



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

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1. Baseline Data

	% 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 checked="" 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)	12 Months		
Numerator	42811	1522	521
Denominator	82128	2073	1552
Rate (Auto-Calculated)	52.1%	74.9%	33.6%
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"/> Data unavailable <input type="checkbox"/> EHR limitation	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation



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	<input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____	<input type="checkbox"/> Workflow not fully implemented <input type="checkbox"/> Other (please describe): ____
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1. Workflow Documentation

Please complete the structured prompts below.

Workflow Component	Response
Social need(s) addressed (check all that apply):	<input type="checkbox"/> Education <input checked="" 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.)	<p>NEMS selected food insecurity as our focus HRSN based on internal population data. Our 2025 UDS data highlights this where 59.2% are at or below 100% of the Federal Poverty Level, and 16.1% are between 101–150% FPL (over 75% are ≤150% FPL). In addition, 56.6% of our patients are enrolled in Medi-Cal and another 17.2% are Medicare-Medicaid dual eligible. These factors indicate significant food insecurity risk within our primarily low-income, publicly insured patient population served across San Francisco, San Mateo, and Santa Clara counties.</p>
Screening population(s) (check all that apply):	<input checked="" 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 checked="" type="checkbox"/> PRAPARE <input type="checkbox"/> Other (specify)



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Administration method:	<input checked="" type="checkbox"/> EHR-embedded tool <input type="checkbox"/> Patient portal <input type="checkbox"/> Paper-based <input checked="" 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 checked="" type="checkbox"/> Other (specify) Member Services Enrollment and Eligibility Team</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 checked="" type="checkbox"/> Other (specify) Member Services Enrollment and Eligibility Team</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 checked="" type="checkbox"/> Other (specify) Member Services Enrollment and Eligibility Team</p>
Screening frequency:	<input type="checkbox"/> Every visit <input checked="" type="checkbox"/> Annually <input type="checkbox"/> At wellness visits <input type="checkbox"/> Other (specify)
Triage protocol:	<p>Member Services staff conduct verbal screening using our modified PRAPARE tool during new patient registration and annual renewal, with results documented in structured fields in the Epic EHR system. The modified tool screens for physical activity, food insecurity, transportation, financial resources, housing stability, safety concerns, intimate partner violence, stress, social connections, and alcohol use.</p> <p>A positive food insecurity screen is defined as a response of “sometimes true” or “often true” to either of the two food-related questions. When food insecurity is identified, the team immediately performs eligibility pre-screening against official CalFresh requirements (income thresholds,</p>



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	<p>immigration status, and existing Medi-Cal coverage such as a white Medi-Cal card), provides education on CalFresh benefits, and offers hands-on application assistance via BenefitsCal if the patient is interested and eligible.</p> <p>NEMS targets food insecurity through two primary interventions:</p> <ol style="list-style-type: none">1. CalFresh enrollment assistance (California’s SNAP/food stamps program), and2. Referrals to food banks, specifically the San Francisco-Marín Food Bank partnership for SF County patients who authorize information sharing. <p>If other social needs screen positive on the modified PRAPARE tool:</p> <ul style="list-style-type: none">- Safety or intimate partner violence concerns are reported right away.- Financial resource concerns result in referral to county social services offices.- Patients who are homeless and reside in San Francisco are immediately enrolled into our Healthcare for the Homeless Program and can access healthcare services for free at the Stockton Clinic.- Housing instability leads to referral to Section A housing support.- Patients who qualify for Medi-Cal receive assistance with Medi-Cal enrollment.
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	<ul style="list-style-type: none">- Transportation concerns (for patients with Medi-Cal and an eligible health plan) result in connection to their respective health plan to arrange transportation for doctor appointments, including specialists outside NEMS.- Alcohol use concerns result in a recommendation that the patient speak with their PCP for further follow-up. <p>As an additional pathway, medical providers, Behavioral Health staff, and Health Education staff can refer patients who mention food insecurity during any visit (even if unrelated to food insecurity) directly to Member Services. Cultural and language considerations are addressed through verbal administration in the patient’s preferred language (with interpreter support when needed) and explicit statement of the patient’s right to decline any question.</p> <p>NEMS uses a modified PRAPARE tool rather than the standard full PRAPARE to make screening more actionable and efficient within our existing workflows. The modified version retains the core PRAPARE domains (housing, transportation, financial resources, stress, social connections, and food insecurity) while adding specific components on physical activity, alcohol use, safety concerns, and intimate partner violence. These additional components were included because they directly map to immediate internal response pathways at NEMS (e.g., immediate reporting of safety/IPV, referral to county social services for financial strain, enrollment in the Healthcare for the Homeless Program, Section A housing support, Medi-Cal assistance, health plan transportation coordination, or PCP referral for alcohol use). Standard PRAPARE components such as education level, employment status, and veteran status are not included in the MS screening because they</p>
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	<p>are already captured during the standard patient registration process in Epic. This customization avoids duplication, reduces screening time during high-volume verbal encounters, and ensures every positive screen leads to a concrete next step for our low-income, immigrant patient population.</p>
Staff Training:	<p>All new Member Services staff receive 2–4 weeks of on-the-job mentoring by senior staff. Training includes verbal administration of the modified PRAPARE tool using a standardized script, Epic SDOH documentation, CalFresh eligibility criteria, BenefitsCal use, closed-loop referral protocols, and documentation of all outcome categories. All staff complete an annual Cultural Humility training as part of our organization’s training requirements. Training also integrates best practices in empathetic and trauma-informed communication. In practice, staff are taught to recognize that many patients — especially from cultures where admitting financial need can feel like a loss of face or bring shame — may hesitate, give short answers, or shut down when the food questions come up.</p> <p>When a patient pauses or looks uncomfortable, staff respond with normalizing language such as: “I know this can be a really hard thing to talk about — a lot of our patients feel the same way, and it’s completely okay if you don’t want to go into it.” They pause and check in: “Would you like me to skip this part for now?” or “We can come back to it later if anything changes.” If the patient seems open but guarded, staff might gently add, “Some folks tell me groceries have been tighter lately and they didn’t realize there are programs that can help stretch their budget — but only if you’re interested, there’s zero pressure.” Staff are trained to never push for details, always give the patient full control, and offer to provide written resources quietly even if</p>



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	<p>the patient chooses not to answer on the spot. These approaches help reduce stigma and make patients feel safe enough to share when they're ready. Cultural sensitivity is emphasized by offering interpreter services proactively and respecting privacy by conducting screening in a quiet, confidential space. Fidelity is monitored through daily supervision, side-by-side call observation, and periodic review of documentation.</p>
<p>Data capture & storage:</p>	<p><input checked="" type="checkbox"/> Results stored in structured EHR fields <input checked="" type="checkbox"/> Z codes used in documentation <input type="checkbox"/> Manual tracking (outside of EHR) <input type="checkbox"/> Population Health Management System <input checked="" type="checkbox"/> Other (specify) - All referral outcomes are documented in Epic and (for SF County) Oasis Insight where applicable. Documentation standards are standardized across sites and extractable for reporting.</p>
<p>Interventions offered to patients with a positive screen (select all that apply, see definitions in foot note)¹</p>	<p><input type="checkbox"/> Adjustment <input checked="" type="checkbox"/> Assistance <input type="checkbox"/> Coordination <input type="checkbox"/> Counseling <input checked="" type="checkbox"/> Education <input checked="" type="checkbox"/> Evaluation of Eligibility <input type="checkbox"/> Provision <input checked="" type="checkbox"/> Referral</p>

¹ 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.



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<p>Referral Tracking:</p>	<p>Referrals are initiated same-day during the screening encounter (or via internal referral) via BenefitsCal application assistance for CalFresh enrollment (California’s SNAP/food stamps program). Member Services maintains a checklist for each patient and performs up to three outreach attempts (phone/text) for non-responsive patients. For San Francisco County patients who authorize information sharing, limited outcome status information is available through the San Francisco-Marín Food Bank’s Oasis Insight system. NEMS also refers eligible patients to food bank resources (primarily the San Francisco-Marín Food Bank) as a second pathway to address food insecurity. Due to limitations in BenefitsCal, comprehensive verification of actual benefit receipt is not currently possible for most patients; however, all positive screens receive pre-screening, same-day assistance, outreach attempts, and annual rescreening as safety-net mechanisms.</p>

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- 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.



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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	Expanded internal outreach to Medi-Cal eligible patients during phone calls and in-person contacts to proactively promote CalFresh	Expanded community outreach targeting Medi-Cal eligible patients to promote CalFresh enrollment in conjunction with food insecurity screening.



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	enrollment in conjunction with food insecurity screening.	
Date of Implementation	1/1/2025	3/1/2024
Results observed, including any impact on POF	<p>This effort contributed to an increase in assisted CalFresh applications from 1,552 in 2024 to 1,663 in 2025. Member Services staff observed that during routine phone calls, patients became increasingly comfortable discussing food insecurity, often sharing concerns they had previously been reluctant to disclose. For example, patients who once gave brief answers or declined to respond began saying things like, "Groceries have been really tight lately" or "I didn't realize I could still qualify for food help while on Medi-Cal," which frequently led to immediate CalFresh application assistance during the same call. This shift was especially meaningful given the cultural dynamics of NEMS' large immigrant patient population, including many Chinese and Vietnamese patients, for whom discussing financial hardship or</p>	<p>Member Services participated in 26 community outreach events, contributing to an increase in assisted applications from 2,073 in 2024 to 2,245 in 2025. Staff observed that patients at these events were often much more open about discussing food insecurity. This was especially significant given the cultural stigma around sharing personal hardships among NEMS' large immigrant patient population, particularly among Chinese and Vietnamese patients, who may be more hesitant to discuss financial struggles or life difficulties with strangers. Several individuals approached the outreach table and began talking about their food situation unprompted, sharing comments such as, "I've been struggling to keep enough food in the house," or "I didn't want to bring this up at the clinic." These interactions made it easier for staff to conduct screenings and provide enrollment assistance on the spot.</p>



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	<p>personal struggles with strangers may carry stigma or discomfort.</p>	<p>To increase community awareness and participation, Member Services regularly promoted outreach events through NEMS' social medial channels ahead of each event. Posts informed community members of the specific dates and locations where staff would be available to assist with CalFresh and other public benefit program enrollments, as well as answer questions related to eligibility, application processes, and available resources. This outreach strategy helped build trust and encourage community members to seek assistance in a more informal and accessible setting outside of the clinical environment.</p>
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4. Data Submission – Performance Metrics

*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

	<p>% screened for social needs</p>	<p>% of positive screens linked to services</p>	<p>% of linked patients with closed-loop referral</p>
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Population	<input type="checkbox"/> Population of Focus only <input checked="" type="checkbox"/> All patients	<input type="checkbox"/> Population of Focus only <input checked="" type="checkbox"/> All patients	<input type="checkbox"/> Population of Focus only <input checked="" type="checkbox"/> All patients
Reporting Period (share the date range for the data reported, can be 6-months or 12-months)	12 Months	12 Months	12 Months
Numerator	74794		
Denominator	93684		
Rate (Auto-Calculated)	79.8		
Frequency of review	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Biannually <input checked="" type="checkbox"/> Annually <input type="checkbox"/> Other:	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Biannually <input checked="" type="checkbox"/> Annually <input type="checkbox"/> Other:	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Biannually <input checked="" 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	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully	<input type="checkbox"/> Data unavailable <input type="checkbox"/> EHR limitation <input type="checkbox"/> Workflow not fully



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	implemented <input type="checkbox"/> Other (please describe): ____	implemented <input type="checkbox"/> Other (please describe): ____	implemented <input type="checkbox"/> Other (please describe): ____
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