Equity and Practice Transformation (EPT) Payment Program
Health-related Social Needs (HSRN) Screening & Linkage

Instructions

Using the EPT deliverable portal, please complete the prompts for all questions in the associated deliverable template. Please respond using complete sentences and with enough detail that the deliverable reviewer can understand how your practice approaches this work. Reviewers will provide a single overall determination (Accepted, Not Accepted - Resubmit This Cycle, or Not Accepted - Resubmit Next Cycle) through the web portal. Practices whose deliverables are not accepted will receive general feedback in a single comment box indicating which sections need improvement.

EPT milestone: Identify one health related social need (HRSN) for the population of focus and implement screening process and linkage to care with closed-loop referrals. This should include development of workflows for who screens and how often, how data is stored in the health record (includes EHR capture of social health Z codes), protocol for triage of patients based on screening results, and linkage to services with closed-loop referrals.

Question 1: Baseline Data & Performance Data

What You Need to Do

Report **baseline AND performance metrics for HRSNs** for a **6 or 12 month period.** Must include numerators + denominators for each measure, reporting period, and review frequency. Note: Population of Focus (PoF) refers to your practice's designated patient population for this EPT program (Pregnant People, Children & Youth, or Adults).

Practices will identify a **6 or 12 month Baseline** period (CY 2024 is recommended; Practices may report on CY 2025, but the baseline period should not overlap with implementation reporting period).

Practices will submit **performance metrics for a 6 or 12 month look-back period** for the 3 HRSN quality measures.

Example 1: The practice reported a baseline period of FY24/25; their implementation look-back period will be FY25/26.

Example 2: The practice baseline period is January-June 2025; their implementation look-back period will be January-June 2026.

Baseline Metrics Reporting Grading Criteria

ACCEPTED: Baseline values for partial or all three measures with defined reporting period that does not overlap with the implementation period **OR** a clear, specific reason why the practice cannot report on the baseline measures.

NOT ACCEPTED: There is a non-specific or unclear justification for unable to report for a portion or all three measures.

Performance Metrics Reporting Grading Criteria

ACCEPTED: Numerator + denominator for all three measures **AND** reporting period that does not overlap baseline **AND** includes review frequency,

OR Partial report of the three measures (numerator + denominator reported for 2/3 measures) with reporting period that does not overlap with baseline **AND** valid and reasonable justification for any measure(s) unable to report.

● **NOT ACCEPTED:** Fewer than two reported measures with a valid numerator + denominator **OR** Missing reporting period **OR** missing or invalid, non-specific justification for unable to report.

Component	Criterion
Reporting Period	☐ Indicates a 6- or 12-month period that does not overlap with the baseline period.
Percent of PoF Screened for selected social needs	☐ Numerator: # of patients who were screened for selected social needs during the reporting period ☐ Denominator: Total number of patients with at least one visit during the reporting period.
Percent of Positive social needs screens who were referred to services within 30 days.	☐ Numerator: # of patients with a positive social needs screen who were referred to services within 30 days. ☐ Denominator: Total number of patients with a positive social needs screen during the reporting period.
Percent of linked patients with closed loop referral and received a service within 30 days	☐ Numerator: # of patients who were referred to services using a closed loop referral and received at least one service within 30 days. ☐ Denominator: Total number of patients who were referred to services within 30 days using a closed-loop referral mechanism.

	• Interpretation: For the purposes of EPT, practices are asked to report the referrals made through a closed loop linkage mechanism that has the capability to report the outcome. Closed Loop referral examples: o A formal MOU with a Community-Based Partner (CBO) o Enhanced Care Management and Community Supports (Closed loop linkage is required to be reported by the receiving provider) o Using Community Health Workers (CHWs) to provide system navigation and provides follow up on the referral outcomes o Using a closed loop referral system like FindHelp, UniteUs, 211, OneDegree or others • If a patient has one or more services successfully linked within 30 days, the numerator = 1.
Screening Rate	Auto-Populated
Frequency of Review	☐ Response must include frequency of review (e.g. Monthly, Quarterly, Bi-annually, Annually, etc)
Unable to Report (If applicable to any measure above)	☐ Reason and description of gaps/barriers in reporting the measure ☐ Justification appears to be a reasonable limitation preventing metric reporting.

Question 2: HRSN Workflow for Screening & Closed Loop Referrals

What You Need to Do

Describe your **complete social need screening and response workflow**, including roles, frequency, methods, triage, documentation, referral process, and training plan.

ACCEPTED:

The response will be accepted if the workflow clearly defines all critical items: selected social need, assigned roles, demonstrates a practice-specific screening process, triage protocol with corresponding tiered interventions, referral workflow and follow-up, staff training plan, and documentation standards.

NOT ACCEPTED:
The submission will not be accepted if more than 4 prompts do not meet the criteria within each prompt **AND/OR** if any key critical items are missing or not clearly described, including but not limited to: the selected social need, assigned staff roles, triage protocol, referral workflow, or training plan.

Required Components	Criterion
Selected Social Need(s)	☐ At least one social need is selected to incorporate into their workflow.
How Social Need(s) are Selected	☐ Includes a description of how the practice selected the social need(s). ☐ Includes at minimum one data informed method (e.g., needs assessment, population data, interviews with patients, etc.)
Screening Population	☐ At least one population that will be tracked in this workflow (e.g., All patients, PoF, Patients due for visit, etc.)
Selected Screening Tool	☐ Identifies a screening tool that will be used to evaluate social needs. Practices may choose an existing tool (e.g., PRAPARE) or a custom developed tool.

Administration Method?	☐ Includes how the screenings will be administered (e.g., EHR form, Patient Portal, Paper-based, Verbal, Tablet, etc.)
What staff role(s) are responsible for conducting initial screening and follow up	☐ Clearly defines the specific role(s) responsible for screening, reviewing results, and responding to the screen. ☐ Indicates if the responsible role varies by the screening workflow stage.
How often is screening conducted?	☐ A specific timeframe is defined for screening (e.g., every visit, annually, well visits, etc.).
Triage Protocol • Positive screen → • Intervention → • Referral → • Closed-loop tracking	☐ Practice uploaded or provided a brief description of protocol ☐ Protocol clearly defines screening workflow, specific interventions, steps, and referral protocol. ☐ There is a clear workflow of tiered or levels of response per social need (e.g. disclosure of intimate partner violence should prompt a different response than disclosure of other social needs such as transportation). ☐ Cultural considerations are outlined in the protocol
Training plan for staff	☐ Defines a training protocol that indicates who is trained, how often staff are trained (e.g. onboarding, annual), describes the training approach/materials, and how training is tracked and monitored for fidelity. ☐ Includes training and monitoring of community partnerships and communication workflows for closed loop referral protocols.
Screening Documentation & Storage	☐ Indicates where the data will be stored (e.g. structured EHR fields, manual tracking, a population health platform, etc.)

	☐ Documentation standards are clearly outlined.
Intervention(s)	☐ Clearly indicates which intervention(s) practices will be deployed to respond to social needs. ☐ Interventions should include 'Referral' plus one additional Intervention to address the PoF positive screens
Referral process	☐ Defines how referrals are initiated, tracked, and monitored for a closed loop outcome. Includes a progressive outreach plan for potential member disengagement. ☐ Indicates plans for CBO & care coordination partnerships such as CalAIM programs (e.g., Enhanced Care Management, Community Supports, Community Health Workers, etc), to address positive screens, and/or use closed loop referral systems (e.g., FindHelp).

Question 3: Evidence of Implementation:

What You Need to Do

List at least **two new actions implemented since the start of EPT and by the November 2026 submission deadline** to strengthen social needs screening for your selected PoF (chronic condition/preventive care PoFs may report on all patients)**.** Include dates, number of patients reached, and results observed. Small-scale pilots and PDSA cycles are acceptable.

ACCEPTED: Two actions, each with (a) description, (b) date, (c) observed result (must be specific).

NOT ACCEPTED: Fewer than two actions are listed **OR,** missing dates, **OR** vague, non-specific qualitative results **OR** Actions do not correspond to the selected social need listed in part 2.

Component	Criterion
Implemented Actions	☐ A minimum of two actions are listed and each action is clearly described and aligns with the social needs listed in Part 2. (e.g. Practice will incorporate FindHelp into the referral workflow to link unhoused patients to ECM & Community Supports Housing Navigation).
Date of Implementation Start	☐ A specific date is provided for at least two actions. This date should not overlap with the baseline period.
Results Observed	☐ Each action has at least one observed result. (qualitative or quantitative). ☐ Qualitative results are clear, narrative descriptions of the observed outcomes (e.g., "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 social health concerns"—that illustrate the real-world impact of implementation with specific, concrete examples).

Overall Milestone Determination

Overall Milestone Determination:
☐ ACCEPTED - Deliverable meets all requirements

☐ NOT ACCEPTED - RESUBMIT THIS CYCLE - Revisions can be completed within current cycle timeline
☐ NOT ACCEPTED - RESUBMIT NEXT CYCLE - Substantial revisions needed requiring additional time
If not accepted, general feedback will be provided in the portal comment box indicating which section(s) need revision.

Appendix

Recommended Screening Tools:

- PRAPARE
- Accountable Health Communities
- Practices may also use a custom or practice-developed tool or another validated HRSN instrument appropriate to their population

NOTE: Adverse Childhood Experiences (ACEs) screening tool is not an accepted HRSN screening tool

Definitions:

- **Positive Screen**
  - A positive screen is determined by the completion of a validated screening tool **AND** clinical assessment & judgement from the provider. Depending on the tool, this may be a 'Yes' or 'No' or likert scale. Practices should reference the tool scoring guides for interpretation if facilitating the full tool. Practices starting with one social need may choose one or two domains of a validated tool as associated with the chosen social need(s).

- **Positive Screens linked to services**
    - This metric refers to the number of patients with a *positive* screen that receives an intervention and/or a referral to an internal or external resource. This includes referrals provided directly to the patient for self-determined follow-up, and/or referrals made on behalf of the patient via a closed loop mechanism.
- **Closed Loop Linkage**
    - 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.
        - Other
    - EPT practices are encouraged to work directly with MCPs and review DHCS resources on closed loop referral implementation guidance.
    - For the purposes of EPT, practices are asked to report the referrals made through a closed loop linkage mechanism that has the capability to report the outcome. Closed Loop referral examples:
        - A formal MOU with a Community-Based Partner (CBO)

        - Enhanced Care Management and Community Supports (Closed loop linkage is required to be reported by the receiving provider)
        - Using Community Health Workers (CHWs) to provide system navigation and provides follow up on the referral outcomes
        - Using a closed loop referral system like FindHelp, UniteUs, 211, OneDegree or others
    - **Example:**
        - A type 2 diabetes patient screens positive for food instability. The Medical Assistant makes 3 referrals for the patient:
            - An external referral to Medically-tailored meals (community supports). The closed loop outcome is reported back by the Community Supports provider as required by DHCS.
            - A referral to the in-house SNAP benefit application support. The closed loop outcome is generated by the in-house case manager follow up with the patient
            - Provides a paper resource sheet with 2 nearby food bank resources. There is no formal partnership or communication method with these resources, thus the closed loop will not be reported.
        - For the purpose of the EPT Closed Loop linkage metric, the practice will report on the outcomes of the first two referrals as they have a closed loop system in place. Because at least one referral was achieved within 30 days, the numerator will be 1; and the denominator is 1. Reminder: the unit of measure is the # of patients, not the # of referrals.

Social Need Interventions:

- **Adjustment:** Modifying care plans or treatment approaches to accommodate a patient's social needs—such as scheduling around transportation or work limitations.
- **Assistance:** Providing direct support or help with applications for services like SNAP or WIC, focusing on urgent needs.

- **Coordination:** Sharing information and organizing care across providers or organizations to ensure a unified response to a patient's social needs.
- **Counseling:** Collaboratively supporting patients in reflecting on their needs, identifying strengths and barriers, and developing realistic action plans.
- **Education:** Giving patients clear information or advice on how to access social resources, such as eligibility criteria or steps to apply.
- **Evaluation of Eligibility:** Assessing whether patients qualify for programs or services and supporting them through application processes.
- **Provision:** Directly supplying resources—like food, transportation vouchers, or hygiene kits—through partners or on-site support.
- **Referral:** Connecting patients to external services, such as to Enhanced Care Management, Community Supports, or community-based services. Closed loop referrals allow the organization making the referral to track if the service was received or not.