

**[Organization Name]:**

**Social Determinants of Health Efforts**

# about us

***Add relevant information about your organization.***

# screening for social needs

*[Organization Name]* uses PRAPARE, a national screening tool and approach to collect standardized social needs data to better understand the patients’ social needs and transform their care. PRAPARE consists of a set of national core measures as well as a set of optional measures for community priorities. It was informed by research, the experience of existing social risk assessments, and stakeholder engagement. For more information about PRAPARE, visit [www.nachc.org/prapare](http://www.nachc.org/prapare).

***[Briefly share your organization’s current use of PRAPARE and # patients screen]***

# understanding our patients’ social needs

Based on our screening efforts using the PRAPARE tool, we have found that the most common social risks for our patients are:

1. *[SDH Risk \_\_\_% of patients served]*
2. *[SDH Risk \_\_\_% of patients served]*
3. *[SDH Risk \_\_\_% of patients served]*

# understanding our patients’ social needs

The healthcare environment is rapidly changing in recognition of the important factors, such as a person's home, job, and/or education play in improving health outcomes. At *[insert clinic name],* we know these social factors are critical for many of our patients and strive to better understand the role of social context for each patient's treatment plan, but also to advocate for needed changes at the policy, payment and systems level to achieve better population health.

|  |  |
| --- | --- |
| ***OPTION 1: Include patient complexity data***  *Consider adding population segmentation data such as:*  *Frequency distribution of # patients by # of SDH needs*  *Frequency distribution of # patients with and without diabetes(or the top risk condition at their CHC, depression?) by mean or median # of patient SDH.* | ***OPTION 2: Add narrative of what unique findings your health center discovered about your patients’ social needs.***  *Consider sharing patient stories of how addressing their social needs made in impact on their care and/or wellness*   * *Were patients were more likely to access social needs serviced if imbedded into a clinic site?* * *Was trust increased between health professionals and patient?* * *Were there willing and successful community partnerships?* |

# health center response to patients’ social needs

***Briefly share how your organization is responding to the data***

# why we believe in this work

***Consider a patient story, quotes, or rationale for why you have developed this program. This section is qualitative and is a good place to tell the story of your health center value!***

Understanding patient’s social needs is at the foundation of the health center movement. Ever since the War on Poverty in the 1960’s, Community Health Centers have strived to provide whole person care. They create space to discuss and address needs well beyond the medical visit. Yet, this work takes staff time, resources, and space to ensure it is done thoughtfully. That’s why *[insert org name]* is proud to share this work with *[insert partner]* and consider opportunities for alignment.