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.

Table of Contents

For more information, visit www.nachc.org/PRAPARE.

What Is PRAPARE?

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 (SDH). 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 SDH, 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 SDH 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, integration, and health improvement & cost reductions.

PRAPARE has been a multi-year effort between the National Association of Community Health Centers, the Association of Asian Pacific Community Health Organizations, the Oregon Primary Care Association, and the Institute for Alternative Futures. A group of pioneer health centers and health center networks in Hawaii, Iowa, New York, and Oregon helped develop and pilot tested PRAPARE, including the Alliance of Chicago Community Health Services, Health Center Network of New York, HRHCare, Iowa Primary Care Association, La Clinica Del Valle, OCHIN, Open Door Family Medical Center, People's Community Clinic, Siouxland Community Health Services, Waianae Coast Comprehensive Health Center, and Waikiki Community Health Center.

PRAPARE was made possible with funding from the Kresge Foundation, the Blue Shield of California Foundation, and the Kaiser Permanente National Community Benefit Fund at the East Bay Community Foundation.

What Does PRAPARE Measure?

The PRAPARE assessment tool was informed by research on SDH domains that predict poor outcomes and high cost, the experience of existing social risk assessments, and stakeholder engagement. It aligns with national initiatives prioritizing the SDH (e.g., Healthy People 2020), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers' current federal reporting requirements (i.e., Uniform Data System). PRAPARE emphasizes measures, listed below, that are actionable.

Core Measures

* Race and Ethnicity
* Farmworker Status
* Veteran Status
* Housing Status
* Insurance Status
* Language Preference
* Education
* Employment
* Transportation
* Neighborhood
* Stress
* Social Integration and Support
* Material Security (food, utilities, clothing)

Optional Measures

* Safety
* Domestic Violence
* Incarceration History
* Refugee Status

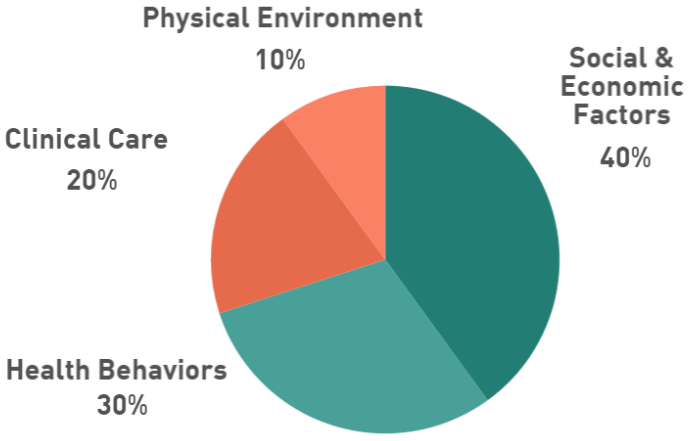
Why Is It Important to Address the Social Determinants of Health?

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%).

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.

The importance of providing services to mitigate the adverse social determinants of health will grow under added pressures of reaching quality targets and lowering total healthcare spending. 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.

Dahlgren and Whitehead, 1991



Robert Wood Johnson Foundation's County Health Rankings Model, 2014.

What Does PRAPARE Ultimately Help Me Do?

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

1) Define and document the increased complexity of patients;
2) Better target clinical care, enabling services, and community partnerships to drive care transformation;
3) Enable providers to demonstrate the value they bring to patients, communities, and payers;
4) 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. If organizations only collect data on parts of PRAPARE, the data will not be as strong or accurate to paint a full picture of the socioeconomic challenges that health center patients face.

What Have We Learned After Using PRAPARE?

In less than a year, PRAPARE pilot teams in Hawaii, Iowa, New York, and Oregon have shown:

IMPLEMENTATION

- PRAPARE data can be collected in EHRs
- PRAPARE does not take long to administer
- PRAPARE can be administered by a wide range of staff at various times in clinic workflow
- Staff find PRAPARE helpful in assessing and addressing patients' needs
- Patients appreciate being asked and feel comfortable answering the questions

DATA and USING DATA

- Most patients face 4 - 9 SDH. But, more complex patients can face upwards of 11 SDH
- There is a moderately positive correlation between the number of SDH a patient faces and having hypertension
- Organizations are using PRAPARE to develop interventions and partnerships and to streamline care management programs

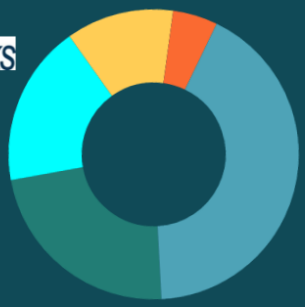
PRAPARE templates exist for four common EHRs that are used by 58% of all health centers.

Centricity

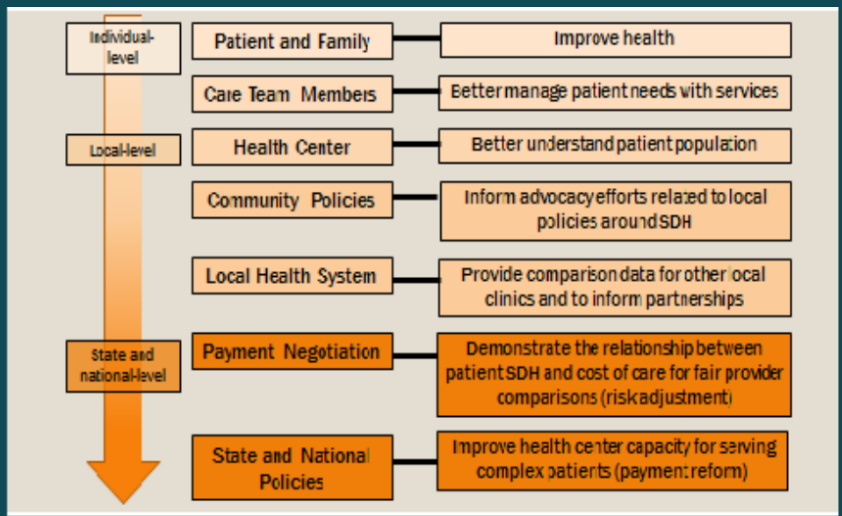
Epic

eClinicalWorks

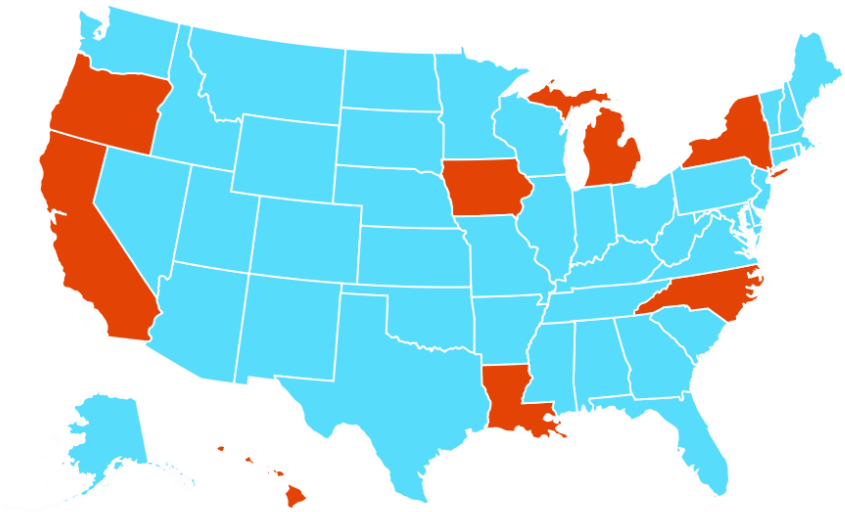
NEXTGEN HEALTHCARE



PRAPARE Positions Staff to Improve Individual and Community Health



PRAPARE Is A National Movement!



Health centers in 8 states are either already using PRAPARE or are planning to being using PRAPARE in 2016

Health centers, state associations, regional networks, and other health care organizations in every other state are interested in using PRAPARE

What's Next for PRAPARE?

PRAPARE partner organizations are focusing on supporting spread with resources and a training system along with planning for further validation.

This includes the following activities:

- Developing a National PRAPARE Learning Network with training resources, webinars to share best practices, coaches to help guide interested users through the process, and networking opportunities to learn from other health centers who have implemented PRAPARE
- Translating PRAPARE into multiple languages
- Creating population-specific PRAPARE tools (e.g., pediatric, etc.)
- Building more EHR templates
- Conducting additional research and analyses on social determinants of health data