Session 3

EPT Program: Health-Related Social Needs (HRSN) Milestone Office Hours Series

Session 3: Intervention & Linkage to Services
March 11, 2026

Facilitated by HealthBegins in collaboration with the Population Health Learning Center

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Welcome & Introductions

Our Facilitators

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Check In Question

Please put your name, role, organization in the chat and respond to our check in question:

What's something you've read or watched recently that you'd recommend?

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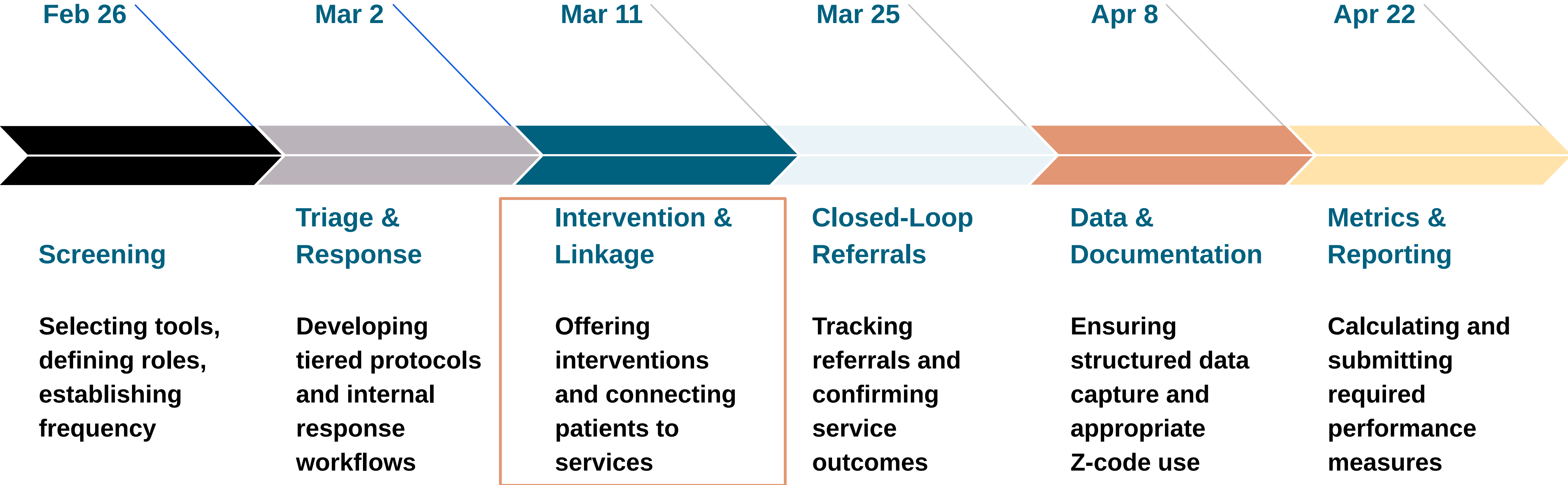
Office Hours Series Overview

This Office Hours Series is structured to support implementation across the full HRSN process:



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Session Format

Time	Activity
12:00–12:05 p.m.	Welcome, Introductions & Framing
12:05–12:13 p.m.	Didactic Content: Interventions
12:13–12:23 p.m.	Participant Sharing: Identifying Resources & Providing Referrals
12:23–12:25 p.m.	Intervention Poll
12:25–12:55 p.m.	Facilitated Discussion & Q&A
12:55–1:00 p.m.	Closing & Evaluation

Key Takeaways from Sessions One and Two

Key Takeaways

- It's okay to start simple—begin with one social needs domain.
- There are additional resources available to support patients, including Medicaid Managed Care Plans and community resources.
- Most clinics screen parents until ages 12 or 13, then screen the patient directly throughout adolescence.
- For practices just beginning social needs screening, the Learning Center recommends waiting until November to submit this milestone to allow additional time and alignment with UDS.

Session Learning Objectives

Remember: These sessions are designed to help you to meet the requirements in the HRSN Documentation Template & EPT Rubric.

By the end of this session, participants will be able to:

1. **Develop** standardized "interventions" for every positive screen.
2. **Identify** key community partners for high-frequency needs (e.g., Food, Housing, Transportation), including partners offering CalAIM-funded Community Supports and Enhanced Case Management.

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Intervention and Linkage Scoring

Questions?

- Clearly indicates which intervention practices will be deployed to address identified social needs:
  - Adjustment
  - Assistance
  - Coordination
  - Counseling
  - Education
  - Evaluation of Eligibility
  - Provision
- Interventions should include a **referral**, plus at least one additional intervention, to address positive POF screens.

Example Food Insecurity Interventions in Practice

	Less Time-Intensive	More Time-Intensive
Adjustment	Focus the clinical conversation on dietary strategies that require limited time and resources.	Create a detailed, personalized dietary plan tailored to the patient's cultural preferences, budget, and available local resources, with scheduled follow-up.
Education	Provide the patient with pre-printed information on how to apply for SNAP.	Educate the patient verbally on how to apply for SNAP and how to purchase healthy food on a budget.
Evaluation of Eligibility	Identify and circle resources the patient is likely eligible for based on age, income, or other known factors.	Assess income and eligibility in greater depth to provide more nuanced and reliable guidance on eligibility.
Referral	Provide the patient with a list of resources.	Support a closed-loop referral by following up with the patient to confirm resources were accessed and needs were met.

Example Interventions in Practice — Continued

	Less Time-Intensive	More Time-Intensive
Counseling	Encourage the patient to apply for government benefits and seek community resources as part of their health strategy.	Using empathic inquiry, assess barriers to accessing services and support the patient in identifying and overcoming psychological and practical barriers.
Assistance	Support the patient in setting up a login to complete an online SNAP application.	Provide hands-on support in completing the SNAP application.
Coordination	Call a local food bank with the patient to determine hours, eligibility requirements, available offerings, and schedule a visit.	Coordinate with multiple community partners (food bank, food pantry, Meals on Wheels, etc.) to create a comprehensive food support plan tailored to the patient's needs and schedule.
Provision	Maintain a lobby bookshelf where staff and patients can donate and pick up food; no monitoring or tracking.	Partner with a local food bank or Food Is Medicine organization to offer pre-packed, diet-specific food bags for patients who are food insecure and have a diet-related disease.

Sources for Identifying Referrals

American Academy of Family Physicians (AAFP) Navigator

https://navigator.aafp.org/

211 California

https://211ca.org/

FindHelp

https://www.findhelp.org/

One Degree (Los Angeles & San Francisco)

https://www.1degree.org/

Support Your Peers: Share how you are identifying and sharing resource information with your patients.

Live Poll: Linkage to Services Workflow Baseline

To begin the discussion, please complete **one** poll question:

Which types of interventions do you plan to employ? *(Select all that apply.)*

- ❑ Adjustment
- ❑ Assistance
- ❑ Coordination
- ❑ Counseling
- ❑ Education
- ❑ Evaluation of Eligibility
- ❑ Provision
- ❑ Referral

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What support would be most helpful as you prepare your Social Needs Screening Milestone submission?

Training Resources

eLearning Modules

- Module 1: Getting Started–Understanding Health-Related Social Needs
- Module 2: Building a Social Needs Strategy
- Module 3: Enhancing Social Needs Data Integration & Community Partnerships

Toolkits

- Interpersonal Violence Health Partners Toolkit

Questions?

Thank You!

Thank you for your participation and engagement.

If you have questions after today's session or would like additional support, please reach out to **info@pophealthlc.org** or **info@healthbegins.org**.

We look forward to continuing this work together in the next session!