



Equity and Practice Transformation (EPT) Payment Program Implement Behavioral Health Screening and Linkage

Implement Behavioral Health Screening & Linkage Template

Milestone Description

Implement depression screening and follow-up using the PHQ-2/PHQ-9 and substance use disorder (SUD) screening and linkage. This should include development of workflows for what staff member screens and how often, how data is stored in the health record, protocol for triage of patients based on screening results, and, when indicated, linkage to appropriate level of behavioral health services with closed-loop referrals. Demonstrate how processes are working through a report of the following:

Depression Screening Components

- Percent of population of focus screened with PHQ-2/PHQ-9 at least once annually (6-12-month look-back)*
- Percent of patients with positive screening for depression (as indicated by 10 or higher OR clinical assessment) who are linked to services as evidenced by one of the following (within 30 days of positive screen)*
 - Outpatient, telephone or e-visit for follow-up for depression/behavioral health documented in the chart
 - Depression case management encounter
 - Behavioral health encounter (assessment, therapy, collaborative care, medication management)
 - Documentation of encounter for exercise counseling, sleep hygiene, behavioral activation or other self-management
 - Dispensed antidepressant medication, as evidenced by prescription being filled
 - Documentation of a negative full-length depression screening on the same day as a positive screen on a brief screening tool (i.e., a negative PHQ-9 as a follow-up to a positive PHQ-2)
 - Repeat screen within 30 days



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- Crisis follow-up (if indicated) as evidenced by additional risk assessment and, if clinically indicated, intervention documented in the note (e.g., safety planning, planning for follow-up with provider or other clinical staff, warm handoff, hotline connection or crisis connection, etc.)
- Percent of patients linked to services with a closed-loop referral
 - Closed-Loop Referrals are a key component of DHCS's Population Health Management Program under CalAIM. DHCS defines a Closed-Loop Referral as a referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a Known Closure. A Known Closure occurs when a Member's initial referral loop is completed with a Known Closure reason. Closure reasons include:
 - Services Received;
 - Service Provider Declined;
 - Unable to Reach Member;
 - Member No Longer Eligible for Services;
 - Member No Longer Needs Services or Declines Services;
 - Authorization Denied.
 - EPT practices are encouraged to work directly with MCPs and review DHCS resources on [closed loop referral implementation guidance](#).

SUD Screening & Follow-Up

- Percent of population of focus screened for SUD with validated screener at least once annually (6-12-month look-back)*
 - Percent of positive SUD screens linked to services as evidenced by one of the following (within 30 days of positive screen)*
 - Brief intervention (e.g., SBIRT-aligned motivational interviewing) is documented in the chart. See more information about [SBIRT \(Screening, Brief Intervention, and Treatment\) in the appendix](#)
 - Behavioral health or SUD intake or follow-up, including peer support (internal or external program, including crisis services, inpatient detox, residential or outpatient treatment)
 - Initiation of medication-assisted treatment (e.g., buprenorphine, methadone, naltrexone)



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- Participation in a peer-led recovery group or community-based program such as AA/NA
 - Engagement with harm reduction services (e.g., naloxone distribution, syringe services, other MAT)
 - Referral to and documented contact with a care coordinator or recovery specialist or other navigator
 - Development of a documented personalized plan of care that aligns with the patient's stage of change (e.g., pre-contemplation, contemplation, preparation, action)
 - Development of a documented self-management, education and follow-up plan when formal services are declined or unavailable.
- € Percent of patients linked to services with a closed-looped referral
- Closed-Loop Referrals are a key component of DHCS's Population Health Management Program under CalAIM. DHCS defines a Closed-Loop Referral as a referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a Known Closure. A Known Closure occurs when a Member's initial referral loop is completed with a Known Closure reason. Closure reasons include:
 - Services Received;
 - Service Provider Declined;
 - Unable to Reach Member;
 - Member No Longer Eligible for Services;
 - Member No Longer Needs Services or Declines Services;
 - Authorization Denied.
 - EPT practices are encouraged to work directly with MCPs and review DHCS resources on [closed loop referral implementation guidance](#).

* Note: The Learning Center recommends 80% as an aspirational screening target for patients screened for depression and SUD, and to link patients with positive screens to services. As this is an aspiration target, EPT directed payment *is not* contingent on meeting this target. EPT practices should refer to the review rubric for the behavioral health deliverable, when released, to determine what is needed to qualify for payment.



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Instructions

This document serves as a structured guide for implementing and tracking behavioral health screenings, triage, and service linkages using PHQ-2/PHQ-9 and validated SUD screening tools. This template is provided for reference only and outlines the required components of your submission. Final responses must be submitted via the EPT Deliverable Portal. If you have questions, email info@pophealthlc.org. **As a reminder, this deliverable is due by the November 2026 submission cycle.**

Documentation in the Template

- Practices must implement standardized depression screening and follow-up using PHQ-2/PHQ-9, and implement substance use disorder (SUD) screening and linkage. This includes:
 - Establish baseline screening values
 - Clear workflows for staff roles and screening frequency
 - Data documentation and storage processes
 - Triage and referral protocols
 - Tracking of closed-loop referrals
 - Submission of progress data for key metrics

Part 1: Baseline Data

Practices will evaluate their baseline data of current behavioral health screening & linkage activities to assist in developing their workflows and implementation plans. EPT practices should use calendar year 2024 to establish the baseline values. EPT Practices with Pregnant People and/or Children & Youth populations will report on their specific Population of Focus (PoF); Adult PoFs may choose to report on all patients or their specific PoF. For each metric:

- Enter the **Numerator** and **Denominator**
- Enter the baseline reporting period timeframe



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- If you are unable to report a metric, leave the numerator and denominator blank and check the appropriate box under “Unable to Report.”
- The **Rate** will auto-calculate based on the numerator and denominator you enter. If you are unable to report a metric, leave the numerator and denominator blank and indicate the reason in the corresponding row of the table.

	Depression Screening Metrics			SUD Screening Metrics		
Measure	Percent of PoF screened with PHQ-2/PHQ-9	Percent of positive screens linked to services (Positive screen defined per tool scoring thresholds or clinical diagnosis.)	Percent of linked patients with closed-loop referral	Percent of PoF screened for SUD	Percent of positive SUD screens linked to services	Percent of linked patients with closed-loop referral
Numerator	# screened with PHQ-2/PHQ-9 (include declines to screen)	# of positive screens linked to services	# of referrals with confirmed completion	# screened with validated SUD tool (include declines to screen)	# of positive screens linked to services	# of referrals with confirmed completion



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Denominator	# of PoF patients with ≥1 visit during the measurement period	# of positive PHQ-2/PHQ-9 screens	# of referrals for depression follow-up	# of PoF patients with ≥1 visit during the measurement period	# of positive SUD screens	# of referrals for SUD follow-up
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A. Depression Screening & Linkage Baseline Data

	Percent of PoF screened with PHQ-2/PHQ-9	Percent of positive screens linked to services	Percent of linked patients with closed-loop referral
Numerator			
Denominator			
Baseline Reporting Period (Can be 6-months or 12-months, use the same reporting			



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period across all BH metrics.)			
Rate (Auto-Calculated)			
Unable to Report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason (If Unable to Report)	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____

B. Substance Use Disorder Screening Baseline

	Percent of PoF screened for SUD	Percent of positive SUD screens linked to services	Percent of linked patients with closed-loop referral
Numerator			
Denominator			



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Baseline Reporting Time Period (Can be 6-months or 12-months, use the same reporting period across all BH metrics.)			
Rate (Auto-Calculated)			
Unable to Report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason (If Unable to Report)	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____



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Part 2: Workflow Documentation

Complete the tables below to describe your workflows for depression and SUD screening, triage, and referral.

A. Depression Screening (PHQ-2/PHQ-9)

Workflow Component	Response
Who Screens	<input type="checkbox"/> MA <input type="checkbox"/> PCP <input type="checkbox"/> BH Staff <input type="checkbox"/> Other: _____
Screening Frequency	<input type="checkbox"/> Every visit <input type="checkbox"/> Annually <input type="checkbox"/> At well visits <input type="checkbox"/> Other: _____
Administration Method	<input type="checkbox"/> EHR form <input type="checkbox"/> Patient portal <input type="checkbox"/> Paper-based <input type="checkbox"/> Verbal <input type="checkbox"/> Tablet <input type="checkbox"/> Other: _____
Triage/Intervention Protocols**	<i>Upload or briefly describe protocol. Indicate tiers or levels of response based on screening result. Must include interventions offered, as well as risk assessment and response, as well as referral steps.</i>
Data Storage	<input type="checkbox"/> Structured EHR fields <input type="checkbox"/> Manual tracking <input type="checkbox"/> Population Health Platform <input type="checkbox"/> Other: _____



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Referral Process	<i>Describe available MH/depression resources in your service area, how these referrals are initiated, tracked, and how you determine if service was received.</i>
Training Plan for Staff	<i>Who is trained? Describe how staff are trained (live, online, job aid), who leads training, and how often (e.g., onboarding, annual).</i>

**Protocols Must Include:

- Escalation steps for moderate to high risk (e.g., notify provider, on-site behavioral health consult, emergency services)
- Referral pathways (e.g., internal BH, mobile crisis unit, psychiatric emergency)
- A clear workflow if a patient endorses suicidal ideation (PHQ-9 item 9 score > 0) and subsequent real-time risk assessment (e.g., Columbia-Suicide Severity Rating Scale (C-SSRS) or clinical interview or 988 handoff)
- Documentation standards and follow-up procedures

B. SUD Screening

Workflow Component	Response
Who Screens	<input type="checkbox"/> MA <input type="checkbox"/> PCP <input type="checkbox"/> BH Staff <input type="checkbox"/> Other: _____



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Screening Tool Used (Adult)**	<input type="checkbox"/> AUDIT-C/DAST-10 <input type="checkbox"/> ASSIST <input type="checkbox"/> TAPS <input type="checkbox"/> 4Ps** <input type="checkbox"/> NIDA Quick Screen <input type="checkbox"/> Other: _____
Screening Tool Used (Child/Adolescent)**	<input type="checkbox"/> CRAAFT <input type="checkbox"/> Other: _____
Screening Frequency	<input type="checkbox"/> Every visit <input type="checkbox"/> Annually <input type="checkbox"/> At intake <input type="checkbox"/> Other: _____
Administration Method	<input type="checkbox"/> EHR form <input type="checkbox"/> Patient portal <input type="checkbox"/> Paper-based <input type="checkbox"/> Verbal <input type="checkbox"/> Tablet <input type="checkbox"/> Other: _____
Triage/Intervention Protocols**	<i>Upload or briefly describe protocol. Reflect clinical responses to all non-zero scores. Indicate tiers or levels of response based on screening result. Must include interventions offered on-site, as well as risk assessment and response.</i>
Data Storage	<input type="checkbox"/> Structured EHR fields <input type="checkbox"/> Manual tracking <input type="checkbox"/> Population Health Platform <input type="checkbox"/> Other: _____
Referral Process	<i>Describe available referrals for SUD in your service area, how referrals are initiated, tracked, and how you determine if service was received.</i>



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Training Plan for Staff	<i>Who is trained? Describe how staff are trained (live, online, job aid), who leads training, and how often (e.g., onboarding, annual).</i>
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**For SUD screening, practices must use the positive score thresholds as indicated by the validated tool they select (e.g., AUDIT-C, DAST-10, ASSIST-LITE, TAPS). For practices using the 4Ps pre-screen measure, one of the above validated measures must be completed following any positive risk identification on the 4P's. Practices should choose the tool that best suits their patient population's needs and capacity. If unsure which measure to implement, PHLC recommends the TAPS and CRAAFT measures as a starting point. Workflows should reflect appropriate clinical responses for any non-zero score, even if it does not meet the threshold for referral.

3. Evidence of Implementation

To meet this milestone, your practice must implement at least two **new actions** (since the start of EPT) focused on depression screening and follow-up using the PHQ-2/PHQ-9 and substance use disorder (SUD) screening and linkage for your selected PoF. Practices should report at least one action for depression and one action for SUD screening and linkage to care. For each action, include the date it was launched (i.e., when it began being used with patients), the number of patients impacted, how success was measured, and any observed outcomes. Small-scale pilots or PDSA cycles are acceptable as evidence.

Notes:

- Results may be qualitative (e.g., staff feedback on ease of workflow, patient engagement) or quantitative (e.g., screening and referral rates, reduced missed appointments). Qualitative reporting should provide clear, narrative descriptions of observed



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outcomes—such as “Medical assistants reported that the new screening workflow is easy to follow and integrates smoothly into patient intake,” or “Providers noted increased patient openness to discussing behavioral health concerns”—that illustrate the real-world impact of implementation with specific, concrete examples.

	Action 1	Action 2
Implemented Action		
Date of Implementation		
Results Observed		

Part 4: Data Submission – Performance Metrics

Please complete the table below using a **6 or 12-month look-back** reporting period for the six Behavioral Health social needs metrics. EPT Practices with Pregnant People and/or Children & Youth populations will report on their specific Population of Focus (PoF); Adult PoFs may choose to report on all patients or their specific PoF. For each metric:

- Enter the **numerator** and **denominator** values.
- Indicate how frequently your team reviews this data.
- If you are unable to report a metric, leave the numerator and denominator blank and check the appropriate box under “Unable to Report.”



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- The **Rate** will auto-calculate based on the numerator and denominator you enter. If you are unable to report a metric, leave the numerator and denominator blank and indicate the reason in the corresponding row of the table.

	Depression Screening Metrics			SUD Screening Metrics		
Measure	Percent of PoF screened with PHQ-2/PHQ-9	Percent of positive screens linked to services	Percent of linked patients with closed-loop referral	Percent of PoF screened for SUD	Percent of positive SUD screens linked to services	Percent of linked patients with closed-loop referral
Numerator	# screened with PHQ-2/PHQ-9 (include declines to screen)	# of positive screens linked to services	# of referrals with confirmed completion	# screened with validated SUD tool (include declines to screen)	# of positive screens linked to services	# of referrals with confirmed completion
Denominator	# of PoF patients with ≥1 visit during the	# of positive PHQ-2/PHQ-9 screens	# of referrals for depression follow-up	# of PoF patients with ≥1 visit during the	# of positive SUD screens	# of referrals for SUD follow-up



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	measurement period			measurement period		
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A. Depression Screening Report

	Percent of PoF screened with PHQ-2/PHQ-9	Percent of positive screens linked to services	Percent of linked patients with closed-loop referral
Numerator			
Denominator			
Reporting Period (Can be 6-months or 12-months, use the same reporting period across all BH metrics.)			
Rate (Auto-Calculated)			



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Frequency of review	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Biannually <input type="checkbox"/> Annually <input type="checkbox"/> Other:	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Biannually <input type="checkbox"/> Annually <input type="checkbox"/> Other:	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Biannually <input type="checkbox"/> Annually <input type="checkbox"/> Other:
Unable to Report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason (If Unable to Report)	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____

B. Substance Use Disorder Screening Report

	Percent of PoF screened for SUD	Percent of positive SUD screens linked to services	Percent of linked patients with closed-loop referral
Numerator			
Denominator			



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Reporting Period (Can be 6-months or 12-months, use the same reporting period across all BH metrics.)			
Rate (Auto-Calculated)			
Frequency of review	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Biannually <input type="checkbox"/> Annually <input type="checkbox"/> Other:	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Biannually <input type="checkbox"/> Annually <input type="checkbox"/> Other:	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Biannually <input type="checkbox"/> Annually <input type="checkbox"/> Other:
Unable to Report			
Reason (If Unable to Report)	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____



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Appendix: Screening Tool Scoring Guides

PHQ-9 (Patient Health Questionnaire-9)

The PHQ-9 consists of 9 items, each scored from 0 (Not at all) to 3 (Nearly every day). Total score range: 0–27.

Scoring Interpretation:

- 0-4: Minimal or no depression
- 5-9: Mild symptoms — consider monitoring or brief intervention
- 10-14: Moderate — positive screen; recommend further evaluation and referral
- 15-19: Moderately severe — active treatment likely needed
- 20-27: Severe — active treatment and possible specialty referral recommended

Of course, any non-zero screening requires a clinical conversation and clinical discretion.

AUDIT-C (Alcohol Use Disorders Identification Test - Consumption)

The AUDIT-C includes 3 questions on alcohol consumption, each scored from 0-4. Total score range: 0-12.

Scoring Interpretation:

- Men: A score of 4 or more is considered a positive screen
- Women: A score of 3 or more is considered a positive screen
- Any score above 0 may warrant brief counseling depending on context



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CRAFFT (Adolescent Substance Use Screening Tool)

The CRAFFT is a brief screening tool for adolescents (generally ages 12–21) used to identify risky alcohol and drug use. It has two parts: Part A (use questions) and Part B (six risk items: C-R-A-F-F-T).

Scoring Method

1. Part A (Use History)

- a. Ask whether the adolescent has used alcohol (more than a few sips), marijuana, or other substances in the past 12 months.
- b. If the adolescent endorses *any* substance use, administer all six Part B questions.
- c. If *no* substance use is endorsed, administer only the "Car" question from Part B.

2. Part B (Risk Behaviors)

- a. Each "yes" response counts as 1 point.
- b. Total score range: 0–6.

Interpretation

- **0 points:** Low risk. Reinforce healthy behaviors and provide preventive counseling.
- **1–2 points:** Moderate risk. Conduct further assessment and provide a brief intervention using motivational interviewing.
- **3 or more points:** High risk. Indicates likely substance use disorder; consider diagnostic evaluation, referral to treatment, and involve caregivers when appropriate.

Additional Notes

- The "Car" question is always asked, even if no substance use is reported.



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DAST-10 (Drug Abuse Screening Test)

The DAST-10 includes 10 yes/no questions about drug use (not including alcohol or tobacco). Each 'yes' response scores 1 point. Total score range: 0-10.

Scoring Interpretation:

- 0: No problems reported
- 1–2: Low level — monitor and reassess
- 3–5: Moderate level — consider brief intervention
- 6–8: Substantial level — referral to treatment recommended
- 9–10: Severe level — intensive assessment and treatment indicated

SBIRT (Screening, Brief Intervention, and Referral to Treatment)

SBIRT is not a specific screener but a comprehensive, public health approach to identifying and intervening with individuals at risk for substance use disorders. It incorporates validated screening tools (e.g., AUDIT, DAST) and uses the risk level to determine appropriate follow-up.

General Interpretation:

- Low Risk: Provide positive reinforcement
- Moderate Risk: Conduct a brief intervention
- High Risk: Refer to specialty treatment and provide follow-up



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Additional trainings and reference materials for SBIRT are provided below:

[Screening, Brief Intervention and Referral to Treatment \(SBIRT\) in Behavioral Healthcare](#)

[Implementing SBIRT \(Screening, Brief Intervention and Referral to Treatment\) in primary care: lessons learned from a multi-practice evaluation portfolio](#)

[SBIRT: Screening, Brief Intervention, and Referral to Treatment](#)

TAPS (Tobacco, Alcohol, Prescription Medication, and Other Substance Use)

The TAPS tool includes a 2-part screen:

- TAPS-1: A brief screening (yes/no) on past 12-month use
- TAPS-2: A follow-up that evaluates frequency of use for substances reported in TAPS-1

Scoring Interpretation (TAPS-2):

- Score of 1: Occasional use — brief intervention may be sufficient
- Score of 2+: Indicates more frequent use — further assessment or referral recommended
- A score of 2 or more for any substance is generally considered a positive screen

ASSIST-LITE (Alcohol, Smoking and Substance Involvement Screening Test – Lite Version)

The ASSIST-LITE is a shorter version of the original WHO ASSIST tool, developed to quickly identify substance use risk across various categories (alcohol, cannabis, cocaine, etc.). It is suitable for primary care and time-limited settings.



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Scoring Interpretation (by substance):

- 0-3: Low risk — no intervention needed
- 4-26: Moderate risk — brief intervention recommended
- 27+: High risk — referral for specialty treatment

(Note: Exact cut points may vary by setting; use clinical judgment.)

4Ps Plus:

The **4Ps Plus**[®] is a brief, validated screening tool designed to identify **substance use risk during pregnancy** in a safe, nonjudgmental way. It helps providers open a supportive conversation early in prenatal care. (Distinct from actual substance-use risk level)

A “yes” to any question signals the need for further discussion, not judgment. The goal is to identify risk early, provide brief intervention or education, and connect patients with support when needed. A “Yes” response triggers action to complete one of the validated measures listed above.

C-SSRS (Columbia–Suicide Severity Rating Scale)

The C-SSRS is a brief, evidence-based tool used to identify the presence and severity of suicidal ideation and behavior. It is suitable for primary care, behavioral health, and any setting where suicide risk needs to be assessed quickly and clearly.

Scoring Interpretation:

- **Ideation Levels (1–5):**



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- **1–2:** Lower-level suicidal ideation (wish to be dead or non-specific thoughts) — monitor, assess contributing factors, provide psychoeducation.
- **3–5:** Clinically significant active suicidal ideation (method, intent, or plan) — requires a more detailed safety assessment and intervention.
- **Behavior Items:**
 - Any endorsed suicidal behavior (e.g., preparatory actions, aborted or actual attempts) indicates **elevated risk** and warrants immediate, more intensive clinical follow-up.

*(Note: The C-SSRS is not scored by adding points; the **highest level of ideation or behavior endorsed** determines clinical concern. Use clinical judgment and consider risk/protective factors.)*

Link to Training: [FREE Training for Individuals and Systems - The Columbia Lighthouse Project](#)