



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

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: 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.

Question 1: Baseline Data & Performance Data

What You Need to Do

Report **baseline AND performance metrics for both depression and SUD** for a **6 or 12 month period**. Must include numerators and 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).



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Practices will submit **performance metrics for a 6 or 12 month look-back period** for the 6 depression and SUD 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 six 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 six measures.

Performance Metrics Reporting Grading Criteria

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



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OR Partial report of the six measures (numerator + denominator reported for 4/6 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 3 reported measures with a valid numerator + denominator **OR** Missing reporting period **OR** missing or invalid, non-specific justification for unable to report.

1A – Behavioral Health Screening Report

Report behavioral health outcomes related to total population screened, percent of positive screens linked to services, and percent of linked patients with closed-loop referrals.

| Component | Criterion |
|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Percent of PoF Screened with PHQ-2/PHQ-9 | <input type="checkbox"/> Numerator: # screened with PHQ-2/PHQ-9 (including patients who decline to complete a screen) <input type="checkbox"/> Denominator: Total # of PoF patients with ≥1 visit during the measurement period |
| Percent of Positive Screens Linked to Services (e.g., received an intervention, referral, or follow up action) | <input type="checkbox"/> Numerator: # of positive screens linked to services* (See appendix for definition) <input type="checkbox"/> Denominator: Total # of positive PHQ-2/PHQ-9 screens |
| Percent of linked patients with closed loop referral | <input type="checkbox"/> Numerator: # of referrals with confirmed completion with closed loop linkage outcome value noted.* (See appendix for definition) <input type="checkbox"/> Denominator: Total # of referrals for depression follow-up |



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| Reporting Period | <input type="checkbox"/> Response should indicate a 6 or 12 month period that does not overlap with the baseline period. |
| Screening Rate | Auto-Populated |
| Frequency of Review | <input type="checkbox"/> Response must include frequency of review (e.g. Monthly, Quarterly, Biannually, Annually, etc.) |
| Unable to Report (If applicable to any measure above) | <input type="checkbox"/> Reason and description of gaps/barriers in reporting the measure <input type="checkbox"/> Justification appears to be a reasonable limitation preventing metric reporting. |

1B – SUD Screening Report

Report SUD outcomes related to total population screened, percent of positive screens linked to services, and percent of linked patients with closed-loop referrals.

| Component | Criterion |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Percent of PoF Screened for SUD | <input type="checkbox"/> Numerator: # screened with a validated SUD screening tool (including patients who decline to complete a screen) <input type="checkbox"/> Denominator: Total # of PoF patients with ≥1 visit during the measurement period |



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| Percent of Positive Screens Linked to Services (e.g., received an intervention, referral, or follow up action) | <input type="checkbox"/> Numerator: # of positive screens linked to services* (See appendix for definition) <input type="checkbox"/> Denominator: Total # of positive SUD screens |
| Percent of linked patients with closed loop referral | <input type="checkbox"/> Numerator: # of referrals with confirmed completion with closed loop linkage outcome value noted.* (See appendix for definition) <input type="checkbox"/> Denominator: Total # of referrals for depression follow-up |
| Reporting Period | <input type="checkbox"/> Response should indicate a 6 or 12 month period that does not overlap with the baseline period. |
| Screening Rate | Auto-Populated |
| Frequency of Review | <input type="checkbox"/> Response must include frequency of review (eg Monthly, Quarterly, Biannually, Annually, etc) |
| Unable to Report (If applicable to any measure above) | <input type="checkbox"/> Reason and description of gaps/barriers in reporting the measure <input type="checkbox"/> Justification appears to be a reasonable limitation preventing metric reporting. |

Question 2: Depression/SUD Workflow for Screening & Closed Loop Referrals

2A. Depression Screening & Linkage strategy:

What You Need to Do



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Describe your **complete depression 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 roles/responsibilities, demonstrates a practice-specific screening process, triage/crisis protocol, referral workflow and follow-up, staff training plan, and documentation standards.

● NOT ACCEPTED:

The submission will not be accepted if 5 or fewer prompts do not meet the criteria within each prompt **AND/OR** if key critical items are missing or are not clearly described (e.g. triage & crisis escalation, suicide screening & intervention, and referral process).

| Required Components | Criterion |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What staff role is responsible for conducting initial and follow up | <input type="checkbox"/> A specific role within the practice care team clearly named (e.g., Medical Assistant). |
| How often is screening conducted? | <input type="checkbox"/> A specific timeframe is defined for screening (e.g., every visit, annually, well visits, etc.) |
| Administration Method? | <input type="checkbox"/> Includes how the screenings will be administered (e.g., EHR form, Patient Portal, Paper-based, Verbal, Tablet, etc.) |
| Triage/Intervention Protocol(s) | <input type="checkbox"/> Practice uploaded or provided a brief description of protocol <input type="checkbox"/> Protocol clearly defines risk assessment workflow, specific interventions, crisis escalation steps, and referral protocol. |



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| <ul style="list-style-type: none"> • Positive screen → • Risk assessment → • Intervention → • Referral → • Closed-loop tracking | <input type="checkbox"/> There is a clear workflow for a patient that endorses suicidal ideation and/or self-injurious behaviors that is assessed by a validated tool (e.g., Columbia Suicide Severity Rating Scale (C-SSRS), clinical interview or 988 hand-off) & follow up plan. <input type="checkbox"/> Cultural considerations are outlined in the protocol |
| <p>Screening Documentation & Storage</p> | <input type="checkbox"/> Indicates where the data will be stored (e.g., structured EHR fields, manual tracking, a population health platform, etc.) <input type="checkbox"/> Documentation standards are clearly outlined. |
| <p>Referral process</p> | <input type="checkbox"/> Includes specific behavioral health resources in the service area. Practices that do not have in-house behavioral health should indicate partners and/or use of a closed loop referral system (e.g., FindHelp) to respond to behavioral health needs. <input type="checkbox"/> Defines how referrals are initiated, tracked, and monitored for a closed loop outcome. <input type="checkbox"/> Workflow demonstrates how positive screens at various risk levels (mild, moderate, high) correspond to clinical decision-making related to the referral workflow (e.g. mild screen receives watchful waiting or care management encounter through in-house CHW; severe screen is referred to behavioral health community-based partner and tracked for closed loop linkage and/or dispensed medication with follow up visit scheduled). |
| <p>Training plan for staff</p> | <input type="checkbox"/> 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. |

2B. Substance Use Disorder (SUD) Screening & Linkage strategy:

What You Need to Do



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Describe your **complete SUD screening and response workflow**, similar to 2A but includes the SUD screening tool selection.

● ACCEPTED:

The response will be accepted if the workflow clearly defines roles/responsibilities, demonstrates a practice-specific screening process, triage/crisis protocol, referral workflow and follow-up, staff training plan, and documentation standards.

● NOT ACCEPTED:

The submission will not be accepted if 5 or fewer prompts do not meet the criteria within each prompt **AND/OR** if triage and escalation protocol is missing or is not clearly described (e.g. validated screening tool is not listed, unclear role responsibility, lack of intervention/referral plan, fails to evaluate risk rating and crisis workflows, etc).

| Component | Criterion |
|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What staff role is responsible for conducting initial and follow up | <input type="checkbox"/> A specific role within the practice care team clearly named (e.g., Medical Assistant). |
| Screening Tool | <input type="checkbox"/> Indicates a validated tool that will be used to evaluate both alcohol and drug screening. Screening tool should be appropriate to the practice population and age range. |
| How often is screening conducted | <input type="checkbox"/> A specific timeframe is defined for screening (e.g., every visit, annually, well visits, etc.) |
| Administration Method | <input type="checkbox"/> Includes how the screenings will be administered (e.g., EHR form, Patient Portal, Paper-based, Verbal, Tablet, etc.) |



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| <p>Triage/Intervention Protocol(s)</p> <ul style="list-style-type: none"> • Positive screen → • Risk assessment → • Intervention → • Referral → • Closed-loop tracking | <ul style="list-style-type: none"> <input type="checkbox"/> Practice uploaded or provided a brief description of protocol <input type="checkbox"/> Protocol clearly defines risk assessment workflow, specific interventions, crisis escalation steps, and referral protocol. This should include the use of motivational interviewing (MI), assessment of the patient’s readiness for change, and appropriate risk assessment and response. <input type="checkbox"/> Clearly defined workflow for mild, moderate, and severe acuity levels (e.g., SBIRT, Stages of Change). Indicates use of MAT if applicable to the practice capabilities. <input type="checkbox"/> Outlines crisis response expectations <input type="checkbox"/> Cultural considerations are outlined in the protocol |
| <p>Screening Documentation & Storage</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Indicates where the data will be stored (e.g., structured EHR fields, manual tracking, a population health platform, etc.) <input type="checkbox"/> Documentation standards are clearly outlined. |
| <p>Referral process</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Includes specific SUD resources in the service area. Practices that do not have in-house SUD should indicate partners and/or use of closed loop referral system (e.g., FindHelp) to respond to behavioral health needs. <input type="checkbox"/> Defines how referrals are initiated, tracked, and monitored for a closed loop outcome. <input type="checkbox"/> Workflow embeds motivational interviewing approaches, assessment of patient readiness for change/stage of change to match the intervention(s) to the patient’s readiness. <input type="checkbox"/> Workflow demonstrates how positive screens at various risk levels (mild, moderate, high) correspond to clinical decision-making related to the referral workflow. |
| <p>Training plan for staff</p> | <ul style="list-style-type: none"> <input type="checkbox"/> 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. <input type="checkbox"/> Training includes best practices including but not limited to Motivational Interviewing, SBIRT, SUD stigma/harm reduction approaches, etc. |

Question 3: Evidence of Implementation:



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What You Need to Do

List at least **two new actions implemented since the start of EPT and completed by the November 2026 submission deadline—one for depression and one for SUD**. 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.

| Component | Criterion |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Implemented Actions | <input type="checkbox"/> A minimum of two actions are listed and each action is clearly described (e.g., our practice made multilingual PHQ-9s available in the client portal to be completed prior to the visit). <input type="checkbox"/> One action addresses Depression Screening <input type="checkbox"/> One action addresses SUD Screening |
| Date of Implementation Start | <input type="checkbox"/> A specific date is provided for at least two actions. This date should not overlap with the baseline period. |
| Results Observed | <input type="checkbox"/> Each action has at least one observed result. (qualitative or quantitative). <input type="checkbox"/> 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 behavioral health concerns”—that illustrate the real-world impact of implementation with specific, concrete examples). |



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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:

Metric Definitions

- **Positive Screen:** A positive screen is determined by the completion of a validated screening tool AND clinical assessment & judgement from the provider. Scoring guides can be found in the appendix to inform clinical decision-making in conducting the assessment, intervention/service, and referral, as applicable to the patient's risk factors. Note that a score above a zero may still warrant brief counseling or follow-up based on context and circumstances.
- **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. It is recommended that providers engage patients in stage of change discussions and match the services and/or referral to the patient's readiness for change. Examples of services include:
 - Depression Interventions/Services:
 - Completed outpatient, telephone, or e-visit (including with PCP)



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- Depression Case Management/Collaborative Care contact
- Behavioral Health Visit (assessment, therapy, medication management)
- Initiation of anti-depressant medication
- Negative PHQ-9 on the same day as positive PHQ-2
- Participation in peer support or group therapy
- Enrollment in a digital mental health platform (e.g. app-based CBT) and follow up plan
- Referral to and documented engagement with a community health worker, care manager (e.g. ECM)
- Development of a documented self-management, education and follow-up plan with PCP when formal services are declined and/or unavailable.
- Crisis follow-up (if indicated) as evidenced by additional risk assessment and if clinically indicated, intervention documented in the note (e.g. safety planning, mobile crisis unit, psychiatric emergency, etc.)
- SUD Interventions/Services
 - Brief Intervention (e.g., SBIRT-aligned motivational counseling) & documented in chart.
 - Behavioral health or SUD intake or follow-up, including peer support (internal or external program, including crisis services, inpatient detox, residential or outpatient treatment)
 - Development of a documented personalized plan of care that aligns with the patient's stage of change (e.g., pre-contemplation, contemplation, preparation, action)
 - Referral to behavioral health, crisis services, inpatient detox, residential or outpatient treatment (referral to internal or external program(s)).
 - Initiation of medication-assisted treatment (e.g, buprenorphine, methadone, naltrexone)
 - Engagement with harm reduction services (e.g. naloxone distribution, syringe services, other MAT)
 - Referral to care management (ECM), recovery specialist, peer-led recovery group or other community-based program.
 - Crisis follow-up (if indicated) as evidenced by additional risk assessment and if clinically indicated, intervention documented in the note (e.g. safety planning, mobile crisis unit, psychiatric emergency, etc.)



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- **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.
- EPT practices are encouraged to work directly with MCPs and review DHCS resources on [closed loop referral implementation guidance](#).
- Note: [42 CFR Part 2](#) is a federal regulation that requires heightened protections for confidentiality of SUD treatment records and disclosures. Authorizations to release information in compliance with 42 CFR Part 2 regulations will be needed to close the loop to some referral sources. Practices are encouraged to seek further guidance from their sponsoring MCP. See below for guidance in adapting Closed loop linkage for SUD populations:
 - Practices may use a tiered closed-loop referral approach, recognizing that full closed-loop confirmation may not always be possible due to referral type, patient consent, or applicable privacy regulations, including HIPAA and 42 CFR Part 2.
 - When bi-directional communication is available (e.g., outpatient behavioral health or MAT providers), referral initiation and completion can be tracked through the EHR or referral platform or other information-sharing agreement.
 - For inpatient or residential substance use treatment, practices may document referral initiation and follow up with the patient to assess disposition when confirmation is not available.



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- For peer-led mutual support groups (e.g., AA/NA), where anonymity limits confirmation, follow-up may rely on documentation of resource provision and patient-reported engagement.
- Across referral types, follow-up can include reassessment of readiness for change using motivational interviewing–informed, culturally responsive, and non-punitive approaches. Where closed-loop referral is simply not practical or possible, this can be noted in submission.

Readiness for Change Examples:

Low readiness (e.g., patient not interested in change):

Provide brief motivational intervention, normalize ambivalence, offer harm-reduction strategies, and schedule re-screening at a future visit.

Moderate readiness:

Conduct brief intervention using MI techniques, offer optional referral to care management or behavioral health, and schedule follow-up.

High readiness:

Initiate referral to appropriate SUD treatment services (e.g., outpatient treatment, MAT, peer support), with closed-loop referral tracking, as applicable.

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



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- 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

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.



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- 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.

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



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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

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.

Scoring Interpretation (by substance):

- 0-3: Low risk — no intervention needed
- 4-26: Moderate risk — brief intervention recommended



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- 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):**
 - **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.



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*(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.)*