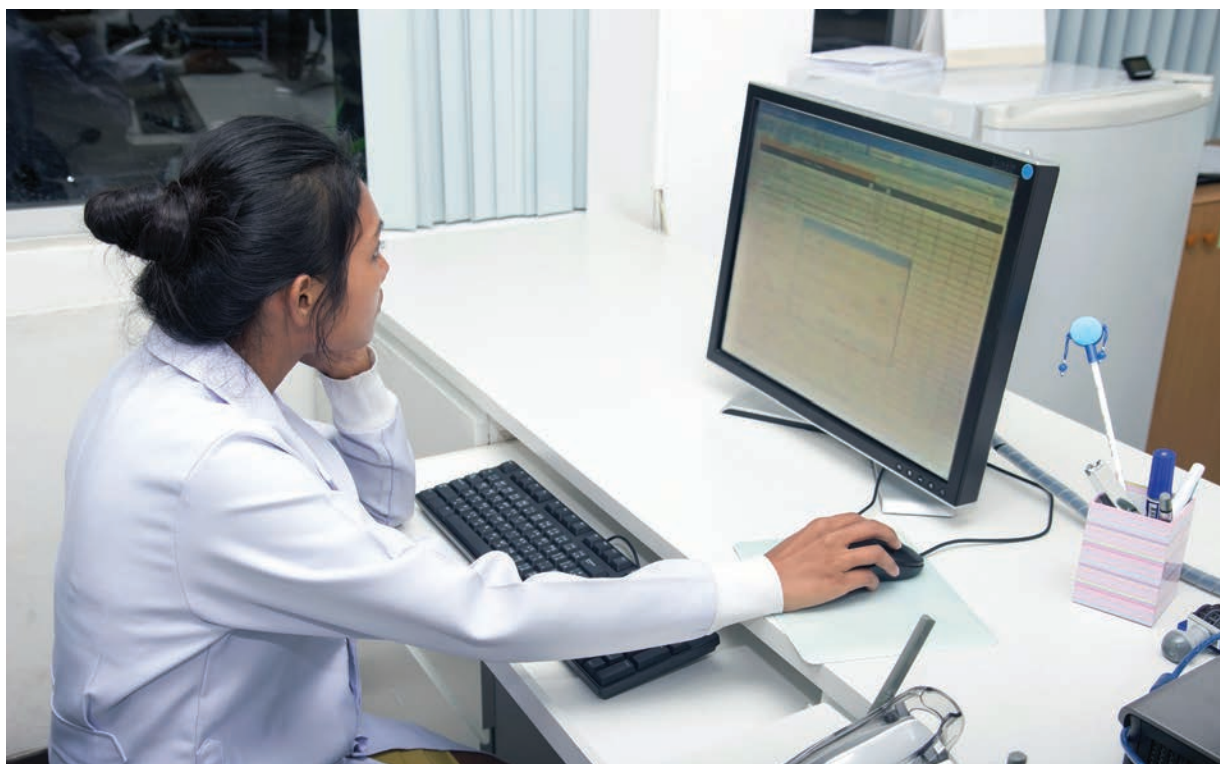
CHAPTER 5
Workflow Implementation

When initiating a new data collection initiative, it is important to educate key staff on the importance of collecting data on the social determinants of health and how it aligns with activities that your organization is already doing. It is also important to use the Five Rights Framework to find the right person to collect the data at the right time in the workflow so as not to lengthen the clinic visit or overburden staff.

This chapter contains resources to help you think through how to train staff in collecting data on the social determinants of health in a way that fits best in your workflow.

Sample Workflow Diagrams To Collect Data on the Social Determinants of Health

Collecting data on the social determinants of health using PRAPARE can be accomplished in a variety of ways. There is no absolute "right way"—only what works best in your setting. Think of your organizational workflow to identify opportunities when patients are waiting to be seen or are not engaged in meaningful connection with staff and use that time instead for dialogue and assessment around social determinants so as not to lengthen the visit. Also, consider how PRAPARE workflows can align with existing staff roles and responsibilities as there are many different types of staff who can help implement PRAPARE. From there, you can determine where in the organization and who amongst your staff would have the available time and skills to administer PRAPARE with the patient and address their needs.

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. **TABLE 5.1** walks through the key questions to consider when determining your PRAPARE workflow.

THE RIGHT INFORMATION	IN THE RIGHT FORMAT	WITH THE RIGHT PEOPLE	VIA THE RIGHT CHANNELS	AT THE RIGHT TIMES
WHAT sociodemographic information is already being collected that PRAPARE can align with rather than duplicate? How will intervention or resource information be organized so that it is readily available and standardized for all when needs are identified by PRAPARE?	**HOW** will the PRAPARE tool be administered to patients to ensure it accurately and respectfully captures the patients' social determinants of health?	**WHO** will collect the PRAPARE data and who will address the social determinant needs identified?	**WHERE** will PRAPARE data be collected and how will it be shared with the appropriate care team members to inform care appropriately and address needs identified?	**WHEN** in the patient visit does it make sense to administer the PRAPARE tool and when is the best time to address the identified needs?

TABLE 5.1. Using Five Rights Framework to Plan Workflow for PRAPARE Data Collection and Response		
5 RIGHTS	**WORKFLOW CONSIDERATIONS**	**RESPONSE WORKFLOW CONSIDERATIONS**
Right Information: WHAT	**What information in PRAPARE do you already routinely collect?** • Part of registration • Part of other health assessments or initiatives	**What information and resources do you have to respond to social determinants data?** • Update your community resource guide and referral list with accurate information • Track referrals, interventions, and time spent
Right Format: HOW	**How are we collecting this information and in what manner are we collecting it?** • Self-Assessment? • In-person with staff?	**How will intervention and community resource information be stored for use and presented to patients?** • Searchable database of resources (in-house or via partner)? • Printed resource for patients to take with them? • Warm hand-off for referrals?
Right Person: WHO	**Who will collect the data? Who has access to the EHR? Who has contact with the population of focus? Who needs to see the information to inform care?** • Providers and other clinical staff? • Non-Clinical Staff?	**Who will respond to social determinants data?** • By a dedicated staff person? • By any staff person who administers PRAPARE with the patients? • By the provider?
Right Channel: WHERE	**Where are we collecting this information? Where do we need to share and display this information?** • In waiting room? In private office? • Share during team huddles? Provide care team dashboards?	**Where will referrals and/or resource provisions take place?** • In private office? • In the exam room?
Right Time: WHEN	**When is the right time to collect this information so as to not disrupt clinic workflow?** • Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?	**When will referrals take place?** • Immediately after need is identified? • After the patient sees the provider? • At the end of the visit?

What follows are sample workflow diagrams. Please note that these workflows do not need to be adopted exactly as presented but are rather meant to serve as samples to help you think through your own clinic workflow. In some cases, the staff involved may differ but the workflow is similar.

TABLE 5.2. Summary of PRAPARE Workflow Models and Response

WHO	WHERE	WHEN	HOW
NON-CLINICAL STAFF (Patient Advocates, Patient Navigators, Community Health Workers, etc.)	In patient advocate's office	After clinical visit	Administered PRAPARE and responded to needs identified. Discussed needs with provider and care team.
NON-CLINICAL STAFF (outreach and enrollment staff, eligibility assistance staff, etc.)	In waiting room	Before provider visit	Administered PRAPARE with patients who would be waiting 30+ minutes for provider
CLINICAL STAFF (nurses, medical assistants, etc.)	In exam room	Before provider enters exam room	Administered PRAPARE after vitals and reason for visit. Provider reviews data to inform treatment plan
CARE COORDINATORS	In care coordinator's office	When completing Health Risk Assessments	Administered PRAPARE in conjunction with Health Risk Assessments to address similar needs in real time
CHRONIC DISEASE MANAGEMENT TEAM	In exam room	During the clinical visit	Administered PRAPARE with patients and discussed needs as a team to develop appropriate response and care management plan
INTERPRETERS	In waiting room or exam room	Before the clinical visit	Administered PRAPARE with patients requiring language assistance.
ANY STAFF (from front desk staff to providers)	"No Wrong Door" approach	"No Wrong Door" approach	"No Wrong Door" approach where any staff can ask PRAPARE questions at any time to paint fuller picture of patient
SELF-ASSESSMENT	In waiting room or at home	Before the clinical visit	Patient self-assesses using paper version of PRAPARE or Ipads, kiosks, tablets, email, patient portal, etc.

Using Non-Clinical Staff After the Visit

Non-clinical staff includes patient navigators, patient advocates, community health workers, eligibility assistance workers, outreach and enrollment workers, among others.

Reasons to Use this Model

- Non-Clinical staff are often employed from the community so can more easily relate to patients, understand their needs, and build trusting relationships
- Non-clinical staff are also often more aware of available community resources
- Non-clinical staff often have similar responsibilities so may have more time to administer and respond to socioeconomic needs compared to other staff
- Ensures staff person administering PRAPARE also addresses needs identified by referring patient to resources

Advantages

- Doesn't delay visit with provider
- Provides immediate warm hand-off to services and resources
- Allows patient to become familiar and comfortable with the clinical setting

Tradeoffs

- Provider doesn't have PRAPARE socioeconomic data available during clinic visit to inform care
- Could lengthen overall visit time

CLINICAL VISIT WITH PROVIDER

- Provider conducts clinical visit
- Provider refers patient to non-clinical staff on an annual basis or if need certain services

REFERRAL TO NON-CLINICAL STAFF

- Non-clinical staff explains why they are administering PRAPARE and how it can help inform the patient's care plan

ADMINISTER PRAPARE

- Non-clinical staff asks the patient to answer PRAPARE questions, either on their own or through conversation
- If patient has already answered PRAPARE questions in the past, staff asks if patient would answer these differently

DOCUMENT PRAPARE RESPONSES

- Non-clinical staff records and dates the patient's answers and/or updates in the PRAPARE EHR template, using ICD-10 Z codes when possible

RESPOND TO NEEDS

- Non-clinical staff connects patient to available resources, either those in-house or those available in the community
- If no needs are identified, non-clinical staff will flag next appointment for annual PRAPARE screening

CLOSE THE LOOP

- Non-clinical staff follows-up with patient to determine if resources were utilized
- Document in the Electronic Health Record

Using Non-Clinical Staff Before the Visit

Non-clinical staff includes patient navigators, patient advocates, community health workers, eligibility assistance workers, outreach and enrollment workers, among others.

Reasons to Use this Model

- Non-clinical staff are often employed from the community so can more easily relate to patients, understand their needs, and build trusting relationships
- Non-clinical staff are also often more aware of available community resources
- Non-clinical staff often have similar responsibilities so may have more time to administer and respond to socioeconomic needs compared to other staff
- Ensures staff person administering PRAPARE also addresses needs identified by referring patient to resources

Advantages

- Socioeconomic needs identified before the visit can be used by the provider and other care team members to shape the visit and treatment plan to match the patient's circumstances and situation
- Ensures that time is not added to the visit but uses "value added" time when the patient is waiting to be roomed or to see the provider

Tradeoffs

- If administered in the waiting room, patient may not feel as comfortable sharing information if waiting room lacks privacy
- If the patient arrives late, there may not be enough time to administer PRAPARE
- PRAPARE assessment or responding to needs could be interrupted if provider is ready to see the patient
- Could delay visit with provider if non-clinical staff is still administering PRAPARE
- May encounter confusion or resistance from patient if they are expecting to meet with a provider. Messaging is key to explain the purpose of PRAPARE and how it can help inform the patient's visit and care plan.

PATIENT WAITS TO SEE PROVIDER
- Patient waits to see provider, either in waiting room or exam room
- Non-clinical staff identifies patients to ask PRAPARE based on their approximate wait times

NON-CLINICAL STAFF ADMINISTERS PRAPARE WHILE PATIENT WAITS
- Non-clinical staff explains why they are administering PRAPARE and how it can help inform the patient's care plan
- Non-clinical staff goes through PRAPARE with patient or lets patient self-administer using Ipad, tablet, or paper form

DOCUMENT PRAPARE RESPONSES
- Non-clinical staff records and dates the patient's answers and/or updates in the PRAPARE EHR template, using ICD-10 Z codes when possible

PATIENT SEES PROVIDER
- Provider views PRAPARE data in the Electronic Health Record
- Patient's socioeconomic situation is taken into account when providing treatment plans and prescriptions

RESPOND TO NEEDS
- Provider or non-clinical staff connects patient to available resources, either those available in-house or those available in the community
- If no needs are identified, provider or non-clinical staff will flag next appointment for annual PRAPARE screening

CLOSE THE LOOP
- Non-clinical staff follows-up with patient to determine if resources were utilized
- Document in the Electronic Health Record

Using Clinical Staff During Clinical Visit

Clinical staff include nurses, medical assistants, and behavioral health specialists, among others.

Reasons to Use this Model

- Clinical staff are trained to collect sensitive information and have experience collecting sensitive data

Advantages

- Administering PRAPARE in the exam room ensures that the information is collected in a private setting, rather than in a waiting room
- Socioeconomic needs identified before the visit can be used by the provider and other care team members to shape the visit and treatment plan to match the patient's circumstances and situation

Tradeoffs

- PRAPARE assessment could be interrupted if provider comes into the exam room ready to see the patient
- Clinical staff typically have heavy workloads and staff burnout is prevalent
- Clinical staff may not be as knowledgeable about community resources to respond to needs

PATIENT ENTERS EXAM ROOM
- Patient is led from waiting room to the exam room to wait and see the provider

CLINICAL STAFF ENTERS EXAM ROOM & ADMINISTERS PRAPARE
- Clinical staff explains why they are administering PRAPARE and how it can help inform the patient's care plan
- Clinical staff uses "value-added" time when patient would otherwise be waiting to go through PRAPARE with patient or lets patient self-administer using Ipad, tablet, or paper form

DOCUMENT PRAPARE RESPONSES
- Clinical staff records and dates the patient's answers and/or updates in the PRAPARE EHR template, using ICD-10 Z codes when possible

RESPOND TO NEEDS
- Clinical staff connects patient to available resources, either those available in-house or those available in the community
- Notifies non-clinical staff, case manager, or social worker to assist patient given needs identified
- If no needs are identified, provider or non-clinical staff will flag next appointment for annual PRAPARE screening

PROVIDER ENTERS ROOM & PERFORMS CLINIC VISIT
- Provider views PRAPARE data in the EHR
- Patient's socioeconomic situation is taken into account when discussing treatment plans

FOLLOW-UP & CLOSE THE LOOP
- If exam room remains open, non-clinical staff, case manager, or social worker will follow-up immediately with needed resources
- If there is no time, non-clinical staff will follow-up with patient to provide resources
- Document in the EHR

Using Care Coordinators After the Clinical Visit

Reasons to Use this Model

- Care coordinators often administer multiple types of assessments that collect similar or complementary information (e.g., mental health screening, depression screening, domestic violence screening, etc.) so adding PRAPARE to their assessments can add value to their work
- Care coordinators are trained to collect sensitive information and have experience collecting sensitive data
- Care coordinators are well suited to coordinate care and services to meet the needs identified by PRAPARE

Advantages

- When administered in conjunction with other assessments, similar needs can be addressed in real time

Tradeoffs

- Care coordinators have many other care coordination responsibilities so may not have as much time to administer and address needs in PRAPARE as other staff

PATIENT HAS CLINIC VISIT WITH PROVIDER

- Provider conducts clinical visit
- Provider refers patient to care coordinator if considered "at risk"

CARE COORDINATOR ADMINISTERS PRAPARE & OTHER ASSESSMENTS

- Care coordinator administers PRAPARE along with other health risk assessments

CARE COORDINATOR DEVELOPS CARE MANAGEMENT PLAN

- Care coordinator develops patient care-management plan based on needs identified by PRAPARE and other health risk assessments

FOLLOW-UP WITH CARE COORDINATION

- Care coordinators follow-up with patient either in-person or telephonically to assist patient with accessing and coordinating care

Using Chronic Disease Management Team

Chronic disease management team typically consists of both clinical and non-clinical staff, including nurses, health educators, social workers, and dieticians, among others.

Reasons to Use this Model

- Using the chronic disease management approach allows your organization to focus on patients who are more at risk

Advantages

- Chronic disease management team has training, expertise, and skills beneficial for collecting PRAPARE data and addressing needs, such as motivational interviewing, crisis intervention, knowledge of community resources, etc.
- Chronic disease management team has established workflow and collaborative atmosphere between clini al and non-clinical staff, which is conducive for collecting PRAPARE data and discussing results as a team to inform care

Tradeoffs

- Potentially lengthens visit with chronic disease management team but will help the team with goal of chronic disease management

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PATIENT ENTERS EXAM ROOM

- Patient is led from waiting room to the exam room to see the chronic disease management team

CHRONIC DISEASE MANAGEMENT TEAM ADMINISTERS PRAPARE

- Chronic disease management team staff explains why they are administering PRAPARE and how it can help inform the patient's care plan
- Staff discusses and administers PRAPARE with patient or lets patient self-administer using Ipad, tablet, or paper form

DOCUMENT PRAPARE RESPONSES

- Clinical staff records and dates the patient's answers and/or updates in the PRAPARE EHR template, using ICD-10 Z codes when possible

CHRONIC DISEASE MANAGEMENT TEAM DISCUSSES APPROPRIATE CARE PLAN

- Team uses PRAPARE findings to inform care management plan

RESPOND TO NEEDS

- Chronic disease management team connects patient to available resources, either those available in-house or those available in the community
- If no needs are identified, staff will flag next appointment for annual PRAPARE screening

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Using Interpreters Before Clinic Visit

Reasons to Use this Model

- Helpful when serving patients speaking a variety of languages and from different cultural backgrounds
- For translated versions of PRAPARE, click here

Advantages

- Interpreters can help provide explanations and/or cultural contexts to PRAPARE questions
- Interpreters recruited from the community help build trust and relationships with patients
- By administering PRAPARE before visit with provider, provider can use PRAPARE resources to inform treatment plans and prescriptions at point of care.

Tradeoffs

- Interpreters are not always available
- Takes more time to administer PRAPARE when translating
- Different interpreters may PRAPARE data inconsistently. Having a staff person work with interpreters to record PRAPARE responses helps ensure consistency of data collection
- PRAPARE assessment could be interrupted if provider is ready to see the patient

IDENTIFY PATIENTS AT REGISTRATION

- Front desk staff checks patient in and asks for patient's language preference
- Staff identifies patients who will be waiting for provider and requires language assistance

STAFF AND INTERPRETERS ADMINISTER PRAPARE

- Staff and/or interpreter administers PRAPARE with patient using paper-translated versions of PRAPARE
- Patient views translated version of PRAPARE on paper while discussing with staff and interpreters

DOCUMENT PRAPARE RESPONSES

- If staff has access to the EHR, records and dates the patient's answers in the PRAPARE EHR template, using ICD-10 Z codes when possible
- If staff does not have access to the EHR, enters data on English translated version of paper PRAPARE tool
- Staff hands completed paper form of PRAPARE to staff with access to EHR to enter data

PATIENT SEES PROVIDER

- Provider views PRAPARE data in the EHR
- Patient's socioeconomic situation is taken into account when discussing treatment plans

RESPOND TO NEEDS

- Provider or non-clinical staff connects patient to available resources, either those available in-house or those available in the community
- If no needs are identified, provider or non-clinical staff will flag next appointment for annual PRAPARE screening

CLOSE THE LOOP

- Staff follows-up with patient to determine if resources were utilized
- Document in the Electronic Health Record

No Wrong Door Approach

Reasons to Use this Model

- Any staff can administer parts of PRAPARE at any time during the clinic visit and at any location within the clinic
- Fits PRAPARE into existing workflow by dividing responsibility across staff

Advantages

- Lessens burden on any one staff by spreading responsibilities across multiple staff
- Everyone has opportunity to help "paint a fuller picture" of their patients and better meet their needs, which leads to staff buy-in

Tradeoffs

- Requires coordination to ensure staff are aware of who is collecting which data to prevent duplication of questions asked to the patient
- Not all staff have access to the EHR to input data
- Hard to pinpoint single point of accountability when responsibilities are divided up across staff

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PATIENT CHECKS-IN AT FRONT DESK

- Front desk staff checks patient in and verifies and/or collects PRAPARE demographic information related to registration (address, race, ethnicity, language, insurance, veteran status, family size, income, etc.)

CLINICAL STAFF ROOMS PATIENT

- Clinical staff checks vitals
- Begins administering other questions from PRAPARE until provider enters the room
- Clinical staff records and dates the patient's answers and/or updates in the PRAPARE EHR template, using ICD-10 Z codes when possible

PROVIDER SEES PATIENT

- Provider conducts clinical visit
- Refers patient to non-clinical staff if needs identified by PRAPARE require additional resources or services

NON-CLINICAL STAFF COMPLETES PRAPARE

- Non-clinical staff completes PRAPARE if not fully administered
- Non-clinical staff connects patient to available resources, either those available in-house or those available in the community
- If no needs are identified, patient is checked out and provider or non-clinical staff will flag next appointment for annual PRAPARE screening

CLOSE THE LOOP

- Non-clinical staff and/or front desk staff follow-up with patient by phone to determine if resources were utilized
- Document in the Electronic Health Record

Self-Assessment Approaches
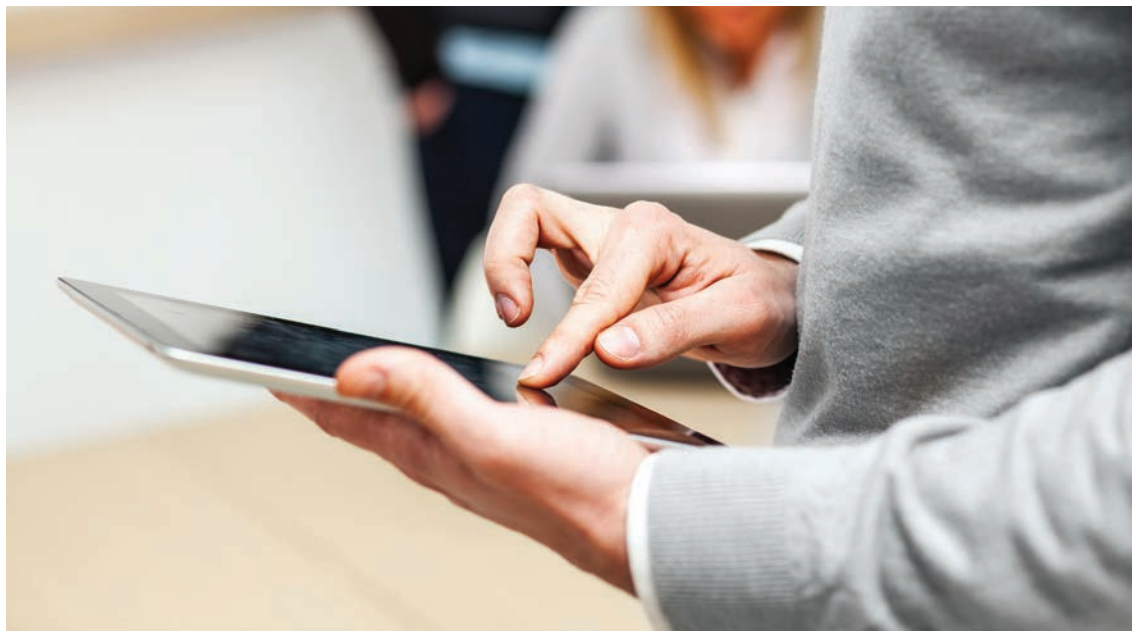
Pilot teams have strategized using other data collection modalities, particularly using patient portals, emails, or telephone interviews before the visit or Ipads or tablets during the visit so that patients may fill out PRAPARE themselves. Pilot teams have used Ipads or tablets for other data collection initiatives and have reported no problems with theft.

Messaging is key when using self-assessment approaches to ensure patients understand why this PRAPARE socioeconomic information is being collected,
how it will be securely stored, and how it will be used to inform care and services.

It is also important to ensure that follow-up care is provided to patients to discuss and/or address social risks identified. This can be achieved by talking to patients about their responses on the phone, at their next appointment, or through a partnership with a social service platform that immediately provides patients with a list of local community resources based on their responses.

Advantages

- Self-assessments may lead to more honest answers because they provide more privacy
- Self-assessments make good use of "value-added time" in that the patient fills out PRAPARE while waiting for staff or providers
- Does not lengthen clinic visit much at all, except to respond to needs identified.

Tradeoffs

- Self-assessments miss the opportunity to build better relationships between providers and staff
- If patient has trouble understanding the questions, there may not be a staff person available to explain and provide clarity

Administering PRAPARE via Email Before the Visit: The "Send, Collect, and Connect" System

Reasons to Use this Model

- If your organization has large patient population and/or your organization lacks adequate staff who can implement PRAPARE in-person during workflow
- Opportunity to align PRAPARE data collection with other direct patient communication and engagement methods

Advantages

- Great potential to collect large quantities of PRAPARE data in a short amount of time with little staff burden and low cost
- Able to acquire data quickly to inform care transformation and population health planning
- Quick for patients to fill out survey and can use mobile version
- Potential to connect patient with referrals to community services immediately upon completing PRAPARE

Tradeoffs

- Does not directly facilitate patient and care team relationship building
- Only reaches patients who are email-literate using translated languages
- No real-time feedback on patients' experience completing PRAPARE via email
- Requires IT-savvy staff to build email administration system

Read one health center's email message to administer PRAPARE.

TRANSFORM PRAPARE TOOL INTO EMAIL ASSESSMENT

- Team consisting of non-clinical staff and data analyst builds PRAPARE into organization's email system and composes email message and ensures it's mobile compatible and at appropriate reading level
- Email message should contain language on why they are administering PRAPARE and how it can help inform patient's care plan as well as normalizing language that social determinant risks are common
- Test email messaging with group of patients for comprehension and sensitivity

SEND PRAPARE VIA EMAIL

- Send to adult population with valid email address who had clinic visit within past year
- Send up to two follow-up emails to non-respondents

PATIENT COMPLETES PRAPARE VIA EMAIL

- Average time to complete PRAPARE via email ~ 35 seconds
- Majority of patients (60%) completed PRAPARE using their mobile device

FOLLOW-UP WITH PATIENTS TO ADDRESS NEEDS

- Staff can discuss PRAPARE results with patients and steps for action over the phone or at next clinic visit
- Organization can partner with social service platform to map community resources to specific PRAPARE responses so that patient receives list of resources available to address needs immediately after completing PRAPARE

Workflow Best Practices and Lessons Learned

The previous workflow examples highlight the fact that PRAPARE can be administered by a wide variety of staff at different times in the clinic visit. There is no right way or wrong way to administer PRAPARE. Only what works best in your setting. What follows are best practices and lessons learned gathered from different PRAPARE users.

FITTING PRAPARE INTO CLINIC WORKFLOW

ISSUE

Staff may feel reluctant to collect more data simply because they feel that it will be hard to fit into their workflow without significantly lengthening or disrupting the clinic visit.

LESSONS LEARNED ON FITTING PRAPARE INTO WORKFLOW

- It is important to find that "value-added" time when the patient would otherwise be waiting: either waiting in the reception area to be roomed or waiting in the exam room to see the provider. Using this value-added time will ensure that the clinic visit is not lengthened much to collect this data.

- Put a prompt or a "flag" in the Electronic Health Record (EHR) to remind staff to complete either certain PRAPARE questions or all PRAPARE questions depending on the patient.

- PRAPARE data collection can also be incorporated and/or streamlined into other data collection efforts or assessments (e.g., patient intake forms, health risk assessments, depression screenings, Patient Activation Measures, etc.). This way, the patient does not have to fill out multiple assessment forms. This also allows staff to address various needs that are identified by different assessments at the same time.

- It is important to note that responding to the needs identified will often require more time than simply identifying the needs. Organizations should strategize their approach to responding to needs, from warm hand-offs to referrals maintained in a community resource guide to particular staff that can discuss the needs and help the patient navigate through those needs and options for ways to respond to those needs (e.g., patient navigator, community health worker, etc.).

- Ensure that ALL staff working with the patient have access to the information discovered in PRAPARE conversations. Patients do not like to be asked for sensitive information multiple times, and it reflects that the patient is heard if they are not asked for the same information again.

BEWARE OF THE EMOTIONAL TOLL ON STAFF

ISSUE

- Staff may experience an emotional toll when collecting data on the social determinants of health, particularly if they feel that they cannot address the needs identified.
- Staff, particularly those employed from the community, may also experience an emotional toll if they have experienced similar socioeconomic challenges, either currently or in the past.

LESSONS LEARNED ON EMOTIONAL TOLL

- Assure staff that the organization has to "start somewhere and do the best with what we have" in their community resource guide and that the organization will not know what the patients' needs are until asked.
- Be sure to provide emotional and/or wellness support to staff experiencing distress. Support can come in the form of peer groups, wellness center or services, culture of empathy and wellness, behavioral health services, etc.
- If the organization's community resource guide is lacking, tracking this information as an organization can help staff feel connected to the bigger organizational need to identify services to be developed or improved, and community partnerships that need to be initiated or strengthened to provide services.
- Even if the organization does not have services to address particular social determinants, knowing a patient's socioeconomic situation can help inform care and treatment plans. For example, knowing a patient's social support system or educational status can inform how staff approach goal-settings with patients or how staff provide educational resources to patients.

EDUCATING AND TRAINING STAFF

ISSUE

Staff may not understand why the organization will collect patient-level data on the social determinants of health. They may also believe that the organization already collects data on the social determinants. Do not assume that staff (even clinical staff) have the training to collect sensitive socioeconomic information.

LESSONS LEARNED ON EDUCATING AND TRAINING STAFF

- Educate ALL staff at a high level so that everyone understands why the organization is collecting this information, how it adds value to other work they are already doing (medical homes, value-based pay systems, etc.), and how it will be used to better understand and care for their patients.
- All data collection staff should be trained in sensitive data collection techniques that build relationships with patients, such as empathic inquiry or talk story approaches.

Data Collection Techniques: Empathic Inquiry

PRAPARE was reviewed by a health literacy expert for a 4th – 5th grade reading level. However, it still contains sensitive questions. This section provides resources and tips on how to handle sensitive questions.

Many questions can be sensitive in nature. In some cases, they may feel intrusive (e.g., income, sexual activity, etc.); in other cases, they may reveal information that could be perceived as less desirable, judged, or unlawful (e.g., lifestyle habits, substance use, violence, etc.). Sensitive questions can be uncomfortable for the person ASKING the questions as well as for the person RESPONDING to the questions. When answering questions on sensitive topics, people sometimes edit their answers to hide things, to avoid talking about issues in front of other people, or to provide what they believe to be more socially acceptable answers. This is known as a "social desirability bias." To avoid this and gather more accurate data, it is important to build a culture around sensitivity and respect.

The purpose of empathetic inquiry approach is to authentically connect with patients to understand their needs and priorities by building trust between the patient and care team. This will ensure that all individuals are treated with respect and consideration and feel that they can speak honestly in a welcoming and open environment, especially when they are asked to speak on topics that open people up to vulnerability. It also builds trust between patients and providers and leads to the provision of more appropriate care and treatment plans. Sometimes answering a question, though sensitive, is therapeutic.

Empathic Inquiry

We advocate using an empathic inquiry approach, talk story approach, and/or motivational interviewing approach to most accurately and respectfully gather PRAPARE data since socioeconomic matters could be viewed as sensitive topics.

Empathic inquiry is the act of asking for information with the intent of understanding the patient's experiences, concerns, and perspectives, combined with a capacity to compassionately communicate this understanding for the purpose of creating human connection between patients and professionals. When using an empathic inquiry approach, the mindset changes from "collecting data" to "getting to know your population--one person at a time" in a way that can enhance patient and staff well-being.

Empathy as Evidence-Based Practice

- A review of 25 randomized trials stated "One relatively consistent finding is that physicians who adopt a warm, friendly, and reassuring manner are more effective than those who keep consultations formal and do not offer reassurance".[1]

- "A retrospective analysis of psychiatrists treating patients with depression reported that practitioners who created a bond had better results in treating depression with placebo than did psychiatrists who used active drug but did not form a bond."[2]

- In a randomized controlled trial studying subjective and objective markers of the severity and duration of infection with a common cold, patients who experienced greater levels of clinician empathy (in the form of empathetic conversation, eye contact, touch) had significantly lower severity and duration of colds than patients who either saw no clinician or who saw a clinician with limited empathy.[3]

PATIENT PERSPECTIVE

A pilot conducted by the Oregon Primary Care Association in 2018 reveals the following from 132 patients screened using PRAPARE by staff who had been trained in empathic inquiry:

- **91%** of patients indicated that having conversations about their socioeconomic circumstances built stronger relationship with the care team.

- **97%** agreed that social determinant of health screening was a good use of time, even though **56%** of them had never met their interviewer prior to this conversation.

- **80%** strongly agreed it was appropriate to be asked about their social needs.

- **Over 70%** strongly agreed they knew more about how the organization could assist them with non-medical needs and that they had information to reach out to new resources.

- **Over 50%** of patients said they would like to be screened for social determinants at every visit.

Skills and Strategies to Use in Empathic Inquiry

- Have conversation in a private area
- Reflectively Listen
- Affirm the individual's responses
- Support the autonomy of the individual: "Is it ok to review this with you?" "At any point, you can let me know you'd like to stop."
- Note the strengths of the individual
- Connect to resources when they are appropriate and/or available
- Use normalizing language to show that other people experience certain needs or exhibit certain behaviors too ("Did you know that 1 in 4 Texans experience food insecurity?")
- Use familiar wording ("love making" vs. "sexual intercourse"; "alcohol" vs. "liquor")[4]

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[1] Di Blasi, Z, et al. Influence of context effects on health outcomes: a systematic review. Lancet 2001; 357: 757-62.

[2] McKay, KM, et al. Psychiatrist effects in the psychopharmacological treatment of depression. J Affect Disord 2006; 92: 287-90.

[3] Rakel, D, et al. Practitioner empathy and the duration of the common cold. Family Medicine 2009; 41(7): 494-501.

[4] Bradburn N., et al. Asking Questions: The Definitive Guide to Questionnaire Design--For Market Research, Political Polls, and Social and Health Questionnaires. San Francisco: Jossey-Bass, 2004.

Staff Training Curriculums

What follows are examples of staff training curriculums that different organizations using PRAPARE have developed to train their own staff. Common themes in the curriculums include: educating staff on the importance of the social determinants, how it aligns with the organization's goals, how to collect those determinants using the specific EHR system, and how to connect patients to available resources to meet the needs identified.

- Sample Staff Training Curriculum: Developed by La Clinica de la Raza in California
- Sample Staff Training Curriculum: Developed by the Health Center Network of New York
- Sample Staff Training Curriculum: Developed by the Alliance of Chicago Community Health Services

CHAPTER 6
Develop a Data Strategy

As you initiate PRAPARE data collection, it is important to develop a strategy and system for reporting your data in a manner that can be effectively communicated to providers, community partners, payers, policymakers and other stakeholders to promote community transformation and other related efforts. Your strategy should include plans to meet your organizational vision and goals as well as considerations to integrate PRAPARE data into a larger national data warehouse to contribute to a critical mass of data for effective delivery system transformation.

The ability to perform data analyses and reporting is essential for organizations to manage the health of their patients and enhances their capacity to make more evidence-based decisions. This chapter provides strategies and sample tools to help you in developing the data strategy including sample reporting templates and data integration planning.

NATIONAL ASSOCIATION OF Community Health Centers

AAPCHO
Association of Asian Pacific Community Health Organizations

OPCA
Oregon Primary Care Association

Building a Data Strategy

After you collect PRAPARE data, what will you do with it and how can you use it to add value to your practice? Start by developing a data strategy to understand how best to organize the data so that you can make informed decisions and help you achieve your intended organizational goals.

This data strategy serves as a roadmap and plan to define what to do with your data, how the data will help achieve your organizational goals, as well as who will access it, the content that you will share to make the most out of the data, and how to support these activities. The following is a checklist of steps to consider in developing a data strategy.

Seven Steps for Developing a PRAPARE Data Strategy

STEP 1	OUTLINE PRAPARE DATA GOALS

DETAILS

- Work with key leadership/staff to identify organizational objectives for PRAPARE data collection.
- Identify your specific objectives with data collection.
- Define your target audience.
- Define baseline as basis for measuring success.
- Ensure alignment with your organizational vision.
- Start with the end in mind: Always focus on your endpoint throughout implementation.
- Be sure to use participatory process: engage clinic staff and all relevant stakeholders in planning / strategy early on.

EXAMPLES

- *Use data to improve at least one key PRAPARE social determinants of health barrier X for the general adult patient population at the community level.*
- *Baseline is 1000 referrals per month.*
- *Increase referrals for barrier X by at least 25% above baseline after 6 months.*

ASSESS PRAPARE DATA CAPACITY AND INFRASTRUCTURE

DETAILS

- People: Assess IT/data, leadership, and other staff and organizational data culture. Leverage existing partners and collaborations.
- Process: Assess existing processes and initiatives (e.g. validation). Determine where efficiencies are possible.
- Technology: Assess data aggregation, reporting, and analysis tools, resources, systems

EXAMPLES AND SOURCES

- *View the Center for Care Innovation's Data Analytics Capability Assessment for examples of assessing data analytics capacity in the three key areas of people, processes, and technology.*

STEP 3

DEVELOP AND IMPLEMENT PRAPARE DATA ROADMAP

DETAILS

- Conduct roadmap or workplan mapping on how you will achieve your objectives.
- Who, what, why, when, resources, risks, contingencies?
- Organization:
  - What specific measures will be used?
  - What data sources will they come from?
  - How will the data be organized? Integrated in what systems?
- Access and Sharing:
  - Who will have access? How will you report and share data?
- Validation:
  - How will data be validated to ensure accuracy and consistency?
- Analysis Plan:
  - What analyses will you run? How will the analyses lead to your goals? How will you report data to understand whether your goal was met?

EXAMPLES AND SOURCES

- *See the Sample Workplan Table in Chapter 3 of the PRAPARE Implementation and Action Toolkit for a customizable template that lays out roles, responsibilities, and progress.*
- *See the table on the following page for suggested roles and responsibilities for different staff involved with the data workplan.*
- *See the Sample Data Strategy Worksheet from the Center for Care Innovations to help build your data strategy.*

TABLE 6.1. Suggested Staff Roles and Responsibilities for Data Workplan	
EHR Lead	• Notifies informatics lead when changes are made to EHR • Lead on data mapping • Promotes documentation amongst staff that adheres to mapping
Clinical Informatics Lead	• Governance lead – decision maker for data systems and operations • Develop and lead data infrastructure
Data Analyst	• Review reports to monitor data trends • Identify errors and serve as point person for identified errors • Troubleshoot and resolve • Support collaboration between QI/operations/finance
Quality Improvement (QI) Lead	• Make data actionable for rest of staff (QI projects, storytelling) • Work with analysts and clinical informatics to develop and support data infrastructure
Finance	• Link clinical quality to revenue • Collaborate on revenue-generating activities such as insurance contracting
Operations	• Utilize data to inform decision making • Support execution of data hygiene practices
Compliance	• Protects security of data

STEP 4	CONDUCT PRAPARE DATA ANALYSIS

Data Analysis is the process of inspecting, cleaning, transforming, and modeling data with the goal of discovering useful information, suggesting conclusions, and supporting decision-making.

DETAILS

- Run descriptive analysis on all data to observe trends.
- Use Excel or other data analysis software.
- Run analysis in a way that will address your goals and objectives.
- Were results validated?
- Share findings with staff. Were results consistent with staff expectations?
- Compare to current baseline data.

EXAMPLES

- *Transportation was found to be the largest barrier.*
- *Compare data for transportation interventions before vs after PRAPARE implementation.*

TABLE 6.2. Six Steps for PRAPARE Data Analysis			
1 What is your analysis question?	• Refer to your roadmap about the measures you are using for your analysis. • Questions should be measurable, clear, and concise	• How is social determinant risk correlated with hypertension at 7 health centers nationally?	[Presentation on Whether Social Determinant Risks Are Correlated with Hypertension](#)
2 How will you measure it?	• Time frame? (e.g., hypertension diagnosed in the last year or currently diagnosed) • Unit of measure? (e.g., ICD, CPT, lab, etc.)	• Used hypertension definition from UDS since already in use • Prepared data reporting template in excel for all clinics to populate • Trained health centers on how to complete uniformly	[PRAPARE Data Documentation](#) with ICD-10 Z codes, LOINC codes, SNOMED codes
3 Gather the data and validate	• Where will data files be sent and stored? • Conduct queries for data validation. • Keep a log with data collection dates and source notes.	• Data template (no PHI) sent to PRAPARE project manager. • Queries automatically included in data template • Kept a log with data collection dates and source notes.	PRAPARE Data Reporting Template and Validation Process
4 Conduct the analysis	• Conduct descriptive analyses • Find data trends, outliers, variation, correlations	• Conducted descriptive analyses. • Assessed data trends, outliers, variations, correlations	[PRAPARE Trend Analysis Presentation](#)
5 Interpret results	• Does the data answer your original question? How? • Does the data help you defend against any objections? How? • Limitations or any angles that you haven't considered?	• Having hypertension was correlated with PRAPARE Tally Score. • Interpretation: The higher the number of PRAPARE risks, the more likely patients have hypertension.	Questions to ask clinic staff to interpret results
6 Evaluate outcomes and next steps	• Was your original PRAPARE data goal achieved? • Was the planning effective? Lessons learned? Next steps?	• Lessons: Patient-level data will yield stronger results, include more queries • Next Steps: Do the same assessment with patient-level data to triangulate analyses, and with other conditions (e.g. diabetes). Also look at mitigating factors of enabling services to provide very important context!	[Checklist for Evaluating Outcomes in Population Health Planning Checklist](#) developed by the Victorian Healthcare Association

STEP 5 — IDENTIFY / PRIORITIZE ACTIONS BASED ON PRAPARE FINDINGS

DETAILS

- Identify options for actions based on PRAPARE data.
- (Re)evaluate potential community partners with similar goals.
- Consider the feasibility and sustainability of options.
- Select mix of strategies based on most feasible and best possible outcome

EXAMPLES

- Diabetes/Hypertension - Share data and partner with health plan to invest in community health workers who can help diabetic patients reduce SDH barriers.
- Transportation is a greater issue for patients than expected, especially for those living in particular rural zip codes.

1. *Attend or host lunch community meetings to meet with transportation related agencies.*
2. *Share data with state transportation agency and negotiate bulk discounts*
3. *Improve bus routes for patients in particular rural zip codes.*

STEP 6 — ACT ON PRAPARE DATA

DETAILS

- Ensure actions are effectively resourced and implemented
- Assign roles and accountability for implementation
- Conduct risk analysis for actions to anticipate potential problems and establish contingency plans

EXAMPLES

- *Decision for Executive staff to share 6-months data with state transportation agency to negotiate discount rates for transportation vouchers by next month.*
- *Contingency/concurrent plan: CMO attend community meetings to meet with transportation-related agencies to establish/strengthen partnerships and discuss mutual goals.*

STEP 7

EVALUATE OUTCOMES AND RESTART AS NEEDED

DETAILS

- Are original/desired PRAPARE goals being achieved?
- Is health equity being addressed?
- Was the planning effective?
- Lessons learned?
- Best practices to share?
- Consider additional PDSAs (Plan, Do, Study, Act).
- Next Steps?

EXAMPLES

- *Successful at negotiating better rate with health plan for providing better care outcomes for patients with SDH barriers.*
- *Successful at negotiating bulk discount transportation vouchers.*
- *Lesson learned is to educate staff about community partner resources for addressing SDH, as not all staff were aware of them.*
- *Next Steps: Assess contribution of mitigating factors of enabling services – very important context.*

PRAPARE Data Documentation, Codification, & Reporting Templates

After developing your data strategy, align any data documentation and reporting requirements with your objectives. These guidelines can help you define, organize, manage, and report your PRAPARE data.

Use the following PRAPARE Data Documentation and Reporting Template to help get started:

Data Documentation of PRAPARE for Implementation

The PRAPARE data documentation includes coding specifications and instructions for all PRAPARE measures. It also maps PRAPARE data to existing codes (such as ICD-10, LOINC, and SNOMED codes) to provide additional data standardization. These specifications can be used to help you develop your internal PRAPARE database that can integrate other clinic data sources. For example, you can link the PRAPARE measures with enabling services or health outcomes and conduct analyses to better understand and address your patients' health.

PRAPARE Reporting Template Sample

The PRAPARE reporting template includes:

1	**2**	**3**
RAW FREQUENCY MEASURES that can identify the most common social determinants for your patients.	**PROCESS EVALUATION MEASURES** that can identify missing data and help you assess the feasibility of PRAPARE questions for your patients.	**POPULATION CHARACTERIZATION MEASURES** that can help you better understand your patients' complexity in terms of how many social determinant risks your patients are facing as well as the most common social determinant risks in your patient populations.

As a result of populating this reporting template, you will have valuable data on your patients' social determinants of health that will help your organization consider strategies to address your patients' risk.

Data Visualization and Interpretation

Data visualization and interpretation help transform the data you have into actionable knowledge and help answer the critical "Now what?" question by demonstrating how data can be used and applied to answer your key questions or address your key challenges.

Once you have developed your reporting template and populated the report, you can visualize the data by developing helpful tables and graphs that can be presented to staff and other stakeholders to better understand your patients' risks and how your organization can use PRAPARE data to inform care, develop new interventions, and/or establish new community partnerships. Data visualization is a great way to engage and educate key stakeholders, whether staff, leadership, patients, community members, and/or policy makers.

The following sample presentations can be used to help you get started to understand how social risks can be analyzed, cross-tabbed, or cross-referenced to produce the results for your local clinic needs.

- Presentation highlighting the prevalence of social determinant of health risks in a population
- Presentation showcasing the difference in social determinant of health risks between a "high risk" population and a general population. This presentation also includes correlation analyses showing the relationship between the number of social determinant of health risks and the likelihood of having hypertension and diabetes
- Demonstration highlighting how a Health Center Controlled Network in Colorado used Tableau to visualize aggregated PRAPARE data from across their member health centers to highlight the prevalence of social determinant risks in their communities, key population health trends in relation to social determinants, and the impact of certain interventions.

Discussion Questions for Interpreting Data

The following questions can be used to brainstorm with staff after the results are presented:

1. What initial questions do you have based on current data presented?
2. What observations across communities did you observe? Which of them are surprising?
3. What are the key takeaways that we are learning from these data snap shots?
4. What explains stark variation?
5. What other data runs would be helpful? Are you doing any already?
   a. Other correlations between SDH factors and with individual SDH and outcomes (need patient level information): (ex: are people who are very stressed also socially isolated and/or experiencing financial barriers? Or how does educational status correlate with outcomes?)

> **RESOURCES**
>
> Visit the Health Information Technology, Evaluation, and Quality Center (HITEQ)'s website on Communicating with Data for more examples on how to visualize data.

Types of PRAPARE Data Analyses

Correlational Analyses

PRAPARE data can be used with other clinic data sources in your population health planning efforts. For example, this sample correlational analysis assesses the link between social determinant risks identified by PRAPARE and hypertension outcomes. In this analysis, we calculated the PRAPARE "risk tally score" (explained more in the following section) which represents the total number of distinct risks that are present vs absent for an individual patient. Keep in mind that this analysis used aggregate-level data. Patient level analysis, though more time-consuming, could yield more rigorous results.
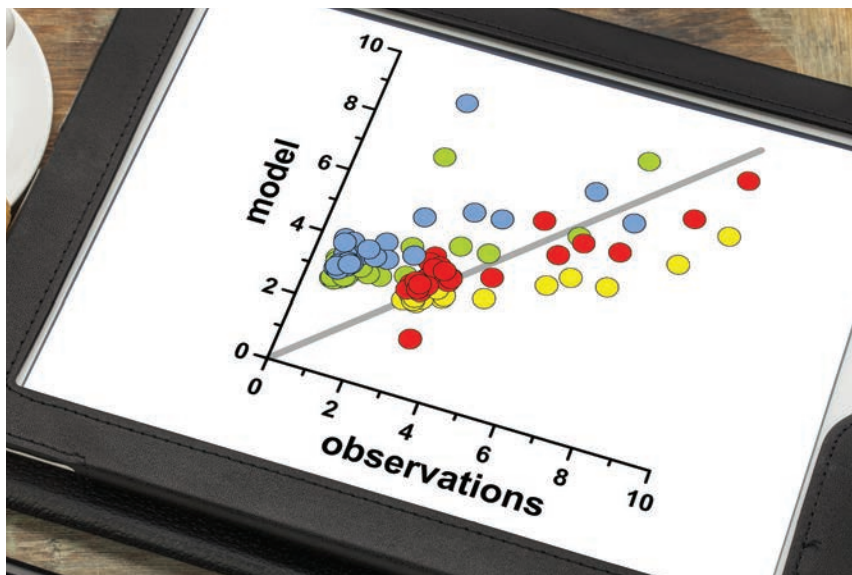
Below are steps organizations can take to submit outcomes data (e.g. diabetes, hypertension) for correlation analysis to see the relationship between social determinant of health factors and outcomes:

1 Compile, validate, and clean data

2 Conduct descriptive statistics and observe trends

3 Calculate the correlation (r) between the PRAPARE social determinant of health total ("tally") score and percent of patients who have hypertension among the designated tally score to see how the percentage changes as tally score increases (this will require the use of statistical software or Excel)

- Only include patients who answered all of the PRAPARE questions
- Only include percents that are not 0% in the calculation of r

4 Create graph to help visualize the trend: display percentage of patients who have the condition as the tally score increases

View this sample correlation analysis to see these steps in a real-world example.

Return on Investment (ROI) Analyses

In today's value-based pay environment, it is important to demonstrate a return on investment (ROI) for work related to social determinants of health. There are several ways to show ROI and how it helps meet the Quadruple Aim in terms of improving outcomes, lowering costs, improving patient experience, and increasing provider satisfaction. Examples range from evaluating the effectiveness of a program or intervention to demonstrating the value of a community partnership or staff role that is focused on addressing social determinants.

PRAPARE ROI CASE STUDY

A health center in Missouri calculated the number of missed appointments and how much money that was costing their organization. After they administered PRAPARE with their population, they found that 1 in 4 of their patients had transportation barriers. With that PRAPARE knowledge, they implemented a couple of transportation interventions and reduced their no-show rate by 50%, which led to a significant increase in revenue for the organization and better care for their patients.

RESOURCES

Commonwealth Fund ROI Calculator: This online tool enables users to calculate the return on investment from integrating social services with medical care, based on user-inputted data about the population, utilization, and costs.

Investing in Social Services as a Core Strategy for Healthcare Organizations: Developing the Business Case: A practical guide to support investments in social services

Using PRAPARE for Risk Stratification and Population-Level Planning

PRAPARE can add value to risk stratification and risk segmentation efforts by incorporating non-clinical data and providing a fuller picture of patients. To facilitate these efforts, we have created a PRAPARE Risk Tally Score. This risk tally score represents the cumulative number of distinct risks as defined by the literature that are present for an individual patient. At this time, this risk tally score is NOT weighted such that certain socioeconomic risks receive a higher score than others. We are currently conducting additional analyses that will allow us to establish a weighted risk score that could also be used for risk adjustment purposes. However, this risk tally scoring methodology facilitates risk stratification by allowing an organization to see the dispersion of risks. For example, what is the average number of social determinant risks that their patients face and who are the patients that face more risks? While our analyses of our various pilot organizations across seven states showed that health center patients faced an average of 4 – 7 social determinant risks, it is important to establish a baseline for your own organization to better determine who might be more "at risk".

Several organizations have even incorporated the PRAPARE risk tally score into their own patient risk score complete with other clinical outcomes data and/or claims data to produce a more holistic risk score. These risk scores help them stratify their patient population and identify those who are "high risk", "moderate risk", and "at risk of becoming high risk". These stratifications help inform the level of intervention needed as well as if resources and/or staff need to be reallocated to meet the need.

Other organizations have used PRAPARE data for population segmentation to understand and respond to needs of target populations. Oregon's use of PRAPARE for population segmentation is highlighted in **FIGURE 6.1** on the following page.

FIGURE 6.1. Using PRAPARE for Population Segmentation Work

As you use PRAPARE data to better understand and manage your own patient population, you can share your PRAPARE data reports, risk scores, and presentations with stakeholders to start meaningful dialogue regarding larger population health planning efforts to improve the health and well-being of populations and health equity between population groups. This population health planning checklist provides step-by-step recommendations to help you get started.

POPULATION

Use analytics to piece together target population characteristics

SUB-POPULATION

- 834 diabetics
- 223 with HbA1c > 9

TARGET POPULATION

56 out of the 223 diabetics with HbA1c>9 who also:

- Missed 2 appointments

UNDERSTAND THEIR NEEDS USING PRAPARE

- Provide transportation intervention to address need
- Demonstrate impact and ROI

*Adapted from the Oregon Primary Care Association

Data Sharing and Integration

As part of your larger data strategy, you may consider sharing data with others, such as your network, primary care association, state Health Information Exchange, Accountable Care Organization, etc. so that PRAPARE data can be summarized for organizations across a state or region(s) to understand commonalities that can support statewide strategies. Data can also be integrated in a larger state or national data warehouse that can support larger transformation, funding, advocacy, and other related efforts. Integration of standardized PRAPARE data is important to help build critical mass that will more effectively move the dial in our nation's upstream community transformation efforts.

The following are considerations to keep in mind for integration of PRAPARE into a larger data warehouse:

CONSIDERATIONS FOR INTEGRATION OF PRAPARE DATA INTO A NATIONAL DATA WAREHOUSE		EXAMPLES
1	Determine data use for national social determinants of health data warehouse	Research, policy, or continuity of point of care
2	Determine the stakeholders	Researchers, lobbyists, policymakers, payers, clinical services, social services
3	List the data elements needed to be captured to share for each type of use and type of stakeholders	Demographic, clinical diagnosis and procedures, social services
4	Determine the type of data warehouse technology	Traditional fact and dimensions tables, big data, or both depending on implementer
5	Determine which format is suitable to transmit data	Existing data structures like C-CDA or custom data structures
6	Pick a small subset of data elements to test implementation	
7	Decide on other standardized codes to use or standardize custom codes for selected subset	ICD-10, CPT, CPTII
8	Pick a small subset of participating stakeholders to test implementation	
9	Expand both data elements and participants in controlled phases	

CHAPTER 7
Understand and Evaluate Your Data

How will you know if PRAPARE is being implemented effectively at your practice? To better understand this, you will need to evaluate your PRAPARE data and data collection process. Evaluation is an ongoing process in which quantitative or qualitative data may be used to assess whether the program is being implemented effectively. It is a systematic method for collecting, analyzing, and using information to answer questions about the effectiveness and efficiency of the implementation. For example, PRAPARE evaluation can help you determine whether you are reaching your targeted populations with all of your intended social determinants of health questions, how well your staff are implementing the tool as planned in your workflow strategy, whether the Electronic Health Record (EHR) tools are working properly, and whether patients are receiving the intended services.

This chapter provides strategies and sample tools on how to evaluate your data as well as the PRAPARE implementation process at your organization so that it can be effectively used, reported, and disseminated to the broader and intended communities.

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Tools for Evaluating Data

There are three sets of strategies and tools that you can use to help evaluate the efficacy of your PRAPARE implementation process and the accuracy of your PRAPARE data. These include:

① DATA VALIDATION

This includes sample processes and questions your organization can consider to assess the accuracy of your PRAPARE data.

② MULTI-STAKEHOLDER ORGANIZATIONAL INTERVIEWS

These include customizable sets of questions for different stakeholder groups (e.g., patients, executive leadership, staff involved with PRAPARE implementation process, IT staff, etc.) that can be used to assess the efficacy of your organization's PRAPARE implementation process and to document what impact PRAPARE has had at your organization.

③ STAFF PROCESS EVALUATION SURVEY

This includes a pre-developed survey that your organization can administer to your staff to quickly gather process evaluation data.

Data Validation

PRAPARE data should be shared with various stakeholders, including board members, community members, patients, clinicians, and enabling services staff for data validation to understand how well the data is capturing meaningful and accurate information.

The following are sample questions to consider to assess the feasibility of asking these questions and the accuracy and validity of these questions in that they collect information on what they intend to measure:

- Are all intended questions being asked of all intended patients?
- Do staff feel that patients understand the questions?
- Are patients skipping questions?
- Do the results surprise the staff or is the information representative of their expectations? Why or why not?

This process of data validation with relevant stakeholders can help ensure data quality, consistency, transparency, as well as accountability. The following are sample questions to ask staff and other stakeholders to help validate the PRAPARE data:

- What initial questions do you have based on the data?
- What observations across communities did you observe? Which of them are surprising?
- What are the key takeaways from these data snapshots?
- What explains stark variation?
- What other data analyses would be helpful?

FIGURE 7.1 showcases an example of a data validation process used by organizations that implemented PRAPARE.

FIGURE 7.1. Social Determinant of Health Data Gathering and Validation Process Sample

Care coordinators complete PRAPARE survey with patient and provide interventions as appropriate.

Data from the PRAPARE assessment is updated in the Electronic Health Record (EHR).

Data from other clinic systems (e.g., outcomes, etc.) are auto-populated in the PRAPARE EHR template.

Social determinant of health reports are generated by project staff to check for accuracy and completeness of each assessment.

Supervisors use PRAPARE reports to conduct staff meetings for feedback, lessons learned, and best practices.

Supervisors conduct observations to ensure PRAPARE assessment is being executed as planned.

Enabling services reports are compared with PRAPARE assessments to see if non-clinical services provided are matching needs identified.

PRAPARE reports are generated semi-monthly for accuracy and completeness.

Multi-Stakeholder Organizational Interviews

It is important to ask patients as well as team members involved with PRAPARE implementation how the process is working for them so that changes can be made to improve the process for optimal workflow and efficiency. The following sample questions can be directed to both patients as well as different PRAPARE staff to help identify issues and opportunities facing health organizations as they implement social determinants of health data collection.

Overall, these questions explore three main themes:

1	**2**	**3**
The process of social determinants of health data collection implementation	An understanding of how data is used to foster change at the patient, organizational, community, and systems-levels	The effectiveness, replicability, and sustainability of the PRAPARE data collection model for health organizations and other stakeholders nationally.

EVALUATION QUESTIONS FOR PATIENTS

1. How well do you understand the questions asked?

2. How well do you understand all of the answer choices?

3. How easy are all the questions for you to answer?

4. Do you feel comfortable answering these questions?

5. Do you think there would be any problems answering these questions on a registration form at this organization? If yes, why?

6. How well do you think these questions allow you to tell us about your current health risks? Why?

7. Are there other questions that would be important for us to ask you about your health risks? If so, what are they and why are they important?

8. How important do you think this information is for your health center staff to know about you? Why?

9. How have these conversations impacted your relationship with the organization's staff?

10. Is there anything else you'd like to tell us about how to improve the questions or how they are asked?

EVALUATION QUESTIONS FOR EXECUTIVE STAFF

1. Please describe your decision to implement PRAPARE and how it fits in your future strategic planning.

2. Please describe the organizational relationship between the key stakeholders in your organization (e.g. clinicians, administrators, patients, technology professionals, decision makers, payers) with regard to PRAPARE implementation.

3. To what extent has the organization standardized PRAPARE implementation at your center?

4. Please describe facilitators and challenges/successes with integration of PRAPARE at your center.

5. What strategies do you think your organization can implement in order to better integrate the use of PRAPARE in daily practice?

6. How have you promoted use of the PRAPARE tool to others inside as well as outside your organization/network? What was successful and/or unsuccessful?

7. How do you plan on using the data for this project for future initiatives and strategic planning? What are the organization's plans for using the data to plan population-level interventions?

8. What are the organization's plans and goals for improving the use/management of PRAPARE data collected at the patient, health center, community, and policy levels?

9. What would you estimate to be the total costs associated with implementing PRAPARE?

10. What benefits do you see or have you seen because of your organization's use of PRAPARE?

11. Please rate your satisfaction to date with the overall implementation. Why?

12. What would you do differently if you had to do the implementation over again?

13. Do you have any further comments or suggestions about PRAPARE implementation?

EVALUATION QUESTIONS FOR DATA COLLECTION STAFF

1. What is your job title?

2. What do you like about the PRAPARE tool so far? How useful is the PRAPARE tool in your daily work?

3. During your use of the PRAPARE tool, what improvements have you noticed for the patients who were administered the tool (e.g. patient referred for interventions immediately, patient provided education about managing diabetes, patient referred to financial counselor, patient referred to community partners, etc.)?

4. How is the data used to help develop new interventions, programs, or community partnerships that can impact change at the patient, health center, and community-level?

5. What improvements within your organization have you noticed as a result of documenting patient social determinants of health?

6. What has been your experience working within the organization to assess and use the PRAPARE data?

7. What best practices have you encountered with the PRAPARE tool?

8. What barriers or challenges have you encountered with the PRAPARE tool? What suggestions do you have to address these barriers in future implementation?

9. Do you have any further comments or suggestions about the PRAPARE implementation?

EVALUATION QUESTIONS FOR IT/ANALYTIC/QI/DATA STAFF

1. Please provide a demo of the PRAPARE Electronic Health Record template.

2. Who are the IT staff involved in the implementation of PRAPARE?

3. Please describe how the PRAPARE data is stored operationally (e.g. Practice Management of EHR system, data warehouse, etc.).

4. Please describe how the data is used by the organization's staff.

5. What kinds of analyses is the organization conducting with PRAPARE data?

6. What systems/software do you use to analyze the data and what reports have you created? What trends are you seeing when you analyze the data?

7. Please describe the capability for the IT systems to pull data and link it to other patient data (enabling services, health outcomes, etc.)? How would we go about assigning weights to the measures in the future?

8. Please describe with whom the data is shared (internal and external to the organization).

9. What kind of tracking are you doing for the purposes of this project to ensure PRAPARE data are being collected consistently and appropriately? Do you run special reports to audit organizational staff activity?

10. How often is the PRAPARE data accessed and reported to staff?

11. How is your IT service delivery function structured? Describe the process for supporting an organizational user community (help desk, on call system administrators, ad hoc)? How much of this function does the network vs the organization provide?

12. What are your plans to share data on a broader scale such as with your primary care association, network, state or other stakeholders?

13. What are the network's goals for improving the IT systems associated with implementation? (e.g. sharing a data warehouse across organizations, interoperability with community partners, etc.) Are there any vendor limitations that need to be addressed?

14. What lessons learned and best practices would you recommend from your experience with implementation? What would you do differently if you had to do the implementation over again?

15. Do you have any further comments or suggestions about the PRAPARE implementation?

Staff Process Evaluation Survey

If you are trying to reach a broader audience and/or have less time than you need for interviewing team members, you may consider using a staff survey to help evaluate the process of implementing PRAPARE data collection at your organization. Aggregated responses from staff can help better assess whether there are trends in terms of needs for process improvement. Feedback from staff is valuable and key to better understanding their experiences in collecting PRAPARE data and how best to improve processes. The following is a sample survey that you can implement among your staff who were involved in implementation.

- PRAPARE Process Evaluation Survey for Data Collection Staff

CHAPTER 8
Building Capacity to Respond to Your Data

If you have implemented PRAPARE and identified social risks that are impacting your patient population, you likely want to act on your data. But where should you begin?

For some organizations, there may be a need to build capacity to address the social determinants of health before actual interventions can be developed. This chapter will outline how best to assess your own setting, abilities, and resources, and how to develop a few key building blocks so as to increase your capacity to act on your data.

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Assess Your Setting

Building capacity to address the social determinants of health begins with an assessment of your organization's current capacity. What resources does your organization have available to focus on addressing identified needs and in what context do these resources exist? Are they internal to your organization or do they exist outside of your organization?

Consider the following resource categories when you assess resources within your own organization to address social determinant of health needs:

PEOPLE

- Do you have staff time that can be dedicated to social determinants-focused initiatives at your organization?
- Are there specific roles (e.g., Community Health Worker) focused on addressing a patient's social needs?

PROCESSES

- Do you have referral workflows in place for connecting patients with resources to address their social determinant needs?
- Have you formed partnerships with external organizations (e.g., local food bank, employment agency, etc.)?

TECHNOLOGY

- Does your EHR support or systematize social services?
- Are you able to share data with external organizations?

After you assess your own organizational resources, it is then important to assess what resources exist in your community. Assessing your setting in terms of the type and extent of resources in your organization and in your community will give you a sense of where to start in bolstering your capacity to address the social determinants of health.

MANY RESOURCES

ORGANIZATIONAL RESOURCES

Create Services In-House

- **PEOPLE:** Develop staffing models to respond to social determinants
- **PROCESS:** Develop resources to support staff in addressing social determinant needs at point of care
- **TECHNOLOGY:** Develop ways to track non-clinical services provided

Form Coalitions with Community Partners and Advocate for Policy and Environmental Changes

- **PEOPLE:** Build and staff a resource desk and community resource guides
- **PROCESS:** Build and sustain effective community partnerships
- **TECHNOLOGY:** Track referrals to non-clinical services and measure intervention impact

Raise Awareness to Strengthen Staff, Patient, and Partner Knowledge of Social Determinants

- **PEOPLE:** Deliver skills training on how to discuss social determinants (e.g., empathic inquiry)
- **PROCESS:** Create opportunities for staff and leadership to message the value of addressing social determinants
- **TECHNOLOGY:** Begin collecting data on social determinants in your EHR

Partner with Community-Based Organizations and Leaders

- **PEOPLE:** Set up volunteer programs at your organization for community volunteers
- **PROCESS:** Focus public health/grant funds to support partnership development with local community organizations
- **TECHNOLOGY:** Develop an electronic referral system or resource guide

LOCAL COMMUNITY RESOURCES

FEW RESOURCES

Develop Cross-Sector Partnerships

Why Form a Partnership?

Interventions to address the social risk factors that are impacting your patients' health outcomes can feel daunting, but it is important to remember that you do not have to develop all of your social determinants interventions in-house or do this work all on your own. Partnering with community-based organizations who have already developed services and programs that address the social needs of your patients can be a great way to get a patient's social needs met and lessen the resource burden placed upon your health organization. In many cases, there is no point in re-creating the wheel. Furthermore, as more health organizations form cross-sector partnerships with non-clinical organizations outside of the medical setting, our healthcare system will further increase its abilities to not only manage disease, but address factors that lead to poor health.

While health care organizations may not always be expert in addressing social needs, they are well-placed to witness the impact of social risk factors that remain unaddressed and are great gateways to receive and then refer patients to resources to meet their needs.

Marin Community Clinics in Novato, California hosts weekly "Health Hubs" where they provide free bilingual services to their community, such as health screenings, nutrition education, Zumba classes, as well as food distribution. **Photo credit:** Marin Community Clinics in Novato, CA

Who Should Your Partners Be?

As you expand your efforts to impact the social determinants of health, there's a wide world of potential partners to consider. How can you narrow down the list of organizations with whom you might connect? **TABLE 8.1** shows various factors to consider and user stories detailing the benefits of these partnerships:

TABLE 8.1. Factors to Consider When Deciding Partnerships		
Start with the data	• Which social risk factors were most prevalent when you screened your patient population? • If there were a handful of issues that rose to the surface, identifying community-based organizations that are focused on addressing those needs might be a good place to start.	**EXAMPLE:** A health center in Iowa found that 1 in 5 of their patients had transportation needs. This health center was able to use this data to form a partnership with local and regional transportation authorities to provide bus tokens and taxi vouchers as well as work to develop more bus routes to areas in need.
Identify strategic opportunities	• Are there well-resourced partners in your community who are looking to serve your patient populations, but don't have the relationships or access points that your clinic offers? Perhaps you can work together. Do not feel that you have to tackle all of these needs on your own! • Alternatively, there might be an under-resourced organization that is already addressing the social determinants you'd like to work on, but could benefit from your financial or staff support.	**EXAMPLE:** The Maine Primary Care Association (MCA) joined state-wide transportation coalitions with other organizations also interested in addressing transportation needs. The Maine PCA was able to share PRAPARE data demonstrating the extent and location of need with the coalition while also benefiting from the resources and staff of the other partners to help address the transportation needs so that they didn't have to address them alone.
Go where the resources are	• Are you located in a rural area or small town where resources are scarce? Consider reaching out to social service organizations in the next closest city to see if they would be willing to partner with you to serve your community.	**EXAMPLE:** A health center in rural Massachusetts discovered that they had high food insecurity amongst their patients after administering PRAPARE. Their town did not have a food bank, but they called a food bank in Boston 70 miles away to see if they could help. Because the health center had data to demonstrate their need, the Boston food bank was happy to form a partnership where the Boston food bank delivers a truckload of food (both fresh and non-perishable) every week to the health center.

TABLE 8.1. Factors to Consider When Deciding Partnerships (continued)

| **Let the needs of your population segmentation guide you** | • If you are working to improve care management for a specific patient subpopulation (i.e. uncontrolled diabetics), consider partnering with external organizations who are also focused on serving this same population, or ones that are addressing social risk factors that have an impact on the target population's health outcomes. | **EXAMPLE:** Health center and Primary Care Associations in different states have partnered with organizations interested in sub-populations such as state chapters of the American Heart Association or organizations focused on the opioid epidemic to work together on addressing social determinants of health that affect these populations. These partnerships can often be a source of funding to do this work. |

Marin Community Clinics in Novato, California partners with CalFresh to help make healthy foods affordable for their community. CalFresh and other community partners set up booths at Marin's weekly Health Hubs to bring more awareness about available community resources and services. **Photo credit:** Marin Community Clinics in Novato, CA

How Do You Form a Successful and Equitable Partnership?

When forming a partnership, it is important to consider these key phases through which a partnership happens:

1 **PARTNERSHIP-FORMATION AND FOUNDATION-BUILDING**	▶	2 **ACTION AND IMPLEMENTATION**	▶	3 **MAINTENANCE AND EVALUATION**

It is important at the beginning of forming partnerships that you clarify the common agenda between the participating organizations and identify clear objectives. Once shared goals and roles and responsibilities have been agreed upon, partners can all sign a partnership agreement and/or a Memorandum of Understanding to secure commitment and accountability. Partners can revisit these goals and responsibilities throughout their partnership to ensure that they continue to align.

Here are sample Memorandums of Understanding between various health organizations and non-clinical organizations:

- Memorandum of Understanding between Redwood Empire Food Bank and Diabetes Wellness Project
- Memorandum of Understanding with a Medical-Legal Partnership for the Elderly

Once partners are committed, they should all collaborate to develop a strategic action plan that helps them achieve their shared goals. As you implement your work together, it is important to regularly check-in on the partnership to discuss what is working well, what could be improved, and to evaluate your collective work. This may require sharing data across organizations. Data Use Agreements can be helpful agreements to safely share data and secure the privacy of the data.

- Sample Data Use Agreement between Association of Asian Pacific Community Health Organizations and a health center

KEEP IN MIND THAT A NECESSARY INGREDIENT FOR ALL PARTNERSHIP ELEMENTS IS PLENTY OF TIME!

Potential Barriers & Challenges to Consider When Forming a Partnership

HIGH FRONT-END INVESTMENT

Forming a partnership often requires a high investment of resources at the onset (i.e. staff time spent writing grants to secure funding) with returns not seen until later on.

Consider starting off your partnership by seeking out low-hanging fruit which requires less effort from partners. An example of this might be sharing informational materials or referring patients to another organization's services.

LACK OF RESOURCES TO SUPPORT PARTNERSHIP

As previously mentioned, partnerships require an investment of resources from the partner organizations involved. If those resources are unavailable internally and cannot be secured externally, the partnership may fizzle out or see limited success.

Be sure to discuss how you'll support your partnership from the onset of the collaboration. Getting clarity on resource needs early on can help determine the feasibility of a partnership and may help you decide with whom you should partner.

POWER IMBALANCE AMONG PARTNERS

Trust and respect are key ingredients of any partnership, and if there is an imbalance of power amongst partners, it can impact how they feel about each other. If both (or all) partners do not have a voice in the partnership, it will suffer.

From the onset of each partnership, there should be a clear understanding of how everyone involved will contribute to the collaborative in a meaningful way. Recognition of each partner's contributions will go a long way in creating trust and respect.

DIFFERING AGENDAS AMONG PARTNERS

It is important that partners maintain clarity on and commitment to their shared agenda. A partnership can't succeed if the parties involved aren't on the same page, and working to achieve the same outcomes.

Honest and clear communication is the key to ensuring everyone is on the same page in a partnership, and that partners have alignment in their expectations and goals for the collaboration. Continue to revisit goals throughout the duration of the partnership to ensure they continue to align.

Engage in Advocacy Work

What's the Value of Engaging in Advocacy Work?

In some cases, taking steps to address the social determinants of health begins with advocacy—acting as an advocate and speaking up about the importance of addressing the social, environmental, and economic conditions in which people live and advocating for the financial support of social resources both within and outside of the four walls of your organization. Without such support and resources, it is difficult to develop sustainable and impactful interventions to address the social determinants of health.

Engaging Your Representatives

To engage in advocacy work, a good starting place is forming relationships with your representatives. But how can you gain access to your elected officials? Think about connecting with them at events or meetings that they attend – Town Hall meetings, community planning gatherings, or campaign events are a good place to start. You might also connect with professional networks (i.e. Primary Care Associations, National Association of Community Health Centers, etc.), to connect with your elected officials as part of a larger, organized concerted effort.

Introduce yourself and your organization and invite them to come for a visit and a tour. It is hugely valuable for you to create opportunities for your elected officials to meet your patients, hear from you and your staff, and see how the work that you do – and the work that you would like to do – is important.

Creating Effective Messaging

How do you tell an effective story about the conditions in which your patients live and how those conditions impact their health outcomes? **TABLE 8.2** highlights some elements to consider as you message the importance of addressing the social determinants of health.

TABLE 8.2. Factors to Consider When Deciding Partnerships	
Choose The Right Messenger	Policymakers love to hear from their constituents, so try and create opportunities for your patients and clients to share their own stories about the social conditions in which they live, and how those conditions impact their health, and how the services that your organization provides (either in-house or through partnership) have positively impacted their lives.
Use Heroes and Villains	Does your story have a protagonist? Think about sharing a story about a specific patient and how the conditions of their life have impacted their health. It is important for your audience to connect with your patient and to see the negative conditions in which they live as things that should be addressed or ameliorated.
Focus on Action & Conflict	A memorable story has both of these elements. When you share your story, think about how to keep it engrossing and how to incorporate a sense of urgency. What negative conditions have your patients experienced in their lives have had led to their poor health? Did they try to combat those conditions? If so, what happened?
Use Your Data	Think about connecting your PRAPARE data to your story. While a protagonist or character gives your message heart, data demonstrates the weight of the issue on which your advocacy efforts are focused. Simple graphs, pie charts, and/or maps can quickly demonstrate the complexity of the patients served at your organization.
Close with a Solution	Research shows that people prefer messages that offer direction, so consider closing your story with a "call to action". This should be relatively simple if you're engaged in advocacy work. What are you advocating for? Resources to support your organization or a partner organization in addressing the social determinants of health? Public policy that ameliorates the impact of social or economic inequality? Close with an ask.[1]

The Art of Finding Alignment

In your advocacy work, you will encounter audiences (including your own stakeholders) who do not always share your view. It is important to have a clear understanding of what their views are and where they align or differ from your own. There may be good opportunities for working together even when your views diverge, and knowing their stance can help you tailor your conversation and seek areas of common ground.

RESOURCES

Advocacy Toolkit: Developed by the National Association of Community Health Centers

Storytelling for Advocacy: Developed by the National Community Land Trust Network

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[1] https://www.hcadvocacy.org/toolkit/

CHAPTER 8: Building Capacity to Respond to Your Data

CHAPTER 9
Act on Your Data

PRAPARE is not simply about collecting data on patients' social determinants of health. It is also about responding to the socioeconomic needs identified. While "painting a fuller picture" of the patient can be therapeutic in many ways for both staff and patients, it is important to provide services to meet the needs when possible to assure patients that providing this information leads to action by providing better care. Even if organizations do not have all of the necessary services to respond to the socioeconomic needs, it is still important to gather this information to inform clinics of the greatest needs in their community and how they should fill gaps in their services, whether by building more services in-house or by developing community partnerships.

To help organizations think through possible services and interventions they can provide or build, this chapter presents more granular-level needs and examples of ways to address or ameliorate those risks for each social determinant of health domain in PRAPARE. While we understand that the social determinants of health do not act in isolation and that they all interact and affect one another, this chapter only lists needs and responses that are largely specific to each social determinant for ease of searching and viewing. Interventions are categorized based on the type of response needed to mitigate the risk, whether an individual-level response, a population-level response, or a response that requires a community and/or advocacy approach. These examples are meant to be "idea triggers" to help clinics think through what might be possible in their own settings. Vignettes and case studies are provided when available to highlight how other organizations built particular interventions and what resources were needed.

In addition to example interventions and responses, this chapter also outlines existing ICD-10 Z codes that closely match the social risks identified by PRAPARE. Some of the PRAPARE Electronic Health Record templates automatically map the ICD-10 Z codes to PRAPARE responses so that they can easily be added to the diagnostic or problem list. This extra layer of standardization facilitates PRAPARE data aggregation across organizations to build a robust dataset for policy and analysis.

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Cultural Consideration

Why Is Cultural Consideration Important?

Health care providers need to be aware of, and sensitive to, cultural diversity, life situations, and other various factors that shape a person's identity to provide safe and quality care to all patients. These factors include refugee status, sexual orientation, cultural and linguistic background, sex and gender, disability, religious beliefs, homelessness, and incarceration history among other factors. (*CDC, Cultural Diversity and Considerations*)

PRAPARE QUESTIONS

Are you Hispanic or Latino?

☐ Yes, Hispanic or Latino

☐ No, not Hispanic or Latino

☐ I choose not to answer this question

Which race(s) are you? Check all that apply.

☐ Asian

☐ Native Hawaiian

☐ Pacific Islander

☐ Black/African American

☐ White

☐ American Indian/Alaskan Native

☐ Other (please write): _____

☐ I choose not to answer this question

What language are you most comfortable speaking?

☐ English

☐ Language other than English (please write):

_____

☐ I choose not to answer this question

Are you a refugee?

☐ Yes

☐ No

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z55.0** Illiteracy and low-level literacy
- **Z60** Problems related to social environment
- **Z60.0** Problems of adjustment to life-cycle transitions
- **Z60.3** Acculturation difficulty
- **Z60.4** Social exclusion and rejection
- **Z60.5** Target of (perceived) adverse discrimination/persecution
- **Z60.8** Other problems related to social environment
- **Z62.2** Upbringing away from parents
- **Z62.22** Institutional upbringing
- **Z65.4** Victim of crime and terrorism
- **Z65.5** Exposure to disaster, war, and other hostilities

- Different cultural beliefs regarding treatment & medication
- Inadequate communication between provider and patient
- Non-English speaker
- Health literacy and understanding of how to take medication
- Unaddressed trauma arising from refugee status, etc.
- Issues with openness about medical history due to patient and provider gender

CLINICAL LEVEL

- Develop dedicated services for medical interpretation that include in-person or telephonic qualified interpreters
- Offer medical documents and medical instructions in preferred language
- Use "teach-back" to ensure patient understanding
- Screen for post-traumatic distress disorder, depression and other mental health issues, along with alcohol and substance abuse
- Recruit and hire culturally and linguistically competent providers and personnel
- Continuously train providers and personnel on communication and cultural competency
- Ask patient for preferred provider gender to increase medical history accuracy
- Understand religion-based gender segregation practices and prepare to accommodate when possible

NON-CLINICAL LEVEL

- Offer or refer patients to English classes
- Provide compiled social services information packages in preferred language listing programs offered at organizations, state and federal levels
- Use visual aids like colored caps for pill containers or calendars to convey which medication need to be taken when
- Provide medication management classes in patient preferred language

COMMUNITY LEVEL

- Organize a cultural family fair to increase interaction across cultures, languages, and religions
- Encourage community business development involving community members to encourage local hiring practices and prevent mortgage increases and any consequences of new development in a low-income community (i.e. gentrification)
- Organize job fair with representatives from both local and community-serving businesses

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

CHAPTER 9: Act on Your Data

Education

Why Is Education Important?

Education is a widely used measure of socio-economic status and is a significant contributor to health and prosperity. Higher education is associated with longer life-span and fewer chronic conditions. Parental education is a determinant of child health outcomes.

PRAPARE QUESTIONS

What is the highest level of school that you have finished?

☐ Less than high school degree

☐ High school degree or GED

☐ More than high school degree

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z55.0** Illiteracy and low-level literacy
- **Z55.1** Schooling unavailable or unattainable
- **Z55.2** Failed School Examinations
- **Z55.3** Underachievement in School
- **Z55.4** Educational maladjustment and discord with teachers and classmates
- **Z55.8** Other problems related to education and literacy

- Need skills for job
- Have skills needed for job but need U.S. certification/ accreditation
- Schedule Problems (can't go to school due to work schedule or lack of child care)
- Poor quality schools
- Poor quality teachers

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Ensure prescriptions and treatment instructions match patient's literacy level and whether he/she needs extra support to assist them in addressing recommended areas of health improvement.
- Check truancy issues in clinic; encourage youth to stay in school
- Provide books after pediatric check-ups and encourage caregivers or older siblings to read to/with

NON-CLINICAL LEVEL

- Offer or refer patient to courses for language, math, reading, financial literacy, computer skills, and art
- Offer or refer to parenting classes, training, advice to teens and adults
- Promote early childhood development and school readiness, pre-school/Head Start
- Offer or refer to after-school and summer programs for youth and families focusing on youth leadership, nutrition and physical exercise, and life skills training
- Prepare for GEDs, citizenship tests, and post-secondary education

COMMUNITY LEVEL

- Establish or operate charter schools
- Support a music teacher for local schools
- Provide community resource centers
- Provide college grants/scholarships
- Propose education policy improvements

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

CASE STUDY

Building Charter Schools: Centro de Salud Familiar La Fe (El Paso, Texas)

Steps for Implementation: How They Did It

Thanks to the vision and support of its CEO and senior leadership, La Fe has been able to create a "comprehensive community wellness network" containing several physically separate but affiliated entities to provide for social socioeconomic needs. All senior CHC staff are expected to research and network for grants while five senior staff take responsibility for writing and managing grants besides their other responsibilities. They have monthly meetings to discuss issues, upcoming events, grants, projects, and opportunities for collaboration.

Staff and Partner Roles

The Preparatory School is managed through the La Fe Community Development Corporation and is staffed with an administrator, principal, assistant principal, seven classroom teachers per grade level, and part-time and full-time tutors, including five college graduates and twelve AmeriCorps members. The administrator continuously looks for funding with help from the CHC's CEO and board members to identify opportunities and develop relationships.

Benchmarks for Success

On an anecdotal level, the staff has noted increased confidence and growth among students with their ability to speak both English and Spanish as well as improved academic performance. In its most recent revaluation (2011), the school was rated "Recognized" with 97 percent of 4th grade students passing the state writing exam, 85 percent of 3rd/4th graders passing the reading, and 80 percent of 3rd/4th graders passing math.

Partners Involved

- **Affiliate organizations:** La Fe Community Development Corporation (submitted charter school application) and La Fe Culture and Technology Center (housed the educational program)
- **Advisory Board for charter school application:** local education service center, University of Texas El Paso, community colleges, school districts, business communities, advertising, banking, and local non-profits
- **Continuously meet** with South El Paso Association, U.S. Mexico Border Health Association, U.S. Mexico Diabetes Collaborative, AIDS Education Technology Coalition of Texas and Oklahoma
- **Community and community champions:** informed of priorities and helped write charter school application

Funding

- **Grants:** National Council de La Raza for developing charter school applications; other 1-2 year grants
- **Fundraising:** annual golf tournament fundraiser
- **Donations** from individuals and businesses and corporate sponsorships

For More Information

- Read the Institute for Alternative Future's Compendium of Case Studies on Health Centers Leveraging Social Determinants of Health

Employment

Why Is Employment Important?

A good-paying job makes it easier for workers to live in healthier neighborhoods, provide quality education for their children, secure child care services, and buy more nutritious food—all of which affect health. In addition to a stable income, employers can provide benefits, including health coverage, workplace wellness programs, job safety training, and education initiatives that contribute to workers' quality of life and health.

In contrast, unemployment can have multiple health challenges beyond loss of income. The unemployed are more likely to have fair or poor health than continuously employed workers, more likely to develop a stress-related condition, and more likely to be diagnosed with depression and report feelings of sadness and worry. (*Robert Wood Johnson Foundation, How Does Employment—or Unemployment—Affect Health?, 2013*)

PRAPARE QUESTION

What is your current work situation?

☐ Unemployed

☐ Part-time or temporary work

☐ Full-time work

☐ Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write: _____

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z56**   Problems related to employment/ unemployment
- **Z56.0** Unemployment
- **Z56.1** Change of job
- **Z56.2** Threat of job loss
- **Z56.3** Stressful work schedule
- **Z56.4** Discord with boss and workmates
- **Z56.5** Uncongenial work environment
- **Z56.6** Other physical and mental strain related to work
- **Z56.9** Unspecified problems related to employment
- **Z57**   Occupational exposure to risk factors
- **Z59.5** Extreme poverty (100% FPL or below)
- **Z59.6** Low income (200% FPL or below)

- Lack of job opportunities
- Lack of health care coverage
- Work too many hours and/or jobs
- Less access and less utilization of health care
- Need skills for job
- Have skills needed for job but need U.S. certification/ accreditation
- Schedule Problems (can't work due to schedule or lack of child care

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Perennially inquire about patient's employment situation beyond the initial new patient form
- For patients who report fair or poor health, ask if there are any health and social services that they think or feel they need and coordinate link to services requested
- Ask patients about stress levels and screen for any stress-related conditions
- Screen for mental health disorders and provide appropriate treatment
- To address patients without health care coverage, implement a sliding scale fee payment method if not already in place; have an enrollment agent on-site during open enrollment and screen for Medicaid, CHIP, and Medicare eligibility and assist with application

NON-CLINICAL LEVEL

- Refer patients to temp agencies for temporary work, employment centers for assistance with resume building and interviewing practice, community colleges to further education or to acquire new, marketable skills. For this option, assistance with financial aid application would also be helpful
- Organize career and job fair for opportunity to directly interact with hiring agents
- Offer SNAP/TANF eligibility and enrollment and unemployment compensation process assistance if loss of income is a result of loss of employment
- Provide after-school academic and art youth programs and create teen jobs to keep youth safely engaged
- Offer and heavily promote mobile clinic services, perhaps partner with community institutions like churches or schools to increase mobile health care access and utilization; organize or promote attendance to any health expo providing free or sliding scale comprehensive health services
- Create list of organizations and state and federal programs that provide free, low-cost, or sliding fee health care

COMMUNITY LEVEL

- Encourage community business development involving community members to encourage local hiring practices and prevent mortgage increases and any consequences of new development in a low-income community (i.e. gentrification)
- Organize job fair with representatives from both local and community-serving businesses

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

Food Insecurity

Why Is Food Security Important?

Material security encompasses both presence of resource and presence of skills and knowledge to manage resources. It is common in households that have material insecurity that patients must make tradeoffs to meet their needs. For example, they may choose not to fill a prescription in order to put food on the table. Overall, material security has been linked to many disparities and has a validated relationship with forgoing care and with cost outcomes.

PRAPARE QUESTION

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

☐ Food

☐ Clothing

☐ Utilities

☐ Childcare

☐ Medicine or any health care (medical, dental, mental health, vision)

☐ Phone

☐ Other please write: _____

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z59.4** Lack of adequate food and safe drinking water
- **Z72.4** Inappropriate diet and eating habits
- **Z91.120** Patient's intentional under dosing of medication regimen due to financial hardship
- **Z59.5** Extreme Poverty (100% FPL or below)
- **Z59.6** Low income (200% FPL or below)

- Food ran out before had money to buy more
- Need help planning healthy meal on a budget
- Unable to afford balanced meals
- Rely only on a few kinds of low-cost food to feed ourselves and our children due to cost
- Lack of knowledge about how to cook healthy meals on a budget
- Need nutritional education
- Lack of storage options to store fresh foods (e.g., refrigerator, etc.)
- Lack of stores or markets within reasonable distance that sell fresh, affordable foods (located in a food desert)
- Lack of schools that provide free or reduced breakfasts or lunches

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Talk to patient, family members, caregivers, friends, or others about the importance of regular eating and nutrition.
- Have providers "prescribe" fruits and vegetables with free vouchers that can be exchanged at nearby grocery store or farmers markets.
- Refer patients to food pantry (either in-house or through partnership) so they can access free foods.
- Check to see if patient is eligible for food programs and benefits, such as WIC (Women, Infant, and Children Food Nutrition Service), SNAP (Supplemental Nutrition Assistance Program), etc.
- Ensure children are enrolled in free or reduced breakfast and lunch at school

NON-CLINICAL LEVEL

- Start a food pantry at your health center filled with donated foods. Hold donation drives throughout the year requesting certain foods if pantry is lacking in specific food groups.
- Build a community garden at your health center with classes or other educational opportunities to teach patients and community members about food, nutrition, and healthy cooking and eating. Be sure to grow foods used in cultures present in your patient population. Any leftover food from cooking classes should be donated to patients.
- Establish a kitchen at your health center to teach healthy cooking and eating skills. Hire (or obtain volunteer) chef to demonstrate healthy cooking with easy recipes.
- Provide culturally appropriate nutrition, healthy cooking, and grocery shopping classes to patients.
- Work with farmers markets to bring them to locations adjacent to the health center to provide accessible healthy foods to patients. Request that farmers markets have capabilities to accept SNAP benefits and "fruit and veggie prescription" vouchers. Set up stalls at farmers markets to demonstrate healthy cooking with easy recipes with produce that can be obtained at the farmers markets and to display and distribute nutrition education materials. Encourage farmers to sell foods used in cultures present in your patient population.
- Work with local soup kitchens to organize regular meals at locations adjacent to the health center for ease of access. Alternatively, provide transport to/from the health center and soup kitchen to make it accessible for patients.

COMMUNITY LEVEL

- Organize a group to build and manage community gardens.
- Work with schools to establish fruit and vegetable gardens at the school, with complementary lessons on food and how to cook the kinds of food grown in healthy, delicious, and culturally appropriate ways.
- Work with local Parent-Teacher Associations to help bring free and reduced breakfasts and lunches to local schools through advocacy campaign.
- Talk to local developers and/or Chambers of Commerce about developing mixed-use buildings to bring in more supermarkets or grocery stores on ground floors.
- Work with Meals on Wheels to provide meals to those in need. If not available, begin own meal and/or food delivery service or volunteer meal delivery service.

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

Housing Status

Why Is Housing Status Important?

Housing as a social determinant of health has many facets that can largely be grouped into three main categories: homelessness, housing insecurity, and quality of housing. Housing interventions can improve health and health outcomes, decrease hospital and emergency department visits, and decrease hospital days.

1. **Homelessness**, according to health centers' annual reporting requirements under the Uniform Data System (UDS), is defined as lacking housing, including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations as well as individuals who reside in transitional housing. Homelessness is associated with shorter life expectancy and poorer health outcomes by exacerbating existing health conditions, creating new health challenges, and delaying the recovery from illnesses.

   "Homeless" for UDS reporting purposes, includes the following:

   – **Shelter:** Shelters for homeless persons are seen as temporary and generally provide for meals as well as a place to sleep for a limited number of days and hours of the day that a resident may stay at the shelter.
   – **Transitional Housing:** Transitional housing units are generally small units (six persons is common) where persons who leave a shelter are provided extended housing stays—generally between 6 months and 2 years—in a service rich environment. Transitional housing provides for a greater level of independence than traditional shelters, and may require that the resident pay some or all of the rent, participate in the maintenance of the facility and/or cook their own meals. Count only those persons who are "transitioning" from a homeless environment. Do not include those who are transitioning from jail, an institutional treatment program, the military, schools or other institutions.
   – **Doubled Up:** Patients who are living with others; the arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period of time.
   – **Street:** This category includes patients who are living outdoors, in a car, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.
   – **Other:** This category may be used to report previously homeless patients who were housed when first seen, but who were still eligible for the Health Care for the Homeless program. Patients who reside in SRO (single room occupancy) hotels or motels, other day-to-day paid housing, as well as residents of permanent supportive housing or other housing programs that are targeted to homeless populations should also be classified as "other".

2. **Housing Insecurity** refers to the growing issue of losing one's home due to not being able to consistently afford housing payments, whether rent or mortgage. As more individuals spend half of their monthly income on housing, they are often one event or one paycheck away from losing their homes. They also often have to face difficult choices, such as whether to pay rent or whether to buy groceries. As a result, it is often associated with poor health and poor nutrition.

3. **Housing Inadequacy** refers to the quality of the housing. It is associated with poor health, poor nutrition, and a reduced ability to manage chronic conditions.

PRAPARE QUESTIONS

What is your housing situation today?

☐ I have housing

☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)

☐ I choose not to answer this question

Are you worried about losing your housing?

☐ Yes

☐ No

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z59** Problems related to housing and economic circumstances
- **Z59.0** Homelessness
- **Z59.1** Inadequate housing
- **Z59.2** Discord with neighbors, lodgers, and/or landlord
- **Z59.5** Extreme poverty (100% FPL or below)
- **Z59.6** Low income (200% FPL or below)
- **Z59.8** Other problems related to housing and economic circumstances

WAYS TO RESPOND TO NEEDS**

RESPONDING TO HOUSING INSECURITY AND HOMELESSNESS

- Refer patients to medical respite care services so that they can recover from acute illnesses or injuries in a safe environment with access to care and supportive services outside the hospital and off the streets
- Connect patients to home loan services
- Aid the patient's family to move to other, lower-cost housing options
- Help patients navigate housing market in the area through referral, information, financial counseling, and classes for first-time buyers
- See if patient is eligible for benefits, such as Medicaid or other health insurance, Supplemental Security Income or Disability Insurance
- Create a housing and community development organization that organizes housing fairs, workshops, and assistance with the purchase of a home, tenant services, and assistance in improvements for income-eligible homeowners and landlords
- Participate in community-wide coordinated entry systems, such as the HUD-funded Continuum of Care, to provide fair and equal access to affordable housing, whether transitional housing, shelter services, supportive housing, or affordable assisted living residences
- Centralize and integrate the strategic collection of health and housing data across project partners. Use data to create and implement new referral systems between agencies
- Connect patients to permanent housing
- Provide classes to educate individuals on basic living, job, and budgeting skills to enable them to help themselves

RESPONDING TO LACK OF ADEQUATE, AFFORDABLE HOUSING

- Convene discussions on gentrification policies and how and where to build affordable and safe housing with access to resources to live healthy lives (healthy foods, parks, gyms, etc.)
- Develop informational resources for agents, builders, developers, and lenders of needs of special populations to consider when building or leasing buildings
- Develop Section 8 low-income housing
- Develop upscale apartment complex with Section 8 units to kickstart area development
- Work with other organizations (Habitat for Humanity, etc.) to build or renovate homes for those in need
- Acquire a motel near farms to provide migrant worker housing

RESPONDING TO HOUSING INADEQUACY AND CONDITIONS

- Avoid prescriptions of medications that require refrigeration where refrigeration is lacking
- Discuss possibilities with landlords about energy-efficient improvements to reduce utility costs (insulation, etc.)
- Conduct assessments and assist landlords in eliminating mold and other asthma triggers
- Install septic tanks, develop deep wells, functioning bathrooms for mobile home residents
- Conduct home visits among seniors to check and remove causes for potential falls and other types of injuries while ensuring high quality of life
- Talk to patient, family members, caregivers, friends, or others to inform them of patients' feelings of loneliness, lack of privacy, or discord with other residents
- Discuss with residential institutions and other building landlords the option of bringing in animals (cats, dogs, birds) to provide residents with purpose in life to care for the animals to decrease loneliness and increase self-worth

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

Income

Why Is Income Important?

Income is a well-documented factor related to health outcomes. For example, it is associated with lower life expectancy. Financial resource strain that results from insufficient income has been shown to lead to stress, depressed mood, self-rated poor health, smoking, and other substance abuse behaviors.

PRAPARE QUESTION

In the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

☐ Please write: _____

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z59.5** Extreme poverty (100% FPL or below)
- **Z59.6** Low income (200% FPL or below)
- **Z59.7** Insufficient social insurance and welfare support
- **Z72.4** Inappropriate diet and eating habits

- Unable to afford medical bills or medications
- Unable to afford costs associated with health insurance (e.g., co-pays, deductibles, premiums)
- Income and/or benefits run out before the end of the month
- Unable to afford non-medical related bills (e.g., rent, mortgage, utility, grocery, childcare, phone)
- Lack of budgeting and other financial management skills
- Lack of knowledge about available economic benefit options, opportunities, programs
- Lack of job opportunities
- Lack of affordable housing options

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- When possible, prescribe generic versions of medication or medications offered through discounted drug pricing programs (340B) or other free or low-cost prescription programs
- Check to see if patient's sliding fee scale should be adjusted
- Refer patient to behavioral health services if patient presents with gambling or other substance abuse habit that depletes income

NON-CLINICAL LEVEL

- Connect patients to community resources and social services offered by state governments, federal programs, charities, and private companies that address access to:
  - Financial literacy education, credit and financial counseling, debt management, fraud, tax assistance and refunds, and microcredit loans
  - Child care, youth development, K – 12/college/adult education
  - Employment, internships, assistance with entrepreneurialism, job skills development for youth and adults
  - Home loan services or short-term rent assistance and assistance with security deposits
  - Foreclosure, home repairs, and housing counseling
  - Financial assistance for utility bills
  - Low cost access to internet for school or work usage
  - Legal aid, immigration status
- Ensure children are enrolled in free or reduced breakfast and lunch at school
- Collect food and gently used goods such as clothing, furniture, work uniforms, toys, school and interview clothes to offer to patients. Or, refer patients to local food banks and good will stores or thrift stores
- Create a wellness space at the health center for a free and safe area to exercise and learn about nutrition
- Provide classes to educate individuals on basic living, job training, and budgeting skills to enable them to help themselves
- Notify people of risks in using lending services and check-cashing services due to risk of either losing money or having high percentage taken out of each paycheck

COMMUNITY LEVEL

- Initiate a dialogue about promoting civic involvement, economic development, workforce development, and leadership training, which may lead to developing and supporting coalitions to address economic challenges in community
- Centralize and integrate the strategic collection of health and economic data across project partners. Use data to create and implement new referral systems between agencies
- Create an economic community development organization that organizes job fairs, workshops, and assistance with financial resource strain
- Discuss possibilities with landlords for energy-efficient improvements to reduce utility costs
- Start businesses, e.g., environmental clean-up, septic system installation, bicycle repair shop

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

Insurance Status

Why Is Insurance Status Important?

Insurance coverage affects access to care and quality of care. More importantly being underinsured, or not insured at all greatly effects a person's ability to be seen in a clinical care setting and can ultimately be the determining factor in an individual's continuity of care as well as their overall physical and mental health and well-being.

PRAPARE QUESTION

What is your main insurance?

☐ None/uninsured
☐ Medicaid
☐ CHIP Medicaid
☐ Medicare
☐ Other public insurance (not CHIP)
☐ Other public insurance (CHIP)
☐ Private Insurance

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

• **Z59.7** Insufficient social insurance and welfare support	• Lack of healthcare and/or inability to afford medications due to underinsurance or lack of coverage • Lack of knowledge on how to apply for insurance or challenges in understanding insurance enrollment process • Inability to receive coverage for all members of family in order to ensure access to care for entire household • Lack of healthcare providers in the area who offer care to underinsured/uninsured • Overuse of hospital emergency rooms due to lack of coverage

CLINICAL LEVEL

- Refer patients to generic brands of medication so as to alleviate costs that may not be covered by insurance plans
- Integrate community health care workers and/or eligibility assistance workers into primary care team in order to better inform patients of resources available to them while they are at the clinic visit
- Integrate social services into care plan when seeing a patient in order to establish a comprehensive care treatment plan for patients challenged with an insurance barrier

NON-CLINICAL LEVEL

- Create weekend workshops during open enrollment periods of health insurance in order to thoroughly explain the benefits and costs associated with the health insurance plans presented when individuals are preparing to apply
- Conduct monthly free health literacy classes in order to better prepare individuals when going into clinical settings
- Identify providers in the community who specifically cater to the insurance status of individuals who frequent the non-clinical setting (uninsured, privately insured, underinsured, Medicare, Medicaid, VA, etc.)
- Work with local advocacy groups in order to mail out information to keep community members informed of what is available to them
- Integrate community and individual social needs to health care providers that address both determinants

COMMUNITY LEVEL

- Establish a community health/social health insurance plan/network
- Have local advocacy organizations provide free training on how to apply for health insurance
- Establish a network of social capital within the community enabling you to advocate for current health care providers to be more accepting of common patient populations insurance status within the community
- Provide community members with an understanding of group dynamics, leadership skills, community action and civic engagement techniques in order to effectively lobby for easily accessible health insurance plans and rates

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.

** Please note that this list is not exhaustive but only includes common examples of needs.

Language and Limited English Proficiency

Why Is Language and Limited English Proficiency Important?

Preventing and reducing adverse events in health care depend on good communication between provider and patient. Research has shown that adverse events that affect limited-English-proficient patients are more likely to be caused by communication challenges and are more likely to result in serious harm compared to English-speaking patients. (*AHRQ, Improving Patient Safety Systems for Patients with Limited English Proficiency, 2012*)

PRAPARE QUESTION

What language are you most comfortable speaking?

☐ English

☐ Language other than English (please write): _____

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z55.0** Illiteracy and low-level literacy
- **Z55.9** Problems related to education and literacy, unspecified
- **Z60.3** Acculturation difficulty
- **Z60.4** Social exclusion and rejection
- **Z60.5** Target of (perceived) adverse discrimination and persecution

- Poor or inadequate informed consent
- Lacks understanding of medical condition, treatment plan, discharge instructions, and follow-up
- Ineffective or improper use of medications
- Cultural traditions and beliefs impacting care
- Trouble navigating social services available
- Limited job opportunities due to language barrier
- Low civic engagement

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Develop dedicated services for medical interpretation that include in-person or telephonic qualified interpreters
- Offer medical documents and medical instructions in preferred language
- Use "teach-back" to ensure patient understanding
- Recruit and hire culturally and linguistically competent providers and personnel
- Continuously train providers and personnel on communication and cultural competency
- Foster a supportive culture for safety of diverse patient populations:
  - Link the goal of overcoming language and cultural barriers into the overall message and mission of the culture of quality and safety, and frame this within existing operational policies and standards related to quality and safety for all patients
  - Share lessons learned from patient safety events with all staff to help build an institutional culture sensitive to issues affecting limited English proficiency patients

NON-CLINICAL LEVEL

- Offer or refer patient to English classes; offer English classes that teach or incorporate technical language likely to be used in a workplace setting
- Provide compiled social services information packages in preferred language listing programs offered at organizations, state and federal levels
- Organize a health, social services, and job fair to provide opportunity for community members to interact with those providing services and to gather more information
- Refer or offer tutoring or homework assistance for children; offer or help enroll children in an after-school program; offer Read Out Loud program to increase children's literacy

COMMUNITY LEVEL

- Encourage civic participation and engagement; partner with civic engagement organizations to coordinate voter registration drives and to mobilize community members during election campaigns and season
- Organize a cultural family fair to increase interaction across cultures and languages
- Offer language classes as a way to teach about and understand different cultures

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.

** Please note that this list is not exhaustive but only includes common examples of needs.

Legal Needs

Why Are Legal Needs Important?

Legal problems are inextricably linked to health problems. Oftentimes, people are made ill or have their access to healthcare threatened because laws are not enforced or poorly written, and because benefits are wrongfully denied. (*National Center for Medical-Legal Partnership*)

PRAPARE QUESTION

In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

☐ Yes

☐ No

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z56.0** Conviction in civil and criminal proceedings without imprisonment
- **Z65.1** Imprisonment and other incarcerations

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Include medically necessary information in the electronic health record and be mindful of the language used to avoid stigma and bias from other care team members
- Create a safe and nurturing space for all patients to reduce the social stigma. Normalize the experience of the patient and speak openly and without judgment
- Help ensure patient has continuity of care and coverage through service eligibility and establishing point of care

NON-CLINICAL LEVEL

- Hire and train community health workers with a personal history of incarceration to assist in case management support, navigation of medical care, and local social services available to the patient.

COMMUNITY LEVEL

- Advocate for legislation to increase the number of job opportunities for people with a criminal or incarceration history
- Advocate for a decrease in administrative or financial costs of such as probation or parole fees

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

"Hotspotting" Housing Code Violations: Cincinnati Children's Hospital Medical Center

When a child sees a doctor at Cincinnati Children's Hospital Medical Center (CCHMC), that doctor is trained to know that unsafe housing may be causing or exacerbating the child's asthma or other chronic health problems. The doctor also knows that when she asks the family about their housing, there will be something she can do to help them. For years, CCHMC has worked with the Greater Legal Aid Society of Cincinnati through their medical-legal partnership to address housing problems for patients.

In the summer of 2010, three separate doctors sent families to the MLP attorneys* because their landlords were threatening eviction if they used air conditioners; a treatment that had been recommended by the doctors to help manage the asthma. When the attorneys met with the families, they asked a very important question, "Who owns your building?"

Turns out, each family lived in a different building owned by the same landlord. And the problem was not just the threatened evictions, but that the landlord lived out of state, was in foreclosure, and was doing nothing to take care of the 19 buildings he owned with 700 units of low-income housing throughout Cincinnati.

Finding the common thread of the landlord opened the door for different kind of intervention. Instead of addressing only the needs of the original three families, the medical-legal partnership helped get improvements made to all the buildings, including new roofs, heating and air-conditioning in many of them. Later the buildings were sold to a local non-profit and the community got a multi-million dollar grant from the Department of Housing and Urban Development to continue improvements to the buildings. Because of these changes, many families who never met with the medical-legal partnership team directly were able to get and stay healthy.

* The Center for Medical-Legal Partnership (CMLP) at The George Washington University, Milken Institute of Public Health, seeks to integrate legal need and care into medical and health care to better address social determinants of health. MLP identifies five main domains, collectively called I-HELP areas, where complicated bureaucracies, wrongfully denied benefits, and unenforced laws commonly impact health and require legal care:

• Income Supports and Insurance
• Housing and Utilities
• Employment and Education
• Legal Status
• Personal and Family Stability

Migrant, Seasonal, and Agricultural Work

Why Is Migrant, Seasonal, and Agricultural Work Important?

Migrant, Seasonal, and Agricultural Workers' health is impacted by the convergence of multiple factors, including mobility and temporality of work, occupational hazards and harsh working conditions, cultural and linguistic barriers, and immigration status, among others. Access to affordable and appropriate health care is often rare. As a result, migrant, seasonal, and agricultural workers are at high risk for many clinical, non-clinical, and communal health needs.

PRAPARE QUESTION

At any point in the past 2 years has seasonal or migrant farm work been your or your family's main source of income?

☐ Yes

☐ No

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z57**   Occupational exposure to risk factors
- **Z57.0**   Occupational exposure to noise
- **Z57.2**   Occupational exposure to dust
- **Z57.3**   Occupational exposure to other air contaminants
- **Z57.4**   Occupational exposure to toxic agents in agriculture
- **Z57.6**   Occupational exposure to extreme temperature
- **Z57.8**   Occupational exposure to other risk factors
- **Z56.2**   Threat of job loss
- **Z59.7**   Insufficient social insurance and welfare support
- **Z60.2**   Problems related to living alone
- **Z60.3**   Acculturation difficulty
- **Z60.5**   Target of (perceived adverse discrimination and persecution
- **Z59.5**   Extreme poverty (100% FPL and below)
- **Z55.0**   Illiteracy and low-level literacy

- Musculoskeletal injuries and/or pains due to hard, physical labor often over long hours, and/or falls
- Stress and anxiety over feeling unsettled, frequency of moving, and uncertainty over when and where next paycheck will come from
- Feelings of disconnection and lack of social support if living away from family and friends
- Fear and concerns about immigration status
- Intra- and inter- language and cultural barriers
- Living with too many people (e.g., lack of privacy and personal space, potential to spread disease, etc.)
- Unsanitary conditions
- Living in areas that are often far away from resources (healthcare, pharmacy, amenities, schools, etc.)
- Lack of health coverage, access, and utilization (can't go to school due to work schedule or lack of child care)

CLINICAL LEVEL

- Provide mobile health services, including medical, dental, behavioral health, pharmacy, prenatal so that migrant, seasonal, agricultural workers can easily access needed care

- Routinely screen for depression and other mental health illnesses, and for alcohol and substance abuse

- Offer peer-support groups to provide opportunities to connect with others experiencing similar issues or conditions

- Continuously train providers and personnel about cultural and linguistic barriers, sensitivity to immigration status, and economic situation of migrant, seasonal, and agricultural workers

- Create a trusting environment by hiring language and culturally conscious workers. Many outreach and enrollment workers or community health workers could come from the migrant, seasonal, and agricultural worker community

- Provide chronic condition self-management classes in appropriate languages

- Provide or refer to employment training centers and skill-building classes as a source for new skill acquirement, such as English as a second language, computer skills, etc. so that workers have more opportunities for other work in the case of job instability

- Encourage diligent use of breathable, personal protective equipment (PPE) to mitigate occupational hazards and injuries; use ergonomic designs whenever possible to reduce occupation-induced chronic pain and musculoskeletal injuries. Provide equipment (back braces, etc.) to help with pains and injuries.

- Run clothing drives or fundraisers to collect hats, sunglasses, breathable clothing, jackets, etc. to provide to workers who work in harsh outside conditions

NON-CLINICAL LEVEL

- Provide or coordinate social services resources including Medicaid/CHIP, WIC, TANF/SNAP eligibility and enrollment; promote and effectively communicate the availability of in-person or paper resources. Organize a social services fair to have in-person interaction with services providers

- Provide assistance or direct the uninsured to resources or organizations that can help with health coverage and medical costs

- Host or refer to English-learning classes

- Host or refer to Spanish-learning classes for indigenous non-Spanish speaking agricultural workers to improve interaction among their colleagues and among largely Spanish-speaking communities

- Host or refer to citizenship classes for those who are eligible; provide or have resources to in-kind immigration services

- Understand the cultural and linguistic variation among the agricultural worker population to provide linguistic and culturally competent services—agricultural workers are not linguistically and culturally monolithic

COMMUNITY LEVEL

- Provide information about low-income or affordable housing options near place of work

- Organize transportation efforts to provide safe, comfortable, and secure travel options for migrant, seasonal, and agricultural community between work, home, and needed resources. Efforts can include: raising funds for bus tokens and taxi vouchers, organizing commuter pools or vans, providing a bus or van service for the community, advocate for new transportation routes to service these communities, providing an information packet to include any transit lines serving known workplace agricultural fields, coordinating affordable car auctions, and raffling out gas cards, among others.

- Work with local farmers to provide farmers markets at the health center so that the community gets to know its farmers and better understand that higher prices for food often correlate with better wages for agricultural workers.

- Educate the community-at-large about the economic contribution and occupational conditions of agricultural workers to reduce prejudice

- Advocate for better living and working conditions for migrant, seasonal, and agricultural workers, potentially by working with oversight or regulatory agencies to create or enforce policies

- Work with the community to bring resources to remote work areas, such as schools, grocery stores, etc.

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

Neighborhood Conditions

Why Are Neighborhood Conditions Important?

Population level data on risks and assets can be used to estimate risk for individuals living within that population, ranging from safety, resources available for healthy living, and economic opportunity. Patient address can be used with geocoded data sets, which have been rapidly growing and will likely expand much further in the next few years. Geocoded information on risk reduces the burden of primary data collection.

PRAPARE QUESTION

What address do you live at?

Street _____

City _____

State _____

Zip code _____

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z57**   Occupational exposure to risk factors
- **Z57.0**   Occupational exposure to noise
- **Z57.1**   Occupational exposure to radiation
- **Z57.2**   Occupational exposure to dust
- **Z57.3**   Occupational exposure to other air contaminants
- **Z57.4**   Occupational exposure to toxic agents in agriculture
- **Z57.5**   Occupational exposure to toxic agents in other industries
- **Z57.6**   Occupational exposure to extreme temperature
- **Z57.7**   Occupational exposure to vibration
- **Z57.8**   Occupational exposure to other risk factors
- **Z65.4**   Victim of crime and terrorism
- **Z65.5**   Exposure to disaster, war, and other hostilities
- **Z59.2**   Discord with neighbors, lodgers, and landlord
- **Z59.4**   Lack of adequate food and safe drinking water
- **Z59.5**   Extreme Poverty

- Lack of transportation options to get to/from medical appointments and things needed for daily living
- Lack of resources (health care, quality schools, after-school programs, pharmacies, grocery stores, affordable housing) to live healthy lives
- Lack of economic development opportunities (jobs, businesses, etc.)
- Unsafe area (crime, violence)
- Neighborhood in poor condition (graffiti, trash, uneven sidewalks, dog poop)
- Lack of community relations or pride within community
- Lack of emergency preparedness for environmental disasters
- High traffic area

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Ensure patient fills and picks up any prescriptions at on-site pharmacy while at the health center
- Provide transportation services to health center and pharmacy
- Refer patient to behavioral health services if patient has been a victim of crime or has witnessed hostilities

NON-CLINICAL LEVEL

- Collect food and gently used goods such as clothing, furniture, work uniforms, toys, school and interview clothes to offer to patients. Or, refer patients to local food banks and good will stores or thrift stores.
- Work with local or state food-based organizations to bring farmers markets, community gardens, and other healthy food vendor opportunities to community
- Create a wellness space at the health center for a free and safe area to exercise and learn about nutrition
- Create walking clubs or teams to provide safe walking options for patients
- Organize events that celebrate the community and its cultural diversity to promote inclusion, sensitivity, understanding, well-being, and involvement.
- Develop after school or summer programs for children to keep kids off the streets and engaged in activities, either at the health center or in partnership with other community organizations, such as the YMCA/YWCA, local churches, local schools, Head Start programs, etc.
- Provide transportation services that not only go to health center and pharmacy but also grocery store, bank, library, YMCA, etc.
- Work with Uber, taxi services, and public transportation agencies to provide discounted rates on transportation services.
- Hold more events in different neighborhoods of the community to engage the community and bring different activities to that neighborhood.
- Aid patients to move

COMMUNITY LEVEL

- Initiate a dialogue about promoting civic involvement, economic development, workforce development, and leadership training, which may lead to developing and supporting coalitions to address neighborhood conditions
- Create or partner with a community development organization to organize job fairs, workshops, and assistance with financial resource strain
- Organize volunteer groups to clean up neighborhoods and toxic sites in the neighborhood
- Get police involved to promote safety in neighborhoods and develop relationships with community members.
- Encourage repairs and refurbishment and development of areas to encourage pride in neighborhood
- Develop parks
- Teach community members understanding of group dynamics, leadership skills, and community action and civic engagement techniques

- Teach community members understanding of group dynamics, leadership skills, and community action and civic engagement techniques
- Lobby the county bus system, with community members, to develop new bus routes to isolated areas.
- Lobby local transportation agency to install traffic lights and pedestrian walk signals at high traffic intersections
- Improve trails and paths for walking and biking
- Promote zoning, land use, and resource use that support the community's health needs
- Develop disaster and emergency preparedness for the community
- Promote economic development zones to encourage businesses to come to neighborhood
- Start businesses, e.g., environmental clean-up, septic system installation, bicycle repair shop
- Develop local charter schools

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.

** Please note that this list is not exhaustive but only includes common examples of needs.

Safety and Domestic Violence

Why Are Safety and Domestic Violence Important?

Domestic violence is a known contributing factor to mental health and well-being, and can lead to other chronic conditions such as heart disease and stroke. Providing access to resources for support and actively creating & engaging in preventative practices will allow for a safer, healthier livelihood.

PRAPARE QUESTION

Do you feel physically and emotionally safe where you currently live?

☐ Yes

☐ No

☐ Unsure

☐ I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner?

☐ Yes

☐ No

☐ I have not had a partner in the past year

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z63** Problems related to primary support group, includes family circumstances
- **Z63.9** Problems in relationship with spouse or partner
- **Z91.41** Personal history of adult abuse
- **Z91.410** Personal history of adult physical and sexual abuse
- **Z62.81** Personal history of abuse in childhood
- **Z62.810** Personal history of physical and sexual abuse in childhood
- **Z62.811** Personal history of psychological abuse in childhood
- **Z62.812** Personal history of neglect in childhood

- Distrust and emotional detachment
- Fear of intimacy
- Strained relationships with health providers and employers
- Unable to access resources for support
- Constant flashbacks of violent acts

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Train physicians/health care providers to be able to identify the early indicators of abuse within a clinical visit. Refer to behavioral health services if necessary
- Create an atmosphere of safety for the patient being seen (i.e. "patient-only" signs beyond a certain point in the office). If partner attends clinic visit with patient, ask partner to leave for part of the visit to discuss private matters, but do not mention it is for domestic violence screening
- Display educational posters & flyers about domestic violence around the clinic to help create a safe, welcoming, & empowering environment

NON-CLINICAL LEVEL

- Develop partnerships with local shelters and housing organizations for victims of domestic violence
- Have staff trained in assessment and screening for domestic violence victims, including their legal obligations for reporting such abuse
- Offer support groups for victims of domestic violence
- Establish a community referral system with ties to local healthcare providers and other social services organizations

COMMUNITY LEVEL

- Work with local government officials to advocate for policies and laws concerning domestic violence victims (e.g., restraining orders, offender lists, etc.)
- Educate your community on the indicators of domestic violence for all age groups
- If dealing with overcrowding at shelters, advocate to build more shelters
- Work with community groups (e.g., churches) to develop a network of "safe houses" where victims of domestic violence can stay and receive support for a period of time if shelters are overcrowded
- Develop a network of community leaders willing to take initiative when necessary for the betterment of the community
- Charge community business owners and leaders to hold themselves accountable to learn, be trained in and recognize the signs, as well as how to take appropriate action

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

Social Integration

Why Is Social Integration Important?

Social relationships impact health as much or more than some major biomedical and behavioral factors. Social integration, or the number of relationships and frequency of contact, has more evidence supporting its role in health outcomes than subjective measures of loneliness (*IOM, Phase I & II Report, 2014*).

PRAPARE QUESTION

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week

☐ 1 or 2 times a week

☐ 3 to 5 times a week

☐ 5 or more times a week

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z60** Problems related to social environment
- **Z60.0** Problems of adjustment to life-cycle transitions
- **Z60.3** Acculturation difficulty
- **Z60.4** Social exclusion and rejection
- **Z60.5** Target of (perceived) adverse discrimination/persecution
- **Z60.8** Other problems related to social environment
- **Z62.2** Upbringing away from parents
- **Z62.22** Institutional upbringing
- **Z59.2** Discord with neighbors, lodgers, and landlord

- Low desire to seek out or engage with healthcare providers
- Lack of knowledge about available resources for individual as well as family members

CLINICAL LEVEL

- Engage new patients who come into the clinic
  - Asking if they just moved to the area, why they came to the new facility, etc.
  - Take note of what you hear that you can relate to and provide information on places that may be of interest to patient
- Host community events on or near healthcare facility so as to actively be inclusive of community members and open up a door for current patients who may be having trouble socially
- Leave flyers and posters about all-inclusive community group events in and around the clinical setting for patients to easily access and learn more
- Encourage patients to participate in social groups within the facility that may be of interest to them based on what the patient has already shared with you
- Integrate patient needs into the care plan

NON-CLINICAL LEVEL

- Connect patients to community resources and social services offered by state governments, federal programs, charities, and private companies that address access to:
  - Financial literacy education, credit and financial counseling, debt management, fraud, tax assistance and refunds, and microcredit loans
  - Child care, youth development, K – 12/college/adult education
  - Employment, internships, assistance with entrepreneurialism, job skills development for youth and adults
  - Low cost access to internet for school or work usage
  - Legal aid, immigration status
- Work with community organizations in order to increase awareness of their presence as well as what resources they can provide
- Be intentional about inclusion of full community when creating and hosting local events

COMMUNITY LEVEL

- Initiate a dialogue about promoting civic involvement, economic development, workforce development, and leadership training, which may lead to developing and supporting coalitions to address economic challenges in community
- Partner with community health centers locally in order to provide community space for workshops and developmental clinics on health and wellness
- Have 'town hall meetings' (if they do not presently exist) for individuals in the neighborhood to be able to come together in order to discuss their thoughts about their environment
- Actively engage community members on a consistent basis focusing on high priority needs as determined by the community

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

Stress

Why Is Stress Important?

Stress has negative health consequences when a patient has insufficient resources to cope with it. Long-term exposure to chronic or severe stressors increases a patient's allostatic load, which is the biological mechanism by which stress produces negative health outcomes. Stress management interventions can prevent stress from becoming toxic to the body and contributing to the development of chronic health conditions (*IOM, Phase I Report, 2014*).

PRAPARE QUESTION

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

☐ Not at all
☐ A little bit
☐ Somewhat
☐ Quite a bit
☐ Very much
☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z72.4** Inappropriate diet and eating habits
- **Z56** Problems related to employment/ unemployment
- **Z56.0** Unemployment
- **Z56.1** Change of job
- **Z56.2** Threat of job loss
- **Z56.3** Stressful work schedule
- **Z56.4** Discord with boss and workmates
- **Z56.5** Uncongenial work environment
- **Z56.6** Other physical and mental strain related to work
- **Z59.0** Homelessness
- **Z59.2** Discord with neighbors, lodgers, and landlords
- **Z60** Problems related to social environment
- **Z60.0** Problems of adjustment to life-cycle transitions
- **Z60.3** Acculturation difficulty
- **Z60.8** Other problems related to social environment
- **Z65.4** Victim of crime and terrorism
- **Z65.5** Exposure to disaster, war, and other hostilities
- **Z59.5** Extreme Poverty (100% FPL or below)
- **Z59.6** Low income (200% FPL or below)

- Acts of self-harm used as a coping mechanism to alleviate stressful environments
- Problems related to substance abuse and addiction as coping mechanisms to manage stress
- Not getting enough sleep

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Be proactive in helping the patient identify where the stressors are coming from
  - Work with patient to draw links between the stressors and resources to help alleviate them
- Provide patient with healthy stress management alternatives to medication
  - Exercising, yoga, meditation, etc.
- Directly address physical manifestations of patient identified stressors
- Introduce patient to relaxation exercises
  - Breathing techniques, muscle relaxing exercises
- Help patient identify calming activities they enjoy and work to build a schedule for patient to work these activities into their lives routinely in order to alleviate the strain stressors may have on their overall health and well-being
- Introduce healthy eating habits in to the patient's diet in order to account for a patient's ability to make better choices while in stressful situations

NON-CLINICAL LEVEL

- Connect individuals with healthy outlets to reduce stress
  - Community gardens, low-cost yoga studios, parks & trails, etc.
- Work with the individual to connect them with social groups that appeal to their interests
- Provide education on ways one can reduce stress and bad habits associated with stress
- Connect individuals to counseling services to help reduce adverse health factors associated with stress

COMMUNITY LEVEL

- Develop a community organizing campaign to keep the neighborhood safe
  - Working together to create a safe atmosphere can in turn provide less anxiety or stress concerning personal safety for individuals in the community
- Establish a firm network of social and psychological communal support through community organizing and deliberate interaction with neighbors and local officials
- Advocate for the growth & maintenance of more parks and open space in your neighborhoods
- Work with local government to advocate for entities within the community to promote overall health and well-being
  - Creating farmer's markets/ bringing organic markets to the community at a low cost that accept all forms of payment (cash, credit, EBT, etc.)
- Starting wellness initiatives (Free yoga in the park on Saturdays, community hiking/walking trips, etc.)

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

Transreportation

Why Is Transportation Important?

Transportation plays a vital role in an individual's life and a critical role in one's ability to sustain a healthy livelihood by determining one's ability to get to and from work, accessing healthy food options, and visiting healthcare providers.

PRAPARE QUESTION

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

☐ Yes, it has kept me from medical appointments or from getting my medications

☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need

☐ No

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z56.2** Threat of job loss
- **Z56.6** Other physical and mental strain related to work

- Greater burden of disease for chronic illnesses due to delays in clinical care
- Inability to effectively adhere to treatment care plans requiring consistent clinical visits
- Overall lack of healthcare utilization as a result of poor access to sustainable transportation
- Issues getting other dependents in the household to school or work or appointments on time
- Inability to access healthier food options based on location
- Increased levels of stress due to strained relationship with adequate transport
- Lack of social integration due to limited mobility
- Minimal or inconsistent funding for public transportation, particularly "door to door" services
- Lack of knowledge about other transit options within community
- Lack of development in areas with limited transportation
- Lack of community engagement and/or lack of representation of the community at community or town hall meetings due to residents who either are unable or are excessively late to such meetings due to transportation barriers

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Talk to patient & family members about affordable options within the community for transit.
- Attempt to schedule treatments, care updates, pharmacy pick-up, etc. within the same clinical visit.
- Work with the patient's schedule (work, extracurriculars, etc.) in order to determine the most feasible days/times to schedule appointments, treatments, and check-ups.
- Check to see if patient is eligible for local transportation vouchers or benefits if they exist within the community (e.g., bus tokens, taxi vouchers, etc.).
- Increase home visitation services for patients that experience difficult transportation barriers.

NON-CLINICAL LEVEL

- Create satellite offices or mobile clinics or vans where community members can access similar clinical and non-clinical services at more convenient locations.
- Work with Uber, taxi services, and public transportation agencies to provide discounted rates on transportation services.
- Develop relationships with local transportation agencies to negotiate bulk discount rates for bus tokens and taxi vouchers to provide to patients.
- Provide a van or bus service loop that takes patients to major community organizations needed for daily living, such as the health center, library, grocery store, YMCA, pharmacy (if not co-located with the health center), bank, etc. to make them accessible to patients.
- Establish a discounted rate bike share program in areas where biking is feasible for residents to get to and from their destinations.
- Work with local grocery stores who accept meal vouchers to provide healthier food options within the vicinity of areas within the community where public transportation is lacking.

COMMUNITY LEVEL

- Bring car share programs in to the community in order to better serve those who may not be able to afford their own vehicle at the time.
- Organize community carpools in the neighborhood with designated stops and drivers for specific zones within neighborhoods.
- Organize a group to facilitate transport services for elderly members of the community who may no longer drive.
- Geocode data on transportation needs to highlight areas of the community that are particularly isolated with few transportation options. Bring this data to local government and transportation agencies to negotiate for new bus routes, trains, roads, etc. to those areas.
- Work with local government in order to establish low-cost communal transportation services within rural areas where public transit may not be as common as city environments.
- Establish needs-based forms of payment for public transportation options (i.e. student prices, senior prices, income below a certain level receiving transportation vouchers, etc.).
- Engage with local businesses and incoming developers to attempt to establish low-cost food stores and farmers markets placed in strategically accessible sites within the community to offer healthy food options.
- Establish a food and medication delivery service for community members who are extremely challenged by their transportation needs.

* Please note that not all PRAPARE questions have relevant ICD-10 Z Codes.
** Please note that this list is not exhaustive but only includes common examples of needs.

CHAPTER 9: Act on Your Data

Veteran Status

Why Is Veteran Status Important?

Veterans face unique health challenges arising from their military service. While in service, they face deadly occupational hazards, and upon return, face issues with mental health and reintegration, among other issues. As such, veterans are at heightened risk for certain health outcomes, including Post-Traumatic Stress Disorder and joint replacement surgery.

PRAPARE QUESTION

Have you been discharged from the armed forces of the United States?

☐ Yes

☐ No

☐ I choose not to answer this question

RELEVANT ICD-10 Z CODES AND OTHER POTENTIAL NEEDS*

- **Z56.82** Military deployment status
- **Z56** Problems related to employment/unemployment
- **Z56.0** Unemployment
- **Z59.0** Homelessness
- **Z59.1** Lack of adequate and affordable housing
- **Z65.5** Exposure to disaster, war, and other hostilities
- **Z57** Occupational exposure to risk factors

- Post-traumatic stress disorder (PTSD), suicide, alcoholism, and substance abuse
- Paralysis, traumatic brain injury, limb loss
- Lack of job skills and joblessness
- Violence induced by PTSD, suicidal thoughts, alcohol/substance abuse relapse
- Legal needs

WAYS TO RESPOND TO NEEDS**

CLINICAL LEVEL

- Screen for PTSD, suicide ideation, and alcohol and substance abuse; offer or refer to clinical psychologists and peer-support groups; provide or link them to a case manager
- Accommodate disabled veterans by offering enabling services such as free transportation, and link them to free or low cost medical equipment such as wheelchairs, bath benches, canes, etc.
- Screen for any exposures prevalent in a military or warfare setting
- Train providers to be aware of military service related infectious disease that are regularly uncommon among the general population

NON-CLINICAL LEVEL

- Provide job training and employment services such as mock interviewing, resume building, vocational guidance and training, computer skills and online job search training, career matching, and interview referrals; host monthly career nights so veterans have direct access to hiring agents
- Partner with or refer to a low-cost barber to provide haircuts for interviews; provide business and business casual interviewing clothing and additional suits to last until he/she is able to afford new clothing
- Ensure smooth military to workforce transition with periodic check-ins
- Provide credit counseling and financial literacy training
- Provide VA benefits counseling
- Offer housing support to help veterans find adequate and affordable housing or link them to existing services providing that assistance
- Compile a veterans-relevant social services package including telephone helplines such as the Veterans Crisis line

COMMUNITY LEVEL

- Promote and encourage mental health care; promote the de-stigmatization of mental health; encourage seeking of mental health care by veterans
- Provide or refer to legal services to help veterans with housing eviction prevention, and to assist with child support and military discharges issues that affect income, among other legal needs
- Encourage veteran discounts at grocery stores to ensure low-income veterans can afford healthy foods

* Please note that this list is not exhaustive but only includes common examples of needs.

CHAPTER 10
Track Enabling Services

This chapter provides tools on how to document the enabling services interventions your organization provides to address patients' social determinants of health barriers. Enabling services are non-clinical support services and interventions that support the delivery of basic health services and facilitate access to comprehensive care and community services. They include referrals to community resources, insurance eligibility assistance for uninsured patients, interpretation for Limited English Proficient patients, and housing assistance for homeless individuals.

Enabling services data collection is important considering the transition from a volume to value-based health care environment, whereby providers are becoming increasingly accountable for achieving quality health outcomes while lowering the total cost of care. Overall, tracking enabling services is important to:

- Make the business case for sustainable funding for non-clinical support services
- Highlight the value of enabling services as an integral component of value-based health care and practice transformation
- Demonstrate organizational eligibility for patient-centered medical home (PCMH) accreditation and other quality incentives
- Provide organizations with standardized data to ensure high quality and comprehensive care for vulnerable, underserved, & diverse populations

This chapter provides tools and resources to guide health centers and health care delivery systems who wish to codify and track enabling services.

Demonstrating Value by Documenting Both Enabling Services/Interventions and PRAPARE

Once you have implemented PRAPARE and developed the appropriate interventions, it is important to track those interventions to better understand the value of existing interventions to address patient risks. Research demonstrates that enabling services lead to positive impacts on outcomes, costs, access, and patient satisfaction as exhibited by **FIGURE 10.1.** By documenting enabling services, your organization can determine which interventions are most effective at addressing particular risks for particular populations which can inform clinical operations as well as resource allocation to lead to improved patient care. You can also better quantify the extent to which your organization already provides enabling services in terms of staff involved, services provided, and time spent providing those services—much of which may not be currently reimbursable.
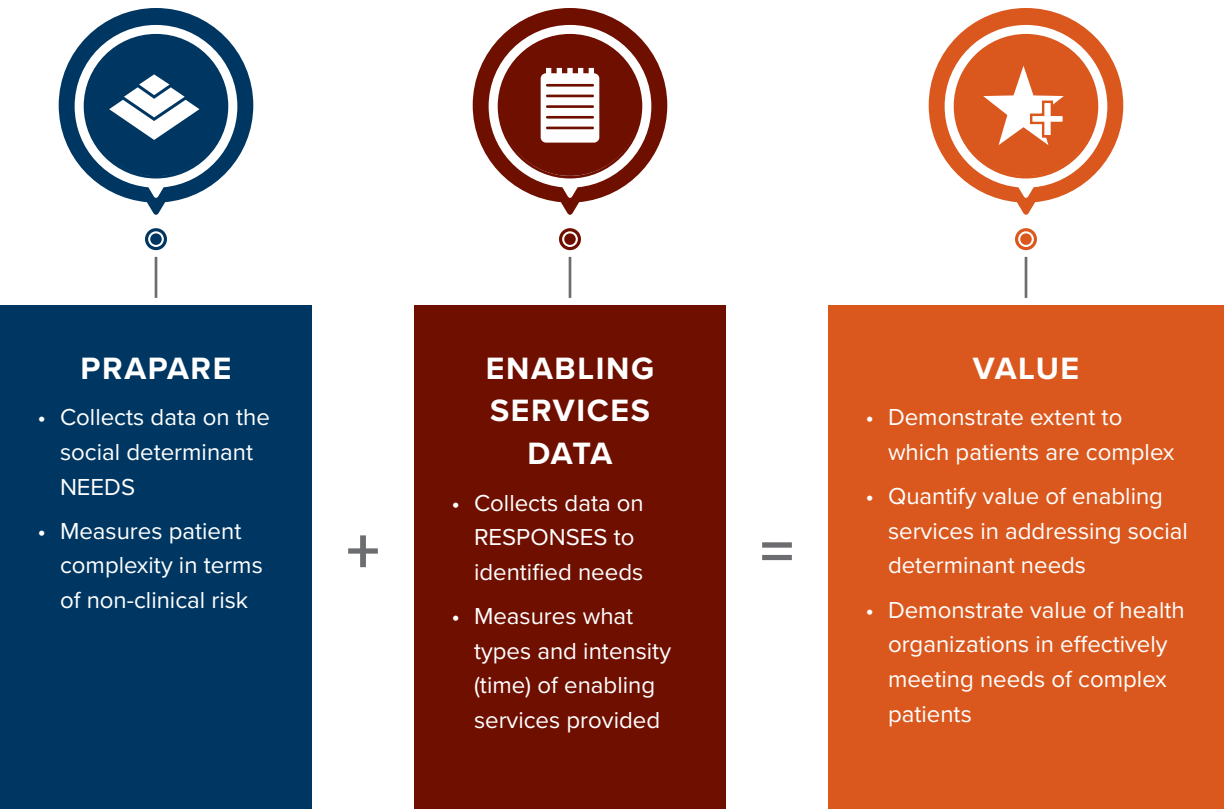
FIGURE 10.1. Enabling Services/Interventions Act as a Moderator to Address Social Determinants of Health and Impact Health Outcomes

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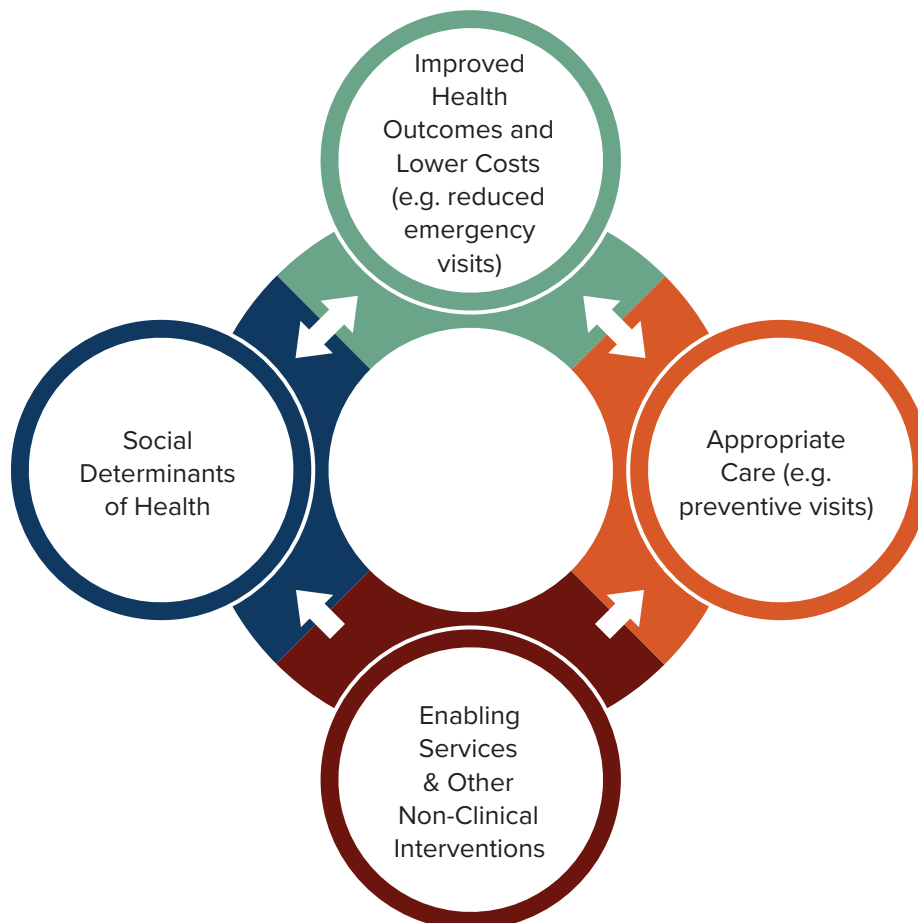
[1] Association of Asian Pacific Community Health Organizations. Fact Sheet: Impact of Enabling Services Utilization on Health Outcomes. 2009. http://www.aapcho.org/projects/enabling-services-accountability-project/. Ngo-Metzger Q, et al. Providing High-Quality Care for Limited English Proficient Patients: The Importance of Language Concordance and Interpreter Use. J Gen Intern Med. 2007;22(Suppl 2): 324-30. Philis-Tsimikas A, et al. Improvement in Diabetes Care of Underinsured Patients Enrolled in Project Dulce: A Community-Based, Culturally Appropriate, Nurse Case Management and Peer Education Diabetes Care Model. Diabetes Care. 2004; 27(1): 110-115.

CHAPTER 10: Track Enabling Services

By linking both PRAPARE data and enabling services data, your organization can better demonstrate the complexity of your patients and how your organization is working to address the barriers that those patients are facing. As a result, having both PRAPARE and enabling services data shows what services *are needed* to care for such complex patients. This data forms the critical evidence needed to make the case to payers that these enabling services are effective and necessary to address many of the social determinant risks that patients face and should therefore be sustainably funded and/or reimbursed **(FIGURE 10.2)**.

FIGURE 10.2. The Non-Clinical Data Value Equation

PRAPARE		ENABLING SERVICES DATA		VALUE
• Collects data on the social determinant NEEDS • Measures patient complexity in terms of non-clinical risk	**+**	• Collects data on RESPONSES to identified needs • Measures what types and intensity (time) of enabling services provided	**=**	• Demonstrate extent to which patients are complex • Quantify value of enabling services in addressing social determinant needs • Demonstrate value of health organizations in effectively meeting needs of complex patients

BEST PRACTICE

Another important reason to collect data on enabling services:
If your organization already delivers enabling services interventions to address your patient social risks, reporting social determinants data alone may underestimate your total patient risks compared to reporting combined social determinants with enabling services intervention data because you are likely addressing their needs.

Enabling Services Categories

There are nine thematic enabling services categories, some of which have sub-categories. These include:

CASE MANAGEMENT ASSESSMENT	**CASE MANAGEMENT TREATMENT AND FACILITATION**	**REFERRALS**
FINANCIAL COUNSELING/ ELIGIBILITY ASSISTANCE	**HEALTH EDUCATION**	**SUPPORTIVE COUNSELING**
INTERPRETATION	**OUTREACH**	**TRANSPORTATION**

Based on the lessons learned with PRAPARE and other enabling services work, the Association of Asian Pacific Community Health Organizations (AAPCHO), one of the leading experts in the area of enabling services, updated the enabling services categories to more comprehensively document the different types of non-clinical services that are related to medical health as well as social services. **TABLE 10.1** shows the comparison between the previous list of enabling service categories to the updated list.

TABLE 10.1. Enabling Services Categories

PREVIOUS ENABLING SERVICES CATEGORIES	UPDATED ENABLING SERVICES CATEGORIES
• Case Management Assessment	• Social Services Assessment
• Case Management Treatment and Facilitation	• Case Management
• CM Referral	• Referral- Health • Referral- Social Services
• Financial Counseling/ Eligibility Assistance	• Financial Counseling/Eligibility Assistance
• Health Education/Supportive Counseling * Individual * Group	• Health Education- Individual (one-on-one) • Health Education- Small Group (2-12) • Health Education- Large Group (13 or more) • Supportive Counseling
• Interpretation	• Interpretation
• Outreach	• Outreach • Inreach
• Transportation	• Transportation- Health • Transportation- Social Services
• Other	• Other

Enabling Services Accountability Project (ESAP) & Enabling Services Data Collection Implementation Companion

AAPCHO's Enabling Services Accountability Project (ESAP) demonstrated the feasibility of collecting standardized enabling services data in the Electronic Health Record (EHR) and highlighted the impact of these services on health care access and outcomes. Overall, the project illustrated the role enabling services play in increasing access and quality of health care for medically underserved communities, providing compelling data to adequately compensate health centers for delivering these essential and non-clinical services. The goals of ESAP are to:

- Develop standard data collection protocol and database for enabling services at health centers nationally
- Describe utilization of enabling services at health centers and the patients who use them
- Evaluate the impact of enabling services on health access, outcomes and utilization of primary care
- Disseminate findings to health centers and policy makers to guide effective resource allocation
- Facilitate research and expansion opportunities to other health centers and networks

AAPCHO's Enabling Services Data Collection Implementation Companion serves as a guide for health organizations wishing to codify and track enabling services using a standardized template. The companion was developed as a standardized data collection model to improve data collection on these essential services, and better understand them and their impact on health care access and outcomes. Health centers may tailor many of the detailed demographic categories to their own health center needs, while keeping uniform the broader categories for national health center aggregation purposes.

The implementation guide includes samples of currently active EHR encounter forms, protocols for data collection, a recommended work plan, and sample fact sheets demonstrating data use, based on AAPCHO's enabling services data collection model. By building a larger comparable dataset nationwide, we'll have a more comprehensive set of data that will more clearly demonstrate the value of enabling services. Additionally, costs and resource allocation needs can be better approximated which will strengthen health organizations' ability to build a business case and obtain adequate funding for sustainability of these critical services and improvement of patient health.

RESOURCES

AAPCHO's Enabling Services Homepage

Enabling Services Accountability Project: Developed by AAPCHO and New York Academy of Medicine

Enabling Services Data Collection Implementation Packet (2017 Version): Developed by AAPCHO and New York Academy of Medicine

PRAPARE

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

NATIONAL ASSOCIATION OF
Community Health Centers

AAPCHO
Association of Asian Pacific Community Health Organizations

OPCA
Oregon Primary
Care Association