Session 4

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

Session 4: Closing the Loop on Referrals
March 25, 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:

Is cereal a soup?

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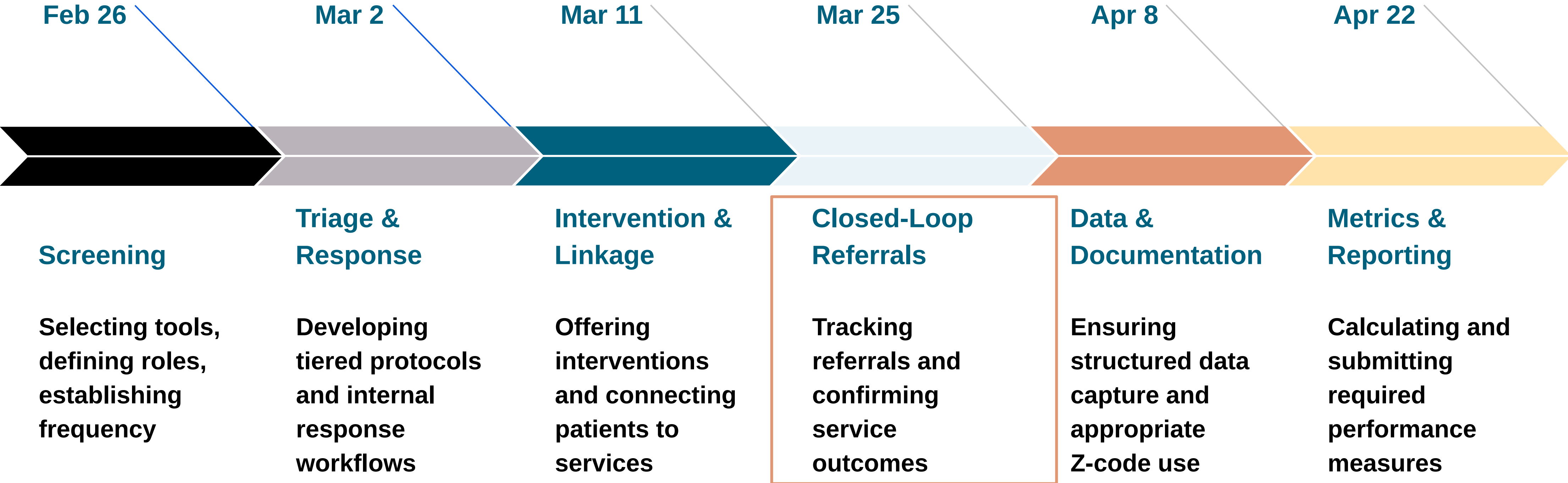
Office Hours Series Overview

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



Session Format

Time	Activity
12:00–12:05 p.m.	Welcome, Introductions & Framing
12:05–12:13 p.m.	Didactic Content: Closed-Loop Referrals
12:13–12:23 p.m.	Participant Sharing
12:23–12:25 p.m.	Closed-Loop Referral Poll
12:25–12:55 p.m.	Facilitated Discussion & Q&A
12:55–1:00 p.m.	Closing & Next Steps

Key Takeaways from Sessions 1-3

- 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.

Key Takeaways from Sessions 1–3 (cont.)

Questions?

- **Reimbursement for Screening**
  - Bill for Community Health Worker (CHW) time
  - Leverage dyadic services benefits for pediatric populations
  - Ensure E&M coding reflects increased complexity identified through social needs screening
  - Engage managed care plans (MCPs) to identify reimbursement opportunities and confirm appropriate billing codes (may vary by plan)
- **Screening Tool Cost**
  - AHCM is free to use, though some question authors may request notification
  - PRAPARE is free for CHCs. For private practices, PRAPARE costs are typically paid by the EHR vendor. If the tool is used independently,it is $5,000 per year.

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. **Establish** feedback channels with community partners to confirm service delivery.
2. **Define** and **document** "Known Closure" reasons (e.g., Service Received, Member Declined) in the EHR.
3. **Implement** a process for follow-up with patients when referral outcomes are unknown.

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What Your Closed-Loop Referral Data Might Tell You

- **The process for making referrals**, and determining which patients are referred to which resources, could be improved.
- For certain patients and social needs, the available **resources can be difficult to access**.
- Even when patients are connected to social resources, those **resources may not fully address their needs**.

Questions?

Closed-Loop Referral Scoring

Questions?

Data

- **Numerator:** Patients referred via closed-loop who received services within 30 days
- **Denominator:** Patients referred via a closed-loop referral within 30 days

Coding

- 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

Coding Closed-Loop Referral Outcomes

Outcome	Description	Example
Services Received	Patient is enrolled and has begun receiving services	Patient has received first Medically Tailored Meals box
Service Provider Declined	CBO unable to accept referral	CBO is not able to provide utility assistance because all funds have been exhausted
Unable to Reach Member	Member unreachable after all outreach attempts	Patient has been called three times and emailed and has not responded
Member no longer eligible for services	Patient was or is ineligible.	Patient's income is too high for the service
Member no Longer Needs Services or Declines	Consider disaggregating for coding for more in-depth insights and then aggregating for submission.	Patient does not want Medically Tailored Meals.
Authorization denied	Patient is or may be eligible but cannot receive the service.	Patient did not complete necessary paperwork. Patient has exceeded the allowable duration or quantity of the service.
Other	Any situation not covered by the above categories.	Patient has transportation or logistical barriers to accessing the service.

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Considerations for Closed-Loop Referrals

Questions?

- Start small
  - Leverage community supports and ECM
  - Align with government benefits
- Ruthlessly prioritize needs and focus areas
  - Identify clinical intersections
  - Assess breadth and depth of need
  - Consider interest and existing relationships
- Establish data use agreements and consent processes
- Evaluate data infrastructure
- Plan for and mitigate loss to follow-up

Closed Loop Referral System Preview

Questions?

Preview of a closed-loop referral system - Findhelp.org

findhelp

People I'm Helping

Monica

Help is available in your neighborhood

Findhelp has resources for food pantries and meal programs near you. You can also find housing, financial assistance, health care, and more.

What are you looking for today?

Enter a need or keyword

Where?

ZIP code

Find Programs

Food | Housing | Goods | Transit | Health | Money | Care | Education | Work | Legal

By continuing, you agree to the Terms & Privacy.

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MCP Closed-Loop Referrals & ECM/CS

Are you receiving ECM or CS closed-loop data from your MCP?

PCP Refers Member to Respite	
Make Referral	PCP submits the initial referral to the MCP for Respite Services.
Authorize Referral	MCP reviews eligibility and authorizes services within five business days.
Notice Referring Entity and Member	MCP informs the PCP next business day and notifies the Member and caretaker within two business days.
Accept Referral	MCP assigns the Member to a Community Supports Provider and sends the Authorization Status File (ASF). Provider reviews the Member, assesses capacity, and contacts the Member and caretaker.
Provide Service	Community Supports Provider begins Respite Services.
Track Referral	Provider updates the Referral Tracking File (RTF) and submits monthly to MCP, who monitors and supports outreach as needed.
Close Referral Loop	Once services start, Provider marks the referral as “Referral Loop Closed” with reason “Services Received” in the RTF; MCP notifies the PCP within two business days.
Monitor Referral	DHCS receives MCP data via JSON to track referrals alongside other Community Supports referrals.

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Live Poll: Closing the Loop Baseline

Poll #1: Does your EHR capture closed-loop data in a discrete format?

- Yes
- No

Poll #2: How do you primarily close the loop?

- Following up with the patient
- Manually contacting the receiving organization
- Receiving a digital alert from the receiving organization
- Other

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Sources for Closing the Loop on Referrals

- DHCS Closed-Loop Referral Policy Guidance
- SIREN Social Needs Referrals in Primary Care Implementation Toolkit
- CalAIM landing page for Community Supports and Enhanced Case Management
- HRSN Screening Crosswalk

Support Your Peers: Any other resources to share with your peers?

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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!