



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

Health-related social needs (HRSN) screening & linkage template

Milestone Description

Identify one health related social need 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)¹, protocol for triage of patients based on screening results, and linkage to services with closed-loop referrals. Demonstrate how processes are working through a report of the following:

1. Percent of population of focus screened for HRSN*
2. Percent of patients with positive HRSN screening who are linked to services*
3. Percent of patients linked to services with a closed-looped referral

* The Learning Center recommends 80% as an aspirational screening target for the percentage of patients screened for HRSN and the percentage of patients with positive screens who are linked 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 HRSN deliverable, when released, to determine what is needed to qualify for payment.

DHCS defines a Closed-Loop Referral (CLR) as a referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and where the results of the referral are known. A Known Closure occurs when a Member's initial referral loop is completed with a Known Closure reason. Closure reasons include: 1. Services Received; 2. Service Provider Declined; 3. Unable to Reach Member; 4. Member No Longer Eligible for Services; 5. Member No Longer Needs Services or Declines Services; 6. Authorization Denied; 7. Other.

¹ Z codes are a set of ICD-10 diagnostic codes that allow providers to document and track patients' social needs. Additional detail on Z codes can be found here – <https://www.cms.gov/files/document/zcodes-infographic.pdf>.



Equity and Practice Transformation (EPT) Payment Program Health-related social needs (HRSN) screening & linkage

As part of the Medi-Cal Population Health Management requirements, Medi-Cal Managed Care Plans (MCPs) are implementing closed-loop referrals as a way to address identified health-related social needs. EPT practices are encouraged to work directly with their MCPs and review DHCS resources on [closed loop referral implementation guidance](#).²

Instructions

This document serves as a structured guide for implementing and tracking health related social needs like screenings, triage, and service linkages. This template is provided for reference only and outlines the required components for your submission. Final deliverables must be submitted via the designated Deliverable Portal. If you have questions, please email info@pophealthlc.org. **As a reminder, this deliverable is due by the November 2026 submission cycle.**

Documentation in the Template

Practices must implement HRSN screening and follow-up. This includes:

- Clear workflows for staff roles and screening frequency
- Data documentation and storage processes
- Triage and referral protocols
- Offering interventions for positive screens, which can include linkage to service and tracking closed loop referrals.
- Submission of progress data for key metrics, including baseline screening data & outcomes per the workflow implementation.

² <https://www.dhcs.ca.gov/CalAIM/Documents/WIP-CLR-Implementation-Guidance.pdf>



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

1. Baseline Data

Practices will evaluate their baseline data of current HRSN screenings 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.
- 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.

Measure	Percentage of patients screened for social needs	Percentage of positive screens linked to services	Percentage of linked patients with closed-loop referral
Numerator	Number of patients who were screened for selected social needs during the baseline reporting period	Number of patients with a positive social needs screen who were referred to services within 30 days.	Number of patients who were referred to services using a closed loop referral and received the at least one service within 30 days.*



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

Denominator	Total number of patients with at least one visit during the baseline reporting period.	Total number of patients with a positive social needs screen during the reporting period.	Total number of patients who were referred to services within 30 days using a closed-loop referral mechanism.
--------------------	--	---	---

*Unit of measure is number of patients. Some patients may receive multiple referrals using a closed loop system. If a least one or more service(s) are received and tracked within 30 days, numerator =1 & denominator =1

	% screened for social needs	% of positive screens linked to services	% of linked patients with closed-loop referral
Population	<input type="checkbox"/> Population of Focus only <input type="checkbox"/> All patients	<input type="checkbox"/> Population of Focus only <input type="checkbox"/> All patients	<input type="checkbox"/> Population of Focus only <input type="checkbox"/> All patients
Baseline Reporting Period (share the date range for the data reported, can be 6-months or 12-months)			
Numerator			



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

Denominator			
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): ____

2. Workflow Documentation

Please complete the structured prompts below.

Workflow Component	Response
Social need(s) addressed (check all that apply):	<input type="checkbox"/> Education <input type="checkbox"/> Food insecurity <input type="checkbox"/> Housing <input type="checkbox"/> Interpersonal violence <input type="checkbox"/> Language <input type="checkbox"/> Legal Support <input type="checkbox"/> Safety <input type="checkbox"/> Social Support <input type="checkbox"/> Transportation <input type="checkbox"/> Utilities <input type="checkbox"/> Other (specify)
Briefly describe how you selected the social need(s) (e.g., needs assessment, population data, interviews with patients, etc.)	
Screening population(s) (check all that apply):	<input type="checkbox"/> All patients <input type="checkbox"/> Population of focus only <input type="checkbox"/> Patients due for visit <input type="checkbox"/> Other (specify)
Screening tool:	<input type="checkbox"/> Accountable Health Communities <input type="checkbox"/> Custom/Practice-developed <input type="checkbox"/> PRAPARE <input type="checkbox"/> Other (specify)



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

Administration method:	<input type="checkbox"/> EHR-embedded tool <input type="checkbox"/> Patient portal <input type="checkbox"/> Paper-based <input type="checkbox"/> Verbal <input type="checkbox"/> iPad <input type="checkbox"/> Other (specify)
For the following roles, specify who screens, who reviews the results of the screening, and who responds to the screen	<p><i>Screens patient:</i> <input type="checkbox"/> MA <input type="checkbox"/> RN / LVN <input type="checkbox"/> Provider <input type="checkbox"/> Community Health Worker / Promotora / Representative <input type="checkbox"/> Social Worker <input type="checkbox"/> Front office staff <input type="checkbox"/> Other (specify)___</p> <p><i>Reviews results:</i> <input type="checkbox"/> MA <input type="checkbox"/> RN / LVN <input type="checkbox"/> Provider <input type="checkbox"/> Community Health Worker / Promotora / Representative <input type="checkbox"/> Social Worker <input type="checkbox"/> Front office staff <input type="checkbox"/> Other (specify)___</p> <p><i>Responds to screen:</i> <input type="checkbox"/> MA <input type="checkbox"/> RN / LVN <input type="checkbox"/> Provider <input type="checkbox"/> Community Health Worker / Promotora / Representative <input type="checkbox"/> Social Worker <input type="checkbox"/> Front office staff <input type="checkbox"/> Other (specify)___</p>
Screening frequency:	<input type="checkbox"/> Every visit <input type="checkbox"/> Annually <input type="checkbox"/> At wellness visits <input type="checkbox"/> Other (specify)
Triage protocol:	<i>Upload or briefly describe protocol. Indicate tiers or levels of response based on screening result.</i>
Staff Training:	<i>Who is trained? Describe how they are trained (e.g., job aid, live session), including the frequency and format of training.</i>
Data capture & storage:	<input type="checkbox"/> Results stored in structured EHR fields <input type="checkbox"/> Z codes used in documentation <input type="checkbox"/> Manual tracking (outside of EHR) <input type="checkbox"/> Population Health Management System <input type="checkbox"/> Other (specify)



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

Interventions offered to patients with a positive screen (select all that apply, see definitions in foot note) ³	<input type="checkbox"/> Adjustment <input type="checkbox"/> Assistance <input type="checkbox"/> Coordination <input type="checkbox"/> Counseling <input type="checkbox"/> Education <input type="checkbox"/> Evaluation of Eligibility <input type="checkbox"/> Provision <input type="checkbox"/> Referral
Referral Tracking:	<i>Describe how referrals are initiated and tracked including how you know the patient received the service, and how you address referrals for populations who are non-responsive or hard to engage. Referrals may be to CalAIM programs or services (e.g., Enhanced Care Management, Community Health Worker, Community Supports), programs/services within your practice or to community-based organizations.</i>

³ Definitions of interventions include:

1. Adjustment: Modifying care plans or treatment approaches to accommodate a patient's social needs—such as scheduling around transportation or work limitations.
2. Assistance: Providing direct support or help with applications for services like SNAP or WIC, focusing on urgent needs.
3. Coordination: Sharing information and organizing care across providers or organizations to ensure a unified response to a patient’s social needs.
4. Counseling: Collaboratively supporting patients in reflecting on their needs, identifying strengths and barriers, and developing realistic action plans.
5. Education: Giving patients clear information or advice on how to access social resources, such as eligibility criteria or steps to apply.
6. Evaluation of Eligibility: Assessing whether patients qualify for programs or services and supporting them through application processes.
7. Provision: Directly supplying resources—like food, transportation vouchers, or hygiene kits—through partners or on-site support.
8. 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.



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

3. Evidence of Implementation

To meet this milestone, your practice must implement **at least two new actions** (since the start of EPT) focused on **HRSNs** for your selected POF. These actions may include screening for social needs, improving referral processes, establishing or enhancing closed-loop referral systems, or strengthening follow-up workflows.

For each action, include:

- The **date of implementation** (when the action began being used with patients).
- Any **results observed** to date. If this has improved care for population of focus, please describe how.

Small-scale pilots or PDSA cycles are acceptable as evidence of implementation. **Notes:** Results may be **qualitative** (e.g., patient stories, staff feedback) or **quantitative** (e.g., increased screening rates, improved referral follow-through). Qualitative reporting should provide clear, narrative descriptions of observed 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 social health concerns”—that illustrate the real-world impact of implementation with specific, concrete examples.

	Action 1	Action 2
Implemented Action		
Date of Implementation		



Equity and Practice Transformation (EPT) Payment Program
 Health-related social needs (HRSN) screening & linkage

Results observed, including any impact on POF		
--	--	--

4. Data Submission – Performance Metrics

Please complete the table below using a **6 or 12-month look-back reporting period** for the three 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.”
- 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.

Measure	Percentage of patients screened for social needs	Percentage of positive screens linked to services	Percentage of linked patients with closed-loop referral
Numerator	Number of patients who were screened for selected social	Number of patients with a positive social needs screen	Number of patients who were referred to services using a closed loop referral and received at least one service within 30 days.*



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

	needs during the reporting period (6 or 12-month look back).	who were referred to services within 30 days.	
Denominator	Total number of patients with at least one visit during the reporting period.	Total number of patients with a positive social needs screen during the reporting period.	Total number of patients who were referred to services within 30 days using a closed-loop referral mechanism.

*Unit of measure is number of patients. Some patients may receive multiple referrals using a closed loop system. If a least one or more service(s) are received and tracked within 30 days, numerator =1 & denominator =1

	% screened for social needs	% of positive screens linked to services	% of linked patients with closed-loop referral
Population	<input type="checkbox"/> Population of Focus only <input type="checkbox"/> All patients	<input type="checkbox"/> Population of Focus only <input type="checkbox"/> All patients	<input type="checkbox"/> Population of Focus only <input type="checkbox"/> All patients
Reporting Period (share the date range for the data reported, can be 6-months or 12-months)			



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

Numerator			
Denominator			
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	<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): ____

Appendix:

Definitions:

- **Positive Screen**



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

- o 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**

- o 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. Interventions include:
 - Adjustment
 - Assistance
 - Coordination
 - Counseling
 - Education
 - Evaluation of Eligibility
 - Provision
 - Referral

- **Closed Loop Linkage**

- o 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;



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

- Unable to Reach Member;
 - Member No Longer Eligible for Services;
 - Member No Longer Needs Services or Declines Services;
 - Authorization Denied.
 - Other
- o EPT practices are encouraged to work directly with MCPs and review DHCS resources on [closed loop referral implementation guidance](#).
 - o 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
 - o **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.



Equity and Practice Transformation (EPT) Payment Program
Health-related social needs (HRSN) screening & linkage

- 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.

List of screeners are available on the Learning Center [website](#) and PopHealth+