

Session 5



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

Session 5: Data Architecture and Storage
April 8, 2026

Facilitated by HealthBegins in collaboration with the Population Health Learning Center

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Welcome & Introductions

Our Facilitators



Monica Dedhia, LCSW
Senior Program Manager
Population Health Learning Center



Kathryn Jantz, MSW, MPH
Consultant
Hearthwise Consulting

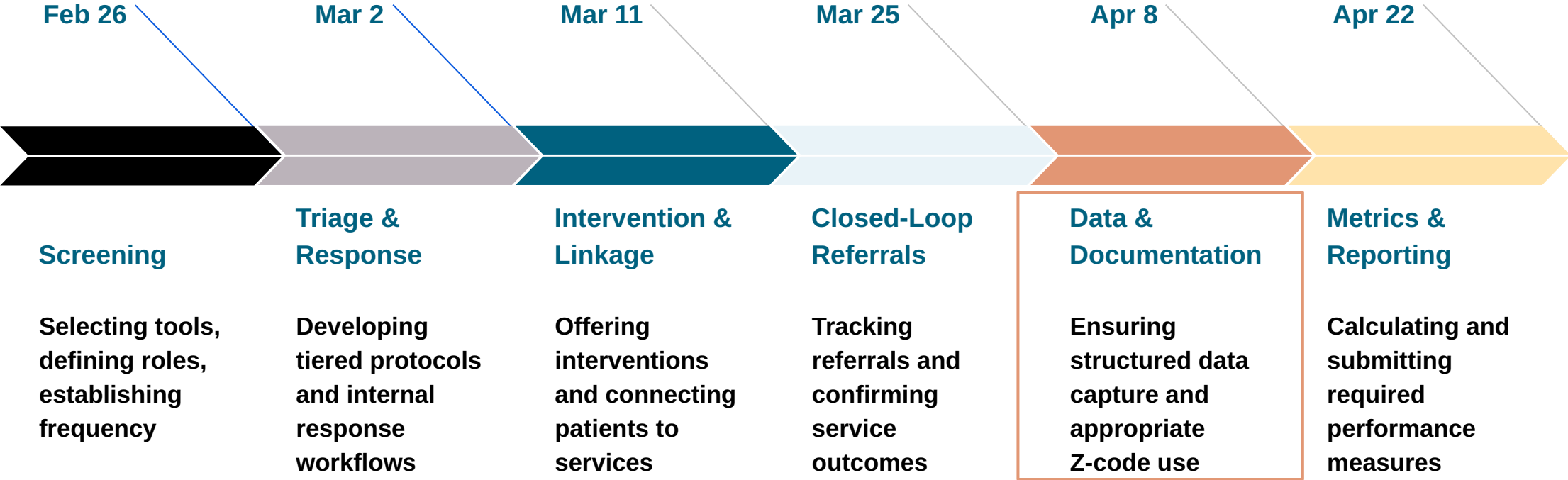
Check In Question

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

If you could take a trip to the moon tomorrow, would you go?

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: Data Architecture & Storage
12:13–12:23 p.m.	Participant Sharing
12:23–12:25 p.m.	Live Poll: Data Architecture & Storage
12:25–12:55 p.m.	Facilitated Discussion & Q&A
12:55–1:00 p.m.	Closing Remarks & Next Steps

Key Takeaways from Sessions 1-4

- It's okay to start simple – begin with one social needs domain.
- Screeners must be social needs screening tools. ACES and PEARLS are not social needs screening tools that assess present need.
- 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 1–4 (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 \$5000 per year.

Key Takeaways from Sessions 1–4 (cont.)

Questions?

- **Closed Loop Referral Coding Clarifications**

- The denominator for closed loop referrals should be only patients who are referred to a service where you are trying to do closed loop referrals. This will not be all referrals.
 - Example: Community Supports or Government Benefits may be closed loop referrals. Some community referrals like food banks may not.
- Closed loop referral outcomes should include “other.”

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. **Identify** where and how HRSN data are stored.
2. **Develop** a process to review HRSN data to support screening and referral quality improvement and inform population health strategies.

How Your Data Infrastructure Can Support Effective Screening

- Identify and **flag patients due for screening**
- Enable patients to complete **electronic screenings**
- Present **screening results to clinicians** at the point of care
- **Document referrals**, including closed-loop tracking
- **Facilitate referrals** to internal teams and/or external partners
- Support **continuous quality improvement** efforts

How Your Data Analysis Can Support Population Health

- Identify **patterns and trends** in needs over time
- Capture **disparities** by race, language, age, insurance status, and other demographics
- Identify **gaps** in services
- Improve **care planning**
- Inform **resource allocation**
- Support **policy and advocacy** efforts
- Inform **future payment models**

Data Needed for Milestone

Questions?

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 service within 30 days.
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.

Key Notes

- Review period is 6 or 12 months
- Baseline period must be separate from the review period

Data capture & storage:

- Results stored in structured EHR fields
 Z codes used in documentation
 Manual tracking (outside of EHR)
 Population Health Management System
 Other (specify)

Case Study Example

Mr. M. is food insecure and has diabetes. He has never accessed any food resources.

**% of
Patients
Screened**

Patient is Screened

Within the past 12 months we worried whether our food would run out before we got money to buy more.

Often True

Within the past 12 months the food we bought just didn't last and we didn't have money to get more. **Often True**

**%
Positives
Referred**

Staff Triage & Refer

Staff identify patient has food presently but has difficulty purchasing food at the end of every month.

Adjust clinical care plan

Evaluate Eligibility for SNAP

Refer to food bank

Refer for Medically Tailored Groceries

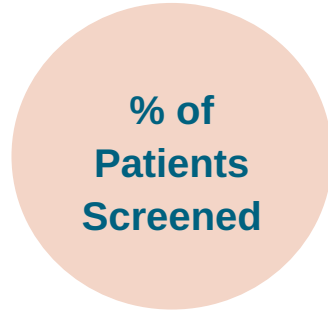
**% Patients
with Closed
Loop
Referral**

Close the Loop

Capture closed-loop data from MCP on Medically Tailored Groceries

Contact patient to see if they were successfully enrolled in SNAP.

Minimum Data Elements



Patient is Screened

Screening date

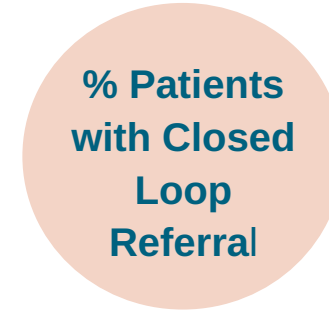


Staff Triage & Refer

Discrete data capturing response to every screening question

Type of intervention

- Referral (organization referred to) AND
- Adjustment
- Education
- Evaluation of Eligibility
- Counseling
- Assistance
- Provision



Close the Loop

Receiving organization for referral

Outcome of referral

- 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

Advanced Data Collection

**% of
Patients
Screened**

Patient is Screened

LOINC code for hunger vital
sign question 1 88122-7

LOINC code for hunger vital
sign question 2 88123-5
LOINC Code for Often True response
A28397-0

**%
Positives
Referred**

Staff Triage & Refer

Diagnose:

- SNOMED CT Code Food Insecurity 733423003
- Add ICD-10-CM Z59.41 to the e-bill

Note interventions

- Adjustment of clinical plan to accommodate social risk -SNOMED CT 1269404007
- Referral to SNAP - SNOMED CT464101000124108

**% Patients
with Closed
Loop
Referral**

Close the Loop

Track closure reasons:

- Services Received
- Service Provider Declined
- Unable to Reach Member
- Member No Longer Eligible for Services
- Member No Longer Needs Services or Declines Services
- Other
- Authorization Denied

Questions for EHR Vendor?

1. What screening templates are already available through this EHR?
2. What is the cost to customize?
3. Can the EHR trigger when a rescreen should be conducted?
4. Can the screening be administered via text, portal or tablet?

Questions for EHR Vendor? (continued)

5. Does the EHR already integrate with local community resources or closed loop referral systems such as FINDHelp or Unite Us?
6. What is the ease for report generation? Especially generating reports based on clinical comorbidities?
7. Does the EHR supporting mapping the data elements to standardized codes?
8. Can data elements that may be sensitive such as interpersonal violence be protected so that they are not disclosed inappropriately?

Z Codes: Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)

- Z59 Problems related to housing and economic circumstances
 - Z59.0 Homelessness
 - Z59.00 Homelessness unspecified
 - Z59.01 Sheltered homelessness
 - Z59.02 Unsheltered homelessness
 - Z59.1 Inadequate housing
 - Z59.10 Inadequate housing, unspecified
 - Z59.11 Inadequate housing environmental temperature
 - Z59.12 Inadequate housing utilities
 - Z59.19 Other inadequate housing
 - Z59.2 Discord with neighbors, lodgers and landlord
 - Z59.3 Problems related to living in residential institution
 - Z59.4 Lack of adequate food
 - Z59.41 Food insecurity
 - Z59.48 Other specified lack of adequate food
 - Z59.5 Extreme poverty
 - Z59.6 Low income
 - Z59.7 Insufficient social insurance and welfare support
 - Z59.71 Insufficient health insurance coverage
 - Z59.72 Insufficient welfare support
 - Z59.8 Other problems related to housing and economic circumstances
 - Z59.81 Housing instability, housed
 - Z59.811 Housing instability, housed, with risk of homelessness
 - Z59.812 Housing instability, housed, homelessness in past 12 months
 - Z59.819 Housing instability, housed unspecified
 - Z59.82 Transportation insecurity
 - Z59.86 Financial insecurity
 - Z59.861 Financial insecurity, difficulty paying for utilities
 - Z59.868 Other specified financial insecurity
 - Z59.869 Financial insecurity, unspecified
 - Z59.87 Material hardship due to limited financial resources, not elsewhere classified
 - Z59.89 Other problems related to housing and economic circumstances
 - Z59.9 Problem related to housing and economic circumstances, unspecified

Live Poll: Data Structure and Storage

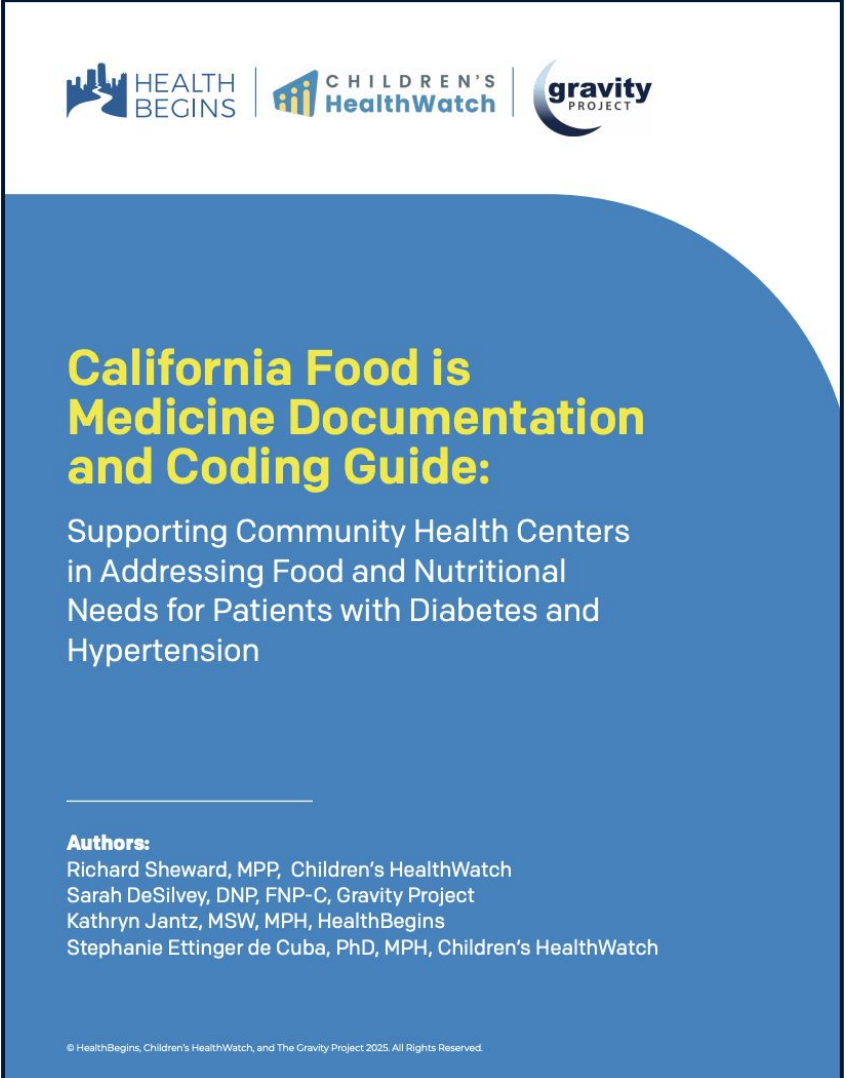
**How are you capturing and storing screening results?
(choose all that apply)**

- Results stored in structured EHR fields
- Z codes used in documentation
- Manual tracking (outside of EHR)
- Population Health Management System
- Other (specify)

Resources for Data Structure and Storage

- [ICD-10 Tool](#)
- [Food Is Medicine Documentation and Coding Guide — California](#)

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



HEALTH BEGINS | **CHILDREN'S HealthWatch** | **gravity PROJECT**

California Food is Medicine Documentation and Coding Guide:

Supporting Community Health Centers in Addressing Food and Nutritional Needs for Patients with Diabetes and Hypertension

Authors:
Richard Sheward, MPP, Children's HealthWatch
Sarah DeSilvey, DNP, FNP-C, Gravity Project
Kathryn Jantz, MSW, MPH, HealthBegins
Stephanie Ettinger de Cuba, PhD, MPH, Children's HealthWatch

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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!

