

PRAPARE Frequently Asked Questions (FAQ)

1. Is PRAPARE a paper based tool or available electronically?

PRAPARE is available in a paper format and has been built into templates in four electronic health records including EPIC, NEXT GEN, eClinical Works and GE Centricity.

2. Is it a web based tool that is offered as a software service?

No, the electronic versions are imbedded in electronic health records.

3. How much does PRAPARE cost?

PRAPARE is an open source product available free. Your electronic health record (EHR) vendor may charge for technical support if you are unable to configure your system within the resources and expertise of your organization. Some vendors also charge extra for custom reports if you do not have an ad hoc reporting tool capacity with your EHR.

4. Is PRAPARE available in all electronic health record solutions?

No, the pilot project was funded to target the four most prevalent electronic health records utilized by Community Health Centers (CHC). Additional vendors may choose to add PRAPARE as a new feature if there is enough demand from the market. Ask you vendor to add PRAPARE as a new tool set.

5. Is there a short version of the tool?

Not currently. Although much work has been undertaken in health care to better understand social determinants of health, there is no sufficient evidence to point to the seminal questions of greatest utility. We believe PRAPARE is the beginning of a validation journey that might eventually lead to a shortened version for certain applications.

6. Why is it important to collect SDH data?

Health Centers have understood the importance of social determinants of health since the inception of the health center movement. This includes a recognition that patients with social determinants of health may require more resources to support their needs. This hypothesis has never been systematically quantified in order to better plan care needs for patients, to plan community wide interventions or to negotiate enhanced reimbursement with the payment system. By systematically collecting standardized questions enables you to gain better insight on your population of patients being served and can help you demonstrate the value you add compared to other community providers. Collecting SDH can also help you target your resources to those who might benefit the most.

7. What if we already collect SDH information? Is PRAPARE meant to replace our questions or work flow?

No. Congratulations on your work! You might benefit from participating in the national learning community that is evolving as a result this project. A second consideration is the degree of standardization of questions for benchmarking purposes. PRAPARE is quickly becoming adopted by health centers and various stakeholders and will have the ability to facilitate benchmarking across organizations and is intended to align with national accepted measures. The more aligned your questions are with the growing national consensus on measures that is reflected in

the PRAPARE tool the better are your prospects from benefitting from the benchmarking and risk adjustment tools and resources that may evolve.

8. Where did the PRAPARE questions come from?

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

9. Why is it so important to have a standardized tool?

A standardized tool enables one to compare across time and across health centers and providers. This is important in order to see whether a change has occurred based on all the hard work underway in the organization. Equally important, systematic collection of standardized data enables one to begin to accelerate population level planning and to collect data to influence the external environment including how health centers get paid for their work. By assessing patients it also can inform care at the point of service.

10. Aren't many of the questions in PRAPARE UDS data elements?

Yes and by design. A design feature of PRAPARE was to minimize the burden of reporting for health centers. Many questions are in data elements used to produce health center UDS measures and for those with an electronic health record that has PRAPARE imbedded those fields are auto-populated.

11. CMS has launched an Accountable Community program and it appears there will be questions endorsed by CMS on SDH. Do they conflict with PRAPARE?

The PRAPARE project team worked closely with many national organizations including CMS in order to facilitate alignment of how SDH are measured. The CMS questions have yet to be announced but once they are made available an effort will be made to align PRAPARE where possible.

12. Should we begin to collect PRAPARE data now or wait until the pilot is over and the implementation packet is ready?

Anyone is able to start using PRAPARE now! Michigan has a Community Health Worker program underway with many health centers that are using the tool to help guide their work. In Oregon, the clinics in the Alternative Payment Methodology are using the tool as well.

13. Health centers already feel overwhelmed with data reporting requirements. How can we reduce burden?

The health centers that piloted the tool reported that the total time to administer was less than nine minutes with many questions already being asked. It was suggested the tool presented a minimum burden on the staff but had a very positive impact on the staff and patient relationships. The tool was viewed as an agenda for a dialogue with the patient in a very different way. Patients also reported positive reactions to the questions as evidence that the health centers care about their patients beyond their clinical needs or complaints of the moment that brought them to the health center. The tool also provides a pathway to begin to tackle

many of the social determinant issues that staff in the center traditionally have felt powerless to address.

14. What is the link between patient level data in PRAPARE and community level data thru GIS/CHNA?

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

15. How do you counter the question/argument, why should you risk adjust if all patients have Medicaid (and therefore the same income levels)?

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

16. How do you counter the argument that risk adjustment masks disparities?

Risk adjustment is a tool and not a panacea. One aim of PRAPARE is that it will unmask disparities and help us better understand their role in driving patient complexity and cost.

17. How do you convince payers to take homegrown PRAPARE data?

PRAPARE is aligned with Meaningful Use 3 and with ICD-10 which are important to payers to help them meet their own billing and compliance issues. Payers are using their own risk adjustment tools which have historically been developed from encounter data but have not factored in SDH. PRAPARE offers the payers the opportunity to develop an even greater understanding of their member population and can be the foundation for working with health centers to address the issues which are driving cost and utilization which they are acutely aware need to be addressed.

18. Why do we need to calculate a patient's overall risk score? A communities?

By assessing individual risk enables you to focus your care management resources. For example, changes in a person's life resulting from several social determinants of health might quickly lead to that person becoming a high cost utilizer. If we understand those issues real time and can intervene we might help that person in crisis while avoiding near and long term costs and demand for services. As we systematically collect at an individual level and then roll up the data to see at a population level it enables an organization to focus energies on those SDH most influencing their patient population.

19. Why do we need to collect BOTH patient-level SDH and ES data?

ESAP is a standardized data collection system to track and document all the different nonclinical strategies and interventions to address SDH. It is not directly the solution for addressing HOW clinics should respond and provide better care to their complex patients. It is simply a tracking

system (just like PRAPARE) so one can track the effectiveness of WHAT interventions are being used and how well patient SDH (based on link to health outcomes) are being addressed so that we can make the value argument for CHCs.

20. Do others already collect this data such as health plans, ACOs, & Medicaid?

Those who are responsible for the cost of populations of patients such as Medicaid or an ACO quickly realize that many of the root causes driving utilization and cost are related to social determinants of health such as transportation, homelessness, etc. Historically there have been few standardized measures or tools available. The Institute of Medicine in 2015 recommended systematic addressing of SDH and proposed domains and measures to better understand which SDH have the greatest impact on the needs of an individual or a population. Many are beginning the routine assessment journey.

21. How are PRAPARE data collected by health centers?

The teams that piloted PRAPARE developed work flows based on their local care team and staffing models. In some case the questions were administered in advance of the visit while waiting to be roomed. In other cases they were administered during rooming and some had case managers administer to only their high risk patients. A concept of “no wrong door” was adopted by one pilot team suggesting any member could contribute to administration of the tool based on the workflow of the center asking questions at various stages of the clinic visit.

22. Why were some measures listed as optional or not included?

The current PRAPARE version is the first generation of the tool and focused on the minimal data set necessary (in order to reduce the burden of collection) while offering the greatest utility and potential for impact. It was quickly realized that as patients responded to core questions that a response might trigger the need to drill down and ask other questions in a particular domain. Over time as a national learning community evolves additional questions are likely to be added to a library of potential questions that health centers can choose to add to their work flow based on local need.

23. How often should the data be collected?

Once administered the organizations has the option to determine for each question the frequency for reassessing the question. For example, race and ethnicity might be answered once and then revalidated annually. In contrast, a health center might determine that a material security question might need to be asked at each visit due to the local economic conditions.

24. What if patients are reluctant to answer the questions or if they feel some questions are irrelevant?

The experience of the pilot teams was a very high completion rate of the question set once administered to a patient. Part of the training in administration of the protocol includes addressing unanswered questions which could be due to health literacy issues. But in the end, there are no penalties for not answering a question. An organization would want to learn more if a particular set of questions were routinely not being answered as it could point to deeper issues.

25. What if staff are reluctant to ask questions if they feel they do not have the ability to respond to the needs?

Some staff in the pilot teams did report it is stressful to ask questions where they felt there was no hope to address the issues if they were identified. As they began to use the tool and understand that in fact there were interventions that could be done and that many issues were actually within their control (e.g. referral to a foodbank for a food insecurity question) this was proving to be invigorating. In addition, they learned that the collection of data was pathway to address community issues and that generated a sense of empowerment and increased job satisfaction. In part this is an education and training issue and if done well could potentially contribute to decreased stress and increased job satisfaction.

26. Will PRAPARE change over time?

The tool was developed to be as broad as possible and avoid the need for constant revision. However, as the field evolves and more is learned there are likely to be updates and changes necessary for alignment with the external environment such as CMS, UDS and Meaningful Use.

27. PRAPARE sounds great but where do we go to find point of service interventions or approaches to community based interventions?

A toolkit is accompanying PRAPARE that provides insights on how to develop a systematic program and examples of strategic approaches at both a patient and community level. In addition, a national Learning Action Network is being formed to provide a forum for sharing with peers and subject matter experts in order to accumulate best practices over time.

28. What patients are typically targeted for PRAPARE?

PRAPARE is a tool with accompanying resources designed to help health centers understand their populations in order to better target care management resources and to develop population level strategies for addressing SDH. Some chose to focus only on high cost users due to limited staffing capacity or for a particular program need. Most chose to administer at a population level and that is the current focus of spread efforts for those pilot organizations.

29. Payers typically focus on wanting results in a very short period of time such as one year.

Especially the for profit ones that are focused on quarterly results. However, addressing social determinants of health can take multiple years to influence the environment and then see the results. How does one justify the use of the tool in that sort term results oriented environment?

There is no question that some interventions will take multiple years to fully address in the community and more than likely will require partnerships to address. That said, we are increasingly finding that there are interventions that can be done in the short term that can influence utilization or cost. For example, a cohort of patients from a particular zip code could be high cost utilizers and frequent users of an emergency room. One organization found these patients were often no shows in the clinic and by working with the City a bus route was established that provided access to that community. By gaining access to care in the health center it can avoid the more costly emergency room admissions while decreasing no show rates for the health center.

30. How long did this process take?

The process to develop the tool took two years including a year of piloting. The actual time to administer for the full question set is nine minutes or less.

31. What languages will the tool be translated into?

The next phase of the project will depend on available funding and is proposed to include translation of PRAPARE to other languages. The languages will likely be those most frequently seen by CHCs and based on the funders' priorities.

32. Is technical assistance available for non-funded CHCs that are interested in implementing PRAPARE?

It is envisioned that a national learning community will be launched that leverages peer support as well as the input of subject matter experts in the field. In addition, a state based dissemination strategy is being pursued where local coaching and technical assistance can be made available through state based primary care associations and health center controlled networks. There is currently no funding available for technical assistance however, the four health center controlled networks that participated are available for direct contracting for technical support.

33. Were any rural health clinics involved in the PRAPARE pilot? And if so, were there any considerations or implications for SDH and related interventions in rural areas that differed from urban CHCs?

Yes the pilot teams included both urban and rural centers. Needs differed depending on the local community context. From our pilot data, we noticed that transportation and social isolation tended to be a larger need in rural areas as opposed to urban areas. Our teams located in rural areas developed innovating interventions to meet these needs.

One team in Iowa started going to the local transportation authority's meetings and developed a relationships with them. The health center invited the transportation authority staff to visit their health center. From that, they have been able to negotiate bulk discounts for taxi vouchers and bus tokens. They also geo-mapped their data to highlight areas experiencing the highest transportation need. They plan to show this data to the regional transportation authority to advocate for new bus routes to those areas.

One team in Hawaii discovered that many of their diabetic patients felt socially isolated. After learning this, they teamed up with local churches and the American Diabetes Association to offer peer support groups for diabetes management in the local churches to provide health care and health education in a supportive environment.

34. How have social service agencies been involved in the creation of the PRAPARE tool?

The question set was derived from the current literature and evidence base and social service agencies were involved in providing input to that process. No social service agencies were directly involved in the PRAPARE.

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

It is too early to draw any conclusion from the pilots due to the small sample size tested. This is an area for further research in Phase 2 of the project.

36. Can you share your criteria for selecting your final 15 domains? And how you decided on the actual wording of the questions?

We included six weighted criteria to objectively narrow down our list of SDH domains to a “core” set for standardized data collection and an “optional” set for local community circumstances and populations. The criteria included: actionability for individual patient management, alignment with national initiatives, evidence in the literature that links the SDH domain to higher healthcare costs, stakeholder feedback, additional burden of data collection, and sensitivity for disclosing this information.

- 37. Is the use of PRAPARE limited to health centers only, or is there a plan to expand at some point, such as in social services CBOs? Reimbursement for health centers is part of the equation. But have you experimented with incentivizing community based organizations (e.g.: social service nonprofits) to gather this information in light of the fact they do that work anyway and could share info with FQHCs?**

The use of PRAPARE is not limited to CHCs and could be used by community based organizations and other social services organizations. The focus of this project was to develop an instrument for assessing health center populations. Health centers certainly would be encouraged to find ways to partner with other organizations to share data and potential administration of the tool.

- 38. How could social service organizations that serve many of the clients served by the health centers take advantage of the alternative payment method? Social service organizations address many of the social determinants of health.**

Systematic collection of data on the needs of the population could be used by social services organizations to advocate to their funding sources. Social services organizations are encouraged to join the national learning community as it evolves and benefit from the opportunities to share insights and best practices.

- 39. Is there any education required to administer PRAPARE? Is there any education required to be able to use the tool or can any staff or "lay" person (volunteer) ask the questions and capture the data?**

The tool was designed to be administered at any level and the process was not prescriptive on how to administer the tool and left that to the judgment of the pilot teams. A staff training guide was developed on the importance of the tool and with examples on how it can be collected. Sensitivity training was part of curriculum. All levels of staff were utilized by the health centers in the pilot test suggesting that educational level was not a factor in administration and the issue was more an issue of staff training and local staffing resources and workflows.

- 40. Can it be integrated into case management?**

Yes, PRAPARE could be integrated and was used in the pilot team by case managers. In paper version it certainly could be used by the case management team. In terms of the electronic health records this would be a function of the vendor solution and the guidance provided on configuration.