



June 2026 Learning Communities

Behavioral Health Implementation in Practice: Building Safe, Operational & Reportable Workflows

PART 1 of 2

June 1 – June 2, 2026 • 2 hours



Welcome

*While we're waiting, please rename yourself.
We'll begin at 2 minutes past the hour.*

RENAME YOURSELF

- 1** Click the Participants icon
- 2** **Hover** over your name & click rename
- 3** **Add** your name, pronouns, and organization
- 4** **Click** OK





**Please no acronyms*

ON PHONE AUDIO?

Here's how to connect.

- 1** Find your participant ID in the top-left of your Zoom window.
- 2** Press #number# (e.g., #24321#) to connect.
- 3** You'll see: "You are now using your audio for your meeting."

Housekeeping Reminders

	Mute	We'll mute lines during the presentation to prevent background noise.
	Questions	Submit questions using the chat feature.
	Slides + Recording	Slides and recording will be posted to PopHealth+ after the session.
	Tech Issues	Private chat Kathleen Figoni for assistance.

Agenda

- **Program Updates:** Where the Cohort Stands
- **BH Integration:** Patterns Identified
- **Evidence-Based Screening:** Foundations & Safety
- **BH Template Walkthrough**
- **Data Deep Dive**
- **Exemplar Practice:** Doctors on Duty
- **Social Health Bridge:** Transferable Skills
- **Live Troubleshooting**
- **Close & Next Steps**

Continuing Education Credit

In support of improving patient care, the Learning Center has partnered with the California Primary Care Association to provide continuing education for the healthcare team by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC).

To receive credit, you will need to fill out the evaluation that will be shared at the end of the session.

Introduce Yourself in the Chat

1	Your Name	Type your first and last name
2	Your Role	E.g. Medical Director, Care Manager, Medical Assistant
3	Your Organization	Practice Name
4	What are you most proud of from EPT?	Share something your practice built, changed, or learned

Meet Your Program Team

*The people running today's session – and walking alongside you through the final stretch of EPT.
We're here to help you finish strong!*



Tammy Fisher
MPH

Chief Program Officer

tfisher@pophealthlc.org



Mary Deane
MPH

Director of Programs

mdeane@pophealthlc.org



Monica Dedhia
LCSW

Senior Program Manager

mdedhia@pophealthlc.org



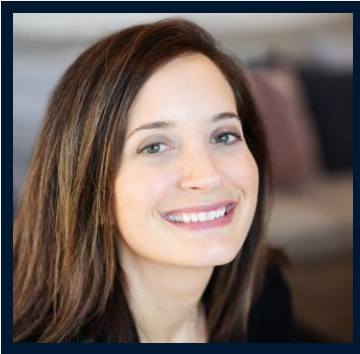
Kathleen Figoni
MS-HCA

Senior Program Manager

kfigoni@pophealthlc.org

Today's Facilitators

The people running today's session



Elizabeth Horevitz

PhD, LCSW

Behavioral Health

Elizabeth.horevitz@gmail.com



Mary Deane

MPH

Director of Programs

mdeane@pophealthlc.org



Monica Dedhia

LCSW

Senior Program Manager

mdedhia@pophealthlc.org



Kathleen Figoni

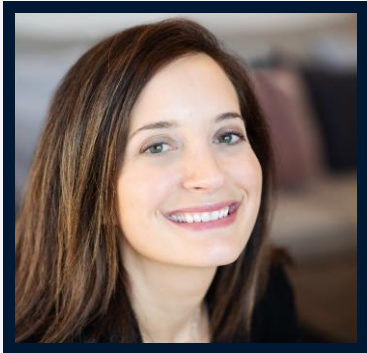
MS-HCA

Senior Program Manager

kfigoni@pophealthlc.org

Meet Your Subject Matter Experts

These clinicians are supporting this learning community – and we're so deeply grateful for their expertise & partnership!



Elizabeth Horevitz

PhD, LCSW

Behavioral Health



Marianna Kong

MD

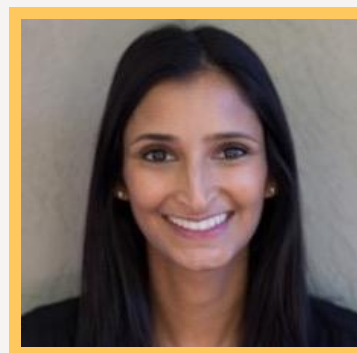
Adults with
Chronic Conditions &
Preventative Needs



Nathana Lurvey

MD

Pregnant People



Neha Gupta

MD

Adults with
Chronic Conditions &
Preventative Needs



Roberto Rodriguez

MD, MPH

Children & Youth

Learning Objectives

1	Workflow Foundations	Describe the core components of a complete BH workflow: roles, screening frequency, triage protocol, suicide risk assessment (C-SSRS, clinical interview, or 988 hand-off), referral pathways, training plan, and documentation.
2	SUD Workflow Essentials	Apply motivational interviewing, stage-of-change assessment, and SBIRT to SUD screening and follow-up, including harm reduction and MAT where applicable.
3	Performance Metrics	Report baseline and performance values for the six EPT BH measures (3 depression + 3 SUD) — numerator, denominator, reporting period, review frequency, and valid justifications when unable to report.
4	Data Validation	Double-check numbers and reporting periods: confirm baseline and performance periods do not overlap, each covers at least 6 months, and the performance period falls within the EPT program.
5	Milestone Readiness	Apply EPT reviewer rubric expectations — what reviewers look for and what causes a submission to be "Not Accepted" — to strengthen your submission.
6	Next Step	Identify at least one workflow, documentation, or reporting improvement to implement before the November submission cycle — with a target date and a way to measure the result.

What's one *Behavioral Health Workflow question* You hope to have answered today?

1

Type Your Answer

Write your response in the chat box. Be honest — no one can see it yet.

2

Don't Hit Enter

Hold off! Wait until everyone has finished typing before you send.

3

3... 2... 1... Send!

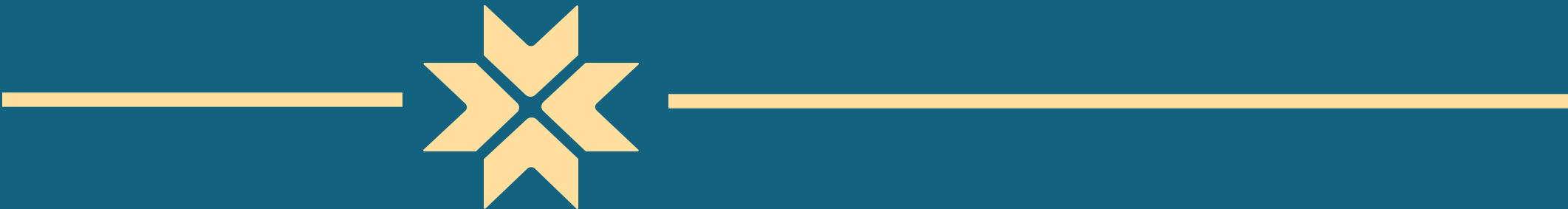
When the facilitator counts down, everyone hits Enter at the same time.

4

Read & Discuss

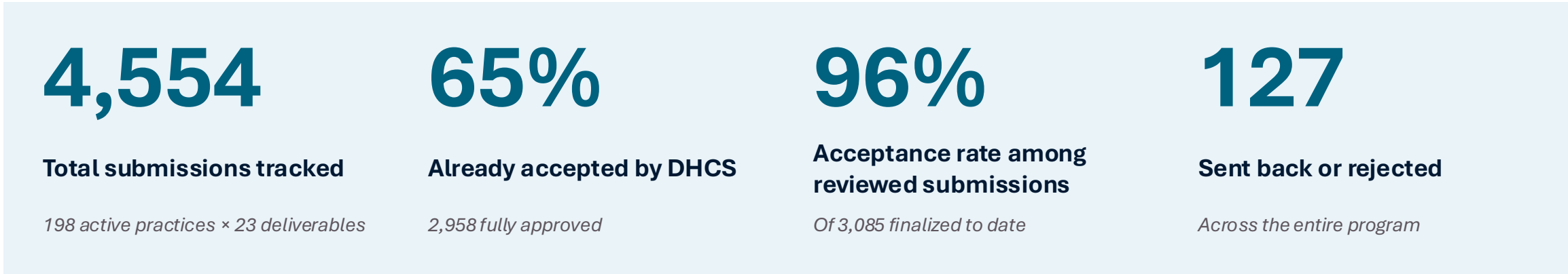
Watch every answer flood in at once. Then talk about what you see.

Program Updates: Where the Cohort Stands



OVERALL TRACK RECORD

96% acceptance rate among reviewed submissions



STATUS MIX OF ALL 4,554 SUBMISSIONS

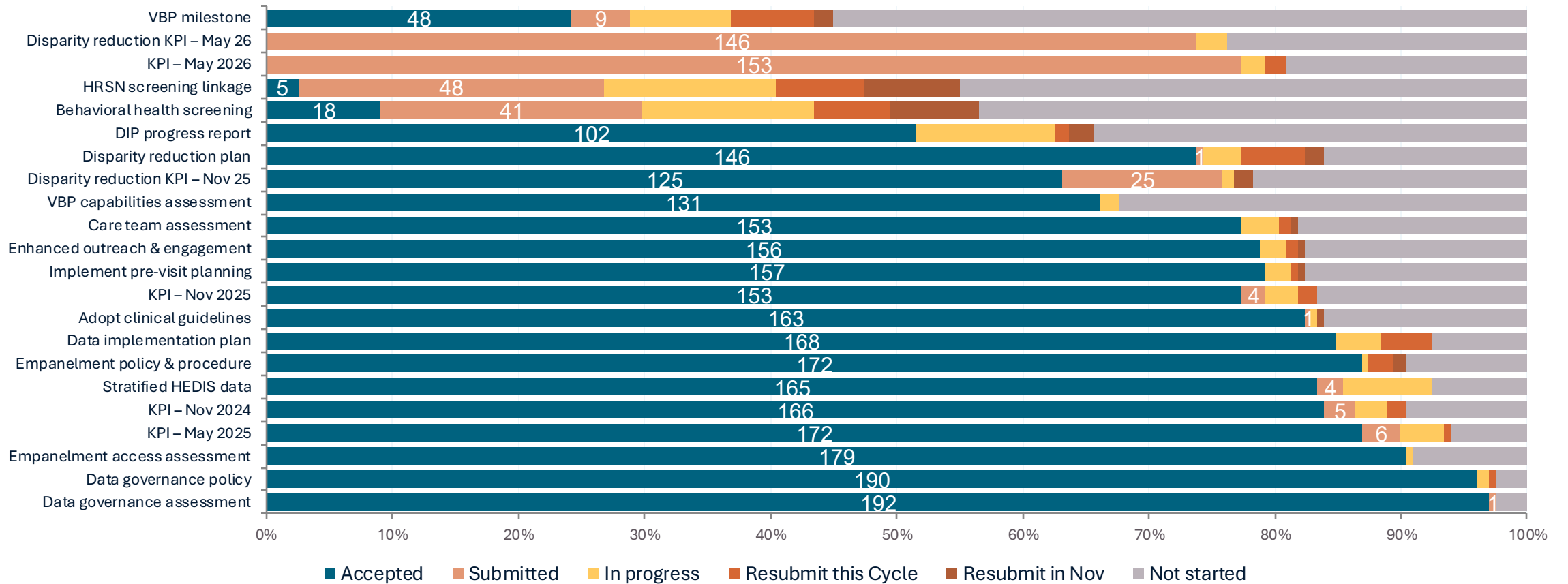


Read: Most submitted deliverables have ultimately been accepted following review, feedback, and revision

***As of Friday, May 29, 2026**

STATUS BY DELIVERABLE TYPE

Older cycle deliverables are mostly accepted; current cycle items are still being actively reviewed by subject matter experts



***As of Friday, May 29, 2026**

BH Milestone submissions:

85

Submissions
Received

12

Resubmit
Next Cycle

86

Not Started

HRSN Milestone submissions:

82

Submissions
Received

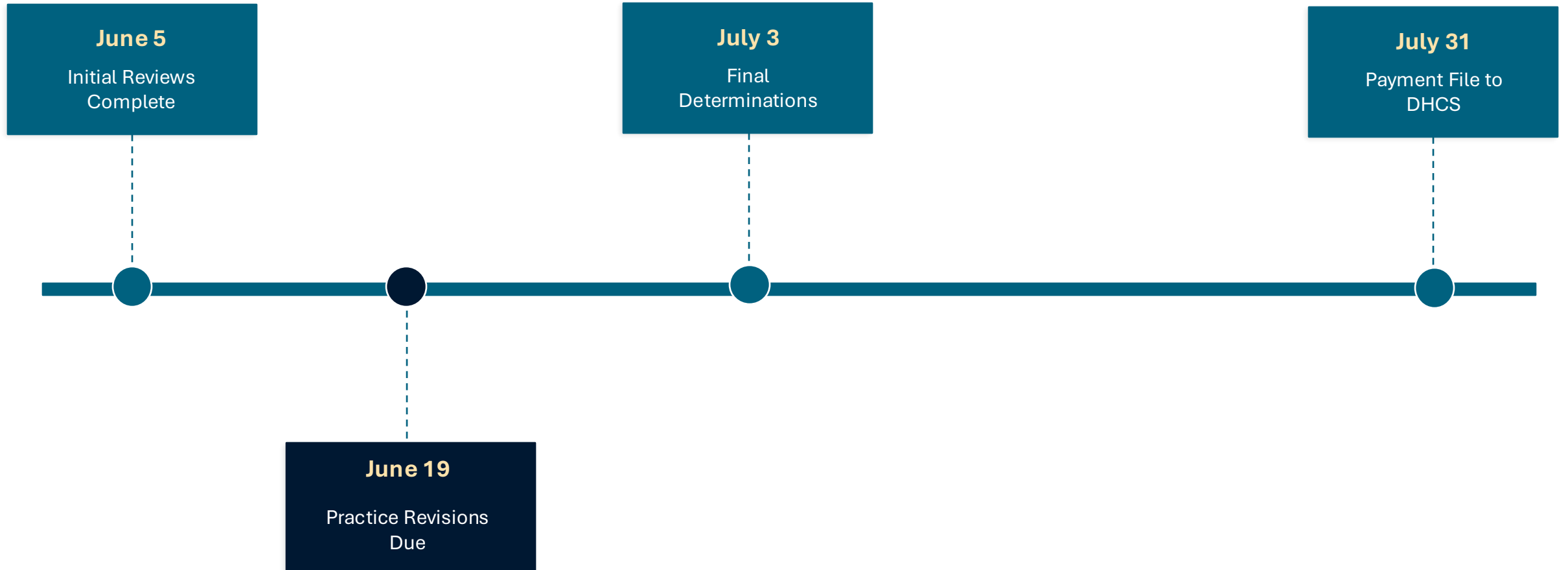
14

Resubmit
Next Cycle

89

Not Started

Review Cycle Timeline: Behavioral Health & Health Related Social Needs



Behavioral Health Integration: Patterns Identified



CHAT ACTIVITY

Drop in the chat:

**What's one BH workflow
challenge your practice
is still working on and why?**

CAPTURING RESPONSES

We'll come back to them during Live Troubleshooting at the end of the session.

What we're seeing across submissions

If any of these sound familiar — you're in the right place.

1	Unclear Protocols	Protocols exist on paper but stop at screening – there is no defined plan for what happens when a patient screens positive, particularly for suicide risk or crisis. This is a safety issue, not just a documentation issue.
2	Data Doesn't Tell the Full Story	Many practices have real barriers to data capture – EHR limitations, workflow gaps, coding issues. We see this. What we need is your interpretation: what does your data show, and what explains it?
3	Automatic SUD Referrals Without Engagement	Automatically referring patients to SUD treatment without assessing readiness, motivation, or stage of change often results in low follow-through and poor patient engagement.
4	Data Doesn't Match the Narrative	Implementation is described as strong, but the data tells a different story. Both need to be true at the same time.
5	Over-Response to Positive Screens	Treating any positive suicide screening as an automatic emergency (e.g., sending all PHQ-9 scores >20 to the ED or calling 911 for any positive item 9 without further assessment). This is not patient-centered and may discourage disclosure.

Evidence-Based Screening: Foundations & Safety



The Foundation of BH Screening in Primary Care

First Principle

Do No Harm.

Screening without trained staff, clear workflows, or a response plan can unintentionally create harm, increase stigma, or reduce trust and disclosure.

*Always ask if the patient *wants a referral* – automatic referrals are not patient-centered and will result in low follow-through rates.*

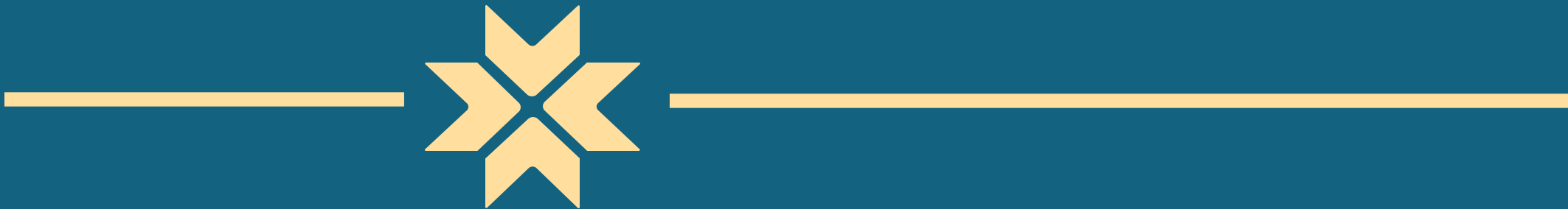
Screening tools are designed to identify risk — not diagnose. Clinicians interpret results in context and conduct further assessment.

A positive screen is the beginning of a conversation, not an automatic referral.

Stigma, judgement, and fear will reduce disclosures and adherence. Empathy (and skillfully conveying it) is the antidote to stigma and will increase disclosures and adherence.

Empathy conveyance: explaining the reason for screening, appreciating and normalizing disclosures, asking permission to share information, asking patient if they *want* a referral.

Walking Through the BH Template



The four documents that anchor this section

Everything in the Template Walkthrough and the rubric guidance referenced throughout this deck comes from these two source documents. Bookmark them.

1. EPT BH Screening & Linkage Template (Rev. April 2026)

Defines the milestone, the six required metrics (3 depression + 3 SUD), workflow components, screening tools, and what counts as “linked to services.” Final responses go in the EPT Deliverable Portal. Due November 2026.

pophealthlearningcenter.org/wp-content/uploads/2026/04/EPT_BH_Screening_Linkage_Template_Final_V2.pdf

2. EPT BH Screening & Linkage Rubric (Rev. April 2026)

The scoring guide reviewers use. Spells out Accepted vs. Not Accepted criteria for each question, including required workflow elements (roles, triage/crisis protocol, C-SSRS for SI, closed-loop tracking, MI/stage-of-change for SUD, training plan).

pophealthlearningcenter.org/wp-content/uploads/2026/04/20251216_Behavioral-Health-EPT-Rubric-1.pdf

3. EPT Health-Related Social Needs (HRSN) Screening & Linkage Template (Rev. April 2026)

Defines the HRSN milestone requirements, required screening and referral measures, implementation planning expectations, workflow documentation requirements, and reporting instructions for baseline and performance periods. Final responses are submitted through the EPT Deliverable Portal. Due November 2026.

<https://pophealthlearningcenter.org/wp-content/uploads/2026/03/EPT-Health-Related-Social-Needs-Deliverable-Template-v2.pdf>

4. EPT Health-Related Social Needs (HRSN) Screening & Linkage Rubric (Rev. May 2026)

The scoring guide reviewers use to evaluate HRSN submissions. Defines Accepted vs. Not Accepted criteria for workflow design, screening implementation, referral processes, closed-loop referral tracking, action plan completion, measure reporting, and sustainability planning.

https://pophealthlearningcenter.org/wp-content/uploads/2026/03/20251219_Health-Related-Social-Needs-EPT-Rubric-v2.pdf

Questions? Email info@pophealthlc.org.



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

Implement Behavioral Health Screening & Linkage Template

Milestone Description

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. Demonstrate how processes are working through a report of the following:

Depression Screening Components

- Percent of population of focus screened with PHQ-2/PHQ-9 at least once annually (6-12-month look-back)*
- Percent of patients with positive screening for depression (as indicated by 10 or higher OR clinical assessment) who are linked to services as evidenced by one of the following (within 30 days of positive screen)*
 - Outpatient, telephone or e-visit for follow-up for depression/behavioral health documented in the chart
 - Depression case management encounter
 - Behavioral health encounter (assessment, therapy, collaborative care, medication management)
 - Documentation of encounter for exercise counseling, sleep hygiene, behavioral activation or other self-management
 - Dispensed antidepressant medication, as evidenced by prescription being filled
 - Documentation of a negative full-length depression screening on the same day as a positive screen on a brief screening tool (i.e., a negative PHQ-9 as a follow-up to a positive PHQ-2)
 - Repeat screen within 30 days

What to know

This page defines the full scope of the BH milestone. It covers both depression (PHQ-2/PHQ-9) and SUD screening, plus the requirement for closed-loop referrals.

What to do

Read through each component and flag any areas where your practice does not yet have a documented workflow in place. Take note of the type of interventions that meet the linkage criteria and how these fit in your protocol.



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

Instructions

This document serves as a structured guide for implementing and tracking behavioral health screenings, triage, and service linkages using PHQ-2/PHQ-9 and validated SUD screening tools. This template is provided for reference only and outlines the required components of your submission. Final responses must be submitted via the EPT Deliverable Portal. If you have questions, email info@pophealthlc.org. **As a reminder, this deliverable is due by the November 2026 submission cycle.**

Documentation in the Template

- Practices must implement standardized depression screening and follow-up using PHQ-2/PHQ-9, and implement substance use disorder (SUD) screening and linkage. This includes:
 - Establish baseline screening values
 - Clear workflows for staff roles and screening frequency
 - Data documentation and storage processes
 - Triage and referral protocols
 - Tracking of closed-loop referrals
 - Submission of progress data for key metrics

Part 1: Baseline Data

Practices will evaluate their baseline data of current behavioral health screening & linkage activities to assist in developing their workflows and implementation plans. EPT practices should use calendar year 2024 to establish the baseline values. EPT Practices with Pregnant People and/or Children & Youth populations will report on their specific Population of Focus (PoF); Adult PoFs may choose to report on all patients or their specific PoF. For each metric:

- Enter the **Numerator** and **Denominator**
- Enter the baseline reporting period timeframe

What to know

This is the submission guide. It lists the six required components and confirms that final responses go through the EPT Deliverable Portal - not this document. The November 2026 deadline applies.

What to do

Review the six components and identify which ones you have already completed and which still need work before submission.

TEMPLATE WALKTHROUGH · PART 1: BASELINE DATA TABLE



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

Denominator	# of PoF patients with ≥1 visit during the measurement period	# of positive PHQ-2/PHQ-9 screens	# of referrals for depression follow-up	# of PoF patients with ≥1 visit during the measurement period	# of positive SUD screens	# of referrals for SUD follow-up
-------------	---	-----------------------------------	---	---	---------------------------	----------------------------------

*Linked to services is defined as an intervention, referral, or follow up action within 30 days of a positive screen

A. Depression Screening & Linkage Baseline Data

	Percent of PoF screened with PHQ-2/PHQ-9	Percent of positive screens linked to services	Percent of linked patients with closed-loop referral
Numerator			
Denominator			
Baseline Reporting Period (Can be 6-months or 12-months, use the same reporting			

What to know

You will enter 2024 data here as your baseline. The table covers all six metrics - three for depression and three for SUD. If you cannot report a metric, you will indicate why.

What to do

Pull your 2024 data for each metric and enter the numerator, denominator, and reporting period. Use the same reporting window across all six BH metrics.

Who goes in the denominator — and why it matters

This is one of the most common points of confusion in BH submissions. Read this before entering your numbers.

The denominator rule

Per the EPT BH Screening & Linkage Template (Rev. 4/22/26), the denominator is “# of PoF patients with ≥ 1 visit during the measurement period.”

We recommend leveraging HEDIS-aligned exclusions; review current HEDIS specifications when building reporting workflows.

HEDIS alignment

EPT’s screening metric aligns with HEDIS logic: the denominator is patients with at least one eligible encounter, not the total panel.

If your EHR pulls total panel size, you need to filter to active patients with a visit in the measurement window.

Common mix-up: percent positive

“Percent positive” means: of everyone who was screened, how many screened positive? It is NOT a percent of all patients.

Example: 80 screened, 12 positive = 15% positive screen rate. That 15% is out of those screened — not out of your PoF.

Community prevalence for depression is 15–20%. If your positive rate is 1–2%, that usually signals a screening threshold, tool, or documentation issue.

TEMPLATE WALKTHROUGH · PART 2: DEPRESSION WORKFLOW



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

A. Depression Screening (PHQ-2/PHQ-9)

Workflow Component	Response
Who Screens	<input type="checkbox"/> MA <input type="checkbox"/> PCP <input type="checkbox"/> BH Staff <input type="checkbox"/> Other: _____
Screening Frequency	<input type="checkbox"/> Every visit <input type="checkbox"/> Annually <input type="checkbox"/> At well visits <input type="checkbox"/> Other: _____
Administration Method	<input type="checkbox"/> EHR form <input type="checkbox"/> Patient portal <input type="checkbox"/> Paper-based <input type="checkbox"/> Verbal <input type="checkbox"/> Tablet <input type="checkbox"/> Other: _____
Triage/Intervention Protocols**	<i>Upload or briefly describe protocol. Indicate tiers or levels of response based on screening result. Must include interventions offered, as well as risk assessment and response, as well as referral steps.</i>
Data Storage	<input type="checkbox"/> Structured EHR fields <input type="checkbox"/> Manual tracking <input type="checkbox"/> Population Health Platform <input type="checkbox"/> Other: _____
Referral Process	<i>Describe available MH/depression resources in your service area, how these referrals are initiated, tracked, and how you determine if service was received.</i>

Rev. 4/22/26

9

What to know

This section documents how your practice operates - who screens, how often, using what method, and what happens after a positive result. Triage and referral protocols must be described in detail.

What to do

Complete every row. Triage/Intervention Protocols must include escalation steps, referral pathways, and a clear workflow for PHQ-9 item 9 scores if above zero.

Your workflow type drives what counts as linkage and closed-loop

Depression

Documented Intervention (Linkage) (Metric 2): A documented **intervention, referral, or follow-up action** within 30 days of a positive screen. Examples: warm handoff to on-site BH clinician, brief intervention, exercise counseling / sleep hygiene / behavioral activation, antidepressant prescription filled, peer support, digital mental health enrollment, self-management plan when services declined.

Onsite BH: Provider delivers brief counseling and offers BH referral with patient consent, completes warm hand-off to onsite Clinical Social worker

Non-Integrated BH: Provider delivers brief counseling, medication evaluation, self-management plan. Referral declined. Schedules follow-up within 30 days

What to document for linkage: what was offered, what the patient agreed to, the action taken.

Closed-loop (Metric 3): A referral tracked to a Known Closure per CalAIM. Easier in integrated settings, the follow-up note in the same EHR closes the loop.

Known Closure reasons: *Services Received · Service Provider Declined · Unable to Reach Member · Member No Longer Eligible · Member Declines · Authorization Denied.*

Substance Use

Documented Intervention (Linkage) (Metric 2): A documented **intervention, referral, or follow-up action** within 30 days. Includes: SBIRT-aligned approach addressing readiness for change, referral to BH/SUD, MAT as appropriate, Harm reduction, care management referral, and self-management plan when referrals are declined.

Onsite BH: Delivers MI structured SBIRT consistent with readiness for change, refers to ECM with patient consent; conducts warm hand-off with onsite CHW.

Non-Integrated BH: Evaluates readiness for change, patient declines referral and presents with low readiness. Engages in collaborative self-management plan & schedules follow up in 30 days

What to document for linkage: the intervention delivered, the referral, what was offered, the patient's response or stage of change.

Closed-loop (Metric 3): Requires active tracking to a Known Closure. Practices may use a tiered approach (e.g., FindHelp, partner agreements). For SUD, 42 CFR Part 2 may limit closure data, document patient-reported engagement when bi-directional confirmation isn't possible.

Known Closure reasons: *Services Received · Service Provider Declined · Unable to Reach Member · Member No Longer Eligible · Member Declines · Authorization Denied.*

⚠ Two metrics, not one: “Linked to services” (Metric 2) and “closed-loop referral” (Metric 3) are separate measures with separate numerators. A referral can count as linkage even without closed-loop confirmation. Closed-loop also counts when the closure reason is “Unable to Reach” or “Member Declines” It’s about tracking the loop to a Known Closure, not about confirming services received.



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

3. Evidence of Implementation

To meet this milestone, your practice must implement at least two **new actions** (since the start of EPT) focused on depression screening and follow-up using the PHQ-2/PHQ-9 and substance use disorder (SUD) screening and linkage for your selected PoF. Practices should report at least one action for depression and one action for SUD screening and linkage to care. For each action, include the date it was launched (i.e., when it began being used with patients), the number of patients impacted, how success was measured, and any observed outcomes. Small-scale pilots or PDSA cycles are acceptable as evidence.

Notes:

- Results may be qualitative (e.g., staff feedback on ease of workflow, patient engagement) or quantitative (e.g., screening and referral rates, reduced missed appointments). 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 behavioral health concerns”—that illustrate the real-world impact of implementation with specific, concrete examples.

	Action 1	Action 2
Implemented Action		
Date of Implementation		
Results Observed		

What to know

You must document at least two new actions taken since EPT began - one for depression and one for SUD. Results can be qualitative or quantitative, but must be specific and concrete.

What to do

Identify your two actions, the date each launched, and what outcomes you observed. Small-scale pilots and PDSA cycles count as evidence. Ensure the data and results observed are aligned with clear and specific narrative descriptions.

These are the most common misunderstandings

We'll show concrete chart-note examples of each on the next two slides.

✓ What counts
Documented positive screen with a corresponding intervention or follow-up note
Validated tool used: PHQ-2/PHQ-9 or EPDS (for Pregnant People) and a validated SUD tool (AUDIT-C/DAST-10, ASSIST, TAPS, 4Ps Plus, NIDA Quick Screen, or CRAFFT for adolescents)
Warm handoff with documentation or referral with confirmation of contact
Evidence of closed-loop follow-up — did the patient connect with services?

✗ What doesn't
"We screen everyone" with no documentation of results or outcomes
Referral to a resource without any follow-up or confirmation
Noting a patient declined without documenting what was offered
A high-level workflow description with no SOP or evidence of implementation

⚠ Important tool reminders: For SUD, alcohol-only tools (e.g., AUDIT-C) must be paired with a drug-screening tool (e.g., DAST-10) or replaced by a combined tool (ASSIST, TAPS, NIDA Quick Screen). Screening frequency aligns with annual screening guidance, not every visit.

Documentation Examples: Depression

The same patient encounter, documented three different ways. Only the right column counts for linkage.

✗ NOT ENOUGH DETAIL

Note in the chart:

“Patient screened positive for depression. Referral provided.”

Why this is weak:

No PHQ score · no provider discussion · no patient acceptance/decline · no follow-up plan · no intervention.

✓ STRONG INTERVENTION DOCUMENTATION

Note in the chart:

“PHQ-9 score = 14. Provider reviewed results with patient and discussed therapy and medication options. Patient interested in therapy referral. Warm handoff completed to onsite BH clinician. Follow-up visit scheduled in 4 weeks.”

Why this works:

Score · Provider discussion · Patient preference/consent · Intervention & linkage · Follow-up plan.

✓ ALSO COUNTS — PATIENT DECLINES REFERRAL

Note in the chart:

“PHQ-9 score = 11. Provider discussed therapy referral and coping strategies. Patient declined referral at this time but agreed to follow-up in 1 month.”

Why this counts: Score documented · Intervention occurred (discussion of options + coping strategies) · Patient preference respected · Follow-up plan in place. A declined referral, when documented well, is patient-centered care and still counts as linkage.

The pattern: Strong documentation includes (1) the score or screen result, (2) what the provider discussed, (3) what the patient agreed to or declined, (4) the intervention or referral taken, and (5) the follow-up plan. Per the EPT Rubric, a documented self-management plan when services are declined counts as linkage.

Documentation examples: SUD

Brief intervention, MI, and closed-loop tracking are what reviewers look for in SUD documentation.

✗ NOT ENOUGH DETAIL

Note in the chart:

“Positive SBIRT. Resource sheet provided.”

What’s missing:

- No specific validated tool or score – SBIRT is NOT a screening tool, it is an evidence-based approach
- No actual intervention documented — resource handoff is not an intervention
- No patient engagement, readiness, or preferences
- No referral tracking
- No confirmation of linkage

✓ STRONG INTERVENTION DOCUMENTATION

Note in the chart:

“DAST-10 score = 5 indicating moderate risk for stimulant use. Provider discussed substance use concerns with patient using motivational interviewing techniques. Patient declined a referral to outpatient SUD counseling, and reported thoughts about reducing use (contemplative stage). Provider discussed self-management plan for patient to track triggers leading to use and alternative coping strategies. Provider scheduled follow up appt in 30 days.”

What this demonstrates:

- Validated tool used with score
- Brief intervention with MI documented
- Referral discussed with patient response
- Closed-loop follow-up completed and documented

Reviewer note: Per the EPT Rubric Q2B, SUD documentation should reflect motivational interviewing, assessment of readiness for change, and stage-matched intervention. Harm reduction services, MAT initiation, and documented self-management plans (when services are declined or unavailable) all count as linkage.

A brief conversation counts.

If you documented it.

What counts as a documented intervention

- ✓ A brief motivational conversation documented in the chart
- ✓ Provider discussion of next steps and patient response, noted in the visit
- ✓ Warm handoff to an on-site BH clinician, documented
- ✓ Referral with follow-up confirmation that the patient connected
- ✓ Exercise counseling, sleep hygiene, or self-management plan documented in the note
- ✓ Prescription filled for antidepressant medication
- ✓ Referral to care management, documented

Why practices miss this

Most practices are already doing the clinical work. The gap is documentation — the conversation happened, but nothing in the chart says so.

If a provider talked through options with a patient and it is not in the note, it does not count. The note is the evidence.

The fix:

Add a brief structured note template or dot phrase for BH follow-up. Even one sentence — “Patient screened positive; provider discussed referral options; patient declined at this time” — is enough to document an intervention.

The same required elements — built differently at different resource levels

FQHC · With CHW Resources

1. MA administers PHQ-9 at intake using empathetic scripting; result flags in EHR
2. Score ≥ 10 **OR** clinical judgement: MA flags provider. Provider engages brief counseling and offers linkage to a CHW for further support
3. Provider conducts warm handoff to CHW within same visit
4. CHW documents patient preference and referral status
5. BH coordinator follows up within 5 business days
6. Closed-loop confirmation documented in chart

Small Private Practice · Limited Resources

1. MA administers PHQ-9; paper or EHR based
2. Score ≥ 10 **OR** clinical judgement: MA places sticky on chart **OR** sends message to provider
3. Provider reviews at visit; offers brief counseling and referral options, asking what the patient wants
4. Provider documents what was offered and patient response
5. Front desk schedules follow-up in 4 weeks
6. Follow-up visit note documents whether patient connected with resources to close the loop

ACTIVITY

What's missing here?

“

BLUE CLINIC

We screen all patients for depression at every visit using the PHQ-9. If a patient screens positive, the provider discusses resources with them and a referral is made if appropriate. If patient screens positive for SI, an ER referral is auto-generated. We have seen improvement in our screening rates.

UNMUTE · DROP IN CHAT

What would need to be added or changed to make this submission consistent with best practices?

Think About: Patient-centered screening approaches, documented outcomes, who does what, evidence of follow-up, risk response plan, screening frequency.

HERE'S WHAT WAS MISSING

What a Complete Submission Includes

The four things reviewers look for – every time.

01 Documented outcomes

Every positive screen has a corresponding note — what was offered, what the patient said, what happened next.

02 Who does what

Named roles, not job categories. Who administers, who reviews, who follows up — and what happens when that person is out.

03 Evidence of follow-up

Closed-loop documentation: did the patient connect with services? Was there a follow-up visit or call? Is it in the chart?

04 Risk response plan

There is a clear, tiered response by risk. A positive PHQ-9 item 9 doesn't automatically require ED referral. Per the EPT Rubric, conduct additional risk assessment (C-SSRS, clinical interview, or 988 hand-off) and follow the clinic's suicide risk protocol — not an improvised reaction.

IMPORTANT

If the submission can't answer all four – it's not complete yet.

Depression & SUD Tiered Response

PHQ-2 / PHQ-9 Protocol — Any non-zero score requires an empathic clinical conversation

TIER 1 — NEGATIVE

PHQ-9: 0–4 | PHQ-2 negative

Low / No Risk

- No immediate intervention required
- Reinforce availability of BH services
- Rescreen annually or sooner if clinically indicated
- Brief empathic acknowledgment from MA

TIER 1 — LOW/NO RISK

Non-zero score, below threshold

Early / Minimal Use

- Brief MI-based conversation with provider
- Assess readiness for change (stages of change)
- Optional resources
- Reassess at next visit
- No referral required unless requested

TIER 2 — MILD

PHQ-9: 5–9

Mild Symptoms

- Provider reviews and briefly discusses with patient
- Ask patient what support would feel helpful
- Education on sleep, exercise, stress management
- Schedule follow-up appointment

TIER 2 — MILD

AUDIT-C: ≥3W / ≥4M | DAST: 1–2 | CRAFFT: 1-2

Deliver Intervention

- Structured SBIRT brief intervention & assess readiness for change
- Collaborative goal-setting with patient
- Ask patient what they want before referring
- Offer BH / SUD counseling referral
- Initiate closed-loop referral tracking
- Follow-up within 1–4 weeks

TIER 3 — MODERATE

PHQ-9: 10–19

Moderate — Positive Screen

- Provider clinical interview and assessment
- Ask patient what they would like BEFORE referral
- Deliver intervention: counseling, medication evaluation, care management, BH referral, self-management, app/peer-based tools
- Closed-loop referral tracking initiated
- Follow-up within 4 weeks

TIER 3 — MODERATE

DAST: 3-5 | CRAFFT: 2-3 with impairment

Likely SUD — Positive Screen

- Notify Provider & comprehensive substance use history
- MI to support engagement & assess readiness
- Referral: outpatient/inpatient SUD treatment with patient consent; MAT if clinically appropriate
- Warm handoff preferred
- Follow-up within 1 week

TIER 4 — HIGH RISK

PHQ-9: 20–27 | Item 9 > 0

Moderately Severe / Severe

- Immediate provider notification
- C-SSRS suicide risk assessment or clinical assessment if item 9 > 0
- Patient not left alone if safety concern
- Warm handoff to on-site BH (if available)
- Safety plan + 988 Lifeline resources
- Higher-level referral or 911 if active plan/intent
- Follow-up within 24–72 hours

TIER 4 — HIGH

DAST: 6+ | CRAFFT: 3+ with impairment | Overdose Risk

Moderately Severe / Severe

- Comprehensive SUD assessment using MI & change readiness
- Evaluate higher level of care: Outpatient, Inpatient, MAT as clinically appropriate
- OD Risk: Call 911 or arrange ED transfer; Naloxone available — administer if needed
- Document all actions immediately
- Follow-up with patient, family/guardian as appropriate

Key Takeaways:

Clinical judgment always guides response level. Scores are a guide — not a diagnosis.

Always ask the patient what they would like before initiating a referral & document patient preference in the chart.

Interventions match the level of risk and patient readiness, noting that referrals may not be the first course of action.

Each tier has a clear time frame for follow up actions

Sample Quick Reference

At-a-Glance Summary for Staff



DEPRESSION (PHQ-9)

Score	Risk Level	Who Acts	Action
0-4	Negative	MA	Annual rescreen; reinforce BH access
5-9	Mild	Provider	Brief conversation/counseling
10-19	Moderate ✓ Positive	Provider + BH	Clinical interview & intervention; review referral if consent
20-27 / Item 9>0	Severe / Safety	Provider + BH + ED (if applicable)	C-SSRS; safety plan; 988; ED if needed

SUBSTANCE USE (AUDIT-C / DAST-10 / CRAFFT)

Score	Risk Level	Action
Non-zero below threshold	Low / Early Use	MI conversation; harm reduction; reassess
At threshold (see tool)	Moderate	SBIRT brief intervention; offer referral, self- management; track
Elevated (DAST 6+, etc.)	High Risk	Provider + MAT + specialist referral; warm handoff
Overdose / withdrawal / crisis	Emergency	911 / ED; naloxone; do not leave alone

Key Reminders

Always use empathic, non-judgmental language

Ask patient what they want BEFORE referring

Document every action in EHR

Scores guide — not replace — clinical judgment

SI prompts assessment and safety plan; ED only
for emergent per clinical judgement

Always evaluate readiness for change with MI
approaches



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

Part 4: Data Submission – Performance Metrics

Please complete the table below using a **6 or 12-month look-back** reporting period for the six Behavioral Health social needs metrics. EPT Practices with Pregnant People and/or Children & Youth populations will report on their specific Population of Focus (PoF); Adult PoFs may choose to report on all patients or their specific PoF. For each metric:

- Enter the **numerator** and **denominator** values.
- Indicate how frequently your team reviews this data.
- If you are unable to report a metric, leave the numerator and denominator blank and check the appropriate box under “Unable to Report.”
- The **Rate** will auto-calculate based on the numerator and denominator you enter. If you are unable to report a metric, leave the numerator and denominator blank and indicate the reason in the corresponding row of the table.

	Depression Screening Metrics			SUD Screening Metrics		
Measure	Percent of PoF screened with PHQ-2/PHQ-9	Percent of positive screens linked to services	Percent of linked patients with closed-loop referral	Percent of PoF screened for SUD	Percent of positive SUD screens linked to services	Percent of linked patients with closed-loop referral

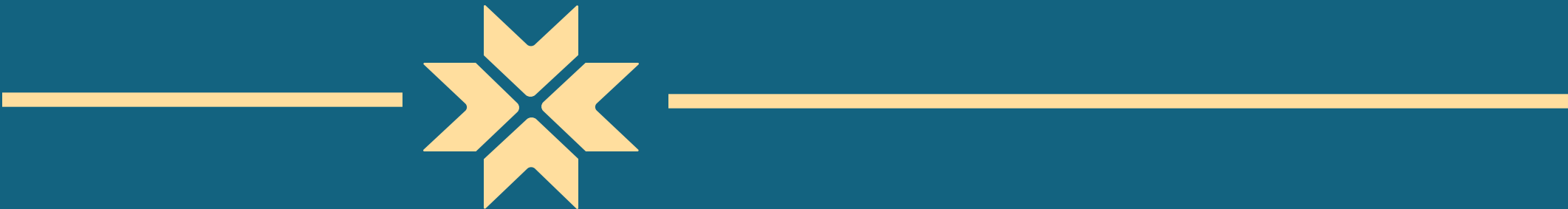
What to know

This is your current data submission - separate from the 2024 baseline. You will report using a 6 or 12-month look-back and indicate how frequently your team reviews each metric.

What to do

Enter your current numerator and denominator for all six metrics and select your reporting period. If you cannot report a metric, check the appropriate box and provide a reason.

Stretch Break



Data Interpretation



Your data and your narrative should tell the same story.

Flag

< 5%

Positive Screen Rate

Community prevalence for depression is 15–20%. A 2% positive screen rate usually signals a threshold, tool, or documentation issue — not that your patients are well. It can also be a sign that patients don't feel comfortable disclosing to your staff.

Flag

0%

Documented Intervention and/or
Linkage to Services

Zero linkage after positive screens either means no follow-up is happening, or it's happening but not being documented.

Gap



Screening Rate Up,
Linkage Flat

Screening without follow-through. The workflow ends at the screen. What happens after a positive result should be documented and operational.

Your implementation story & your data should match

“

BLUE CLINIC: NARRATIVE SAYS

Our screening rates have improved significantly, and more patients are getting linked to services.

DATA SHOWS

Screening rate:	12%
Positive screen rate:	1.8%
Linkage documented:	0 referrals
Follow-up:	not captured

The Fix: Before you submit, read your first page (data) then your last page (narrative). Do they agree?

How we interpret our data

“ CONTEXT TO INCLUDE

- EHR limitations — what tools, fields, or pulls aren't available yet?
- Coding or workflow gaps that affect numerator/denominator accuracy
- Referral tracking or closed-loop gaps
- Workflow changes or pilots underway
- Patient engagement and community barriers

QUESTIONS TO ANSWER

What does the data show?	Don't spin it
What might explain it?	Name the gap
What are we doing about it?	Pilots underway
What can plan partners help with?	Data, training, links

The Goal: Help reviewers understand the “why” behind your numbers. Don't leave gaps unexplained.

Exemplar Practice: Doctors on Duty



As Doctors on Duty presents, listen for:

One thing they built that would survive a key person leaving.

How they sequenced

What they built first — and why. The order matters.

Who owns what

Not just who does the work, but who holds it when staff change.

What their data shows

They have baseline from 2024. Real before/after.

One thing to steal

Their single most transferable recommendation for your practice.

Doctors on Duty



ABOUT US

Practice type:

Hybrid Urgent Care and Primary Care

Patients served:

Approximately 189,000 annual visits,
20,000 Assigned MediCal Lives

EPT focus area:

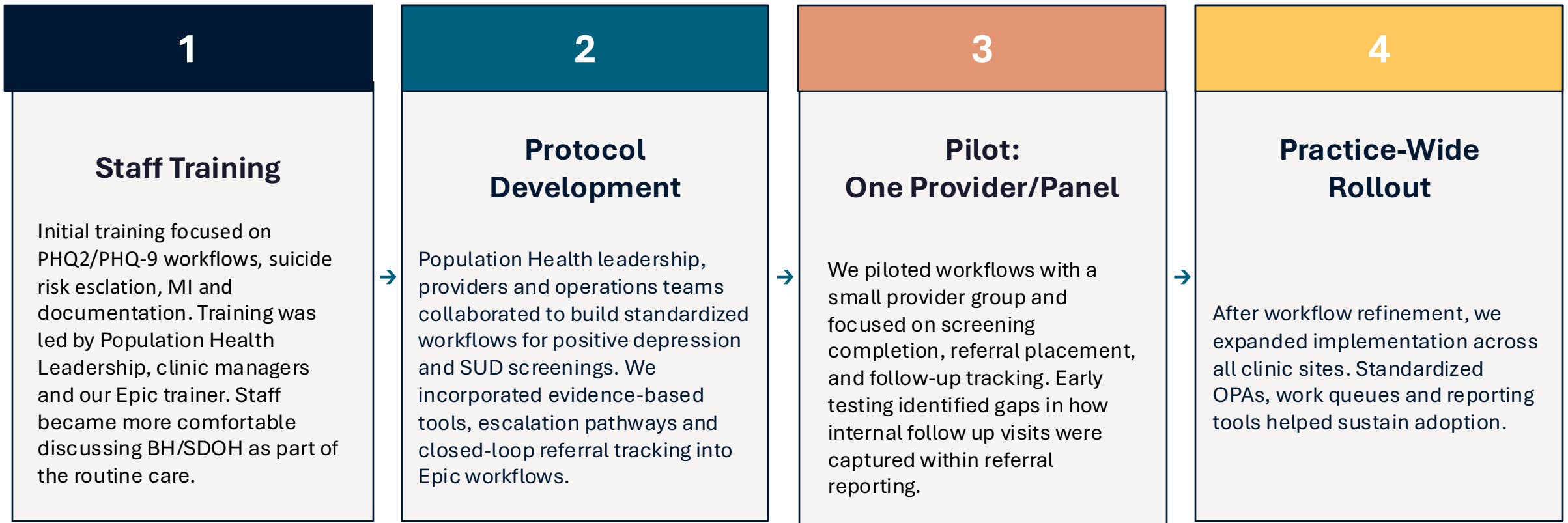
Adults with Preventative Care Needs

What we'll share today:

How workflow redesign and Epic optimization improved behavioral health follow-up and care coordination.

How We Sequenced Our Implementation

What we built first — and why the order mattered



Our Workflows & Protocols

What we built and how staff roles are defined

What did you build?

Pop Health team completes PHQ-2, PHQ-9, AUDIT-C, DAST-10, and CRAFFT screenings during pre-visit planning or MA completes at the time of visit. Positive screens trigger Epic OPAs for providers, prompting additional assessment, counseling, suicide risk evaluation when indicated and referral placement.

Patients with positive depression screenings are routed into a dedicated Epic follow-up workqueue managed by Pop Health staff to ensure outreach and follow-up within 30 days. All referrals are tracked through our 'Close the Loop' process to confirm linkage and follow-up.

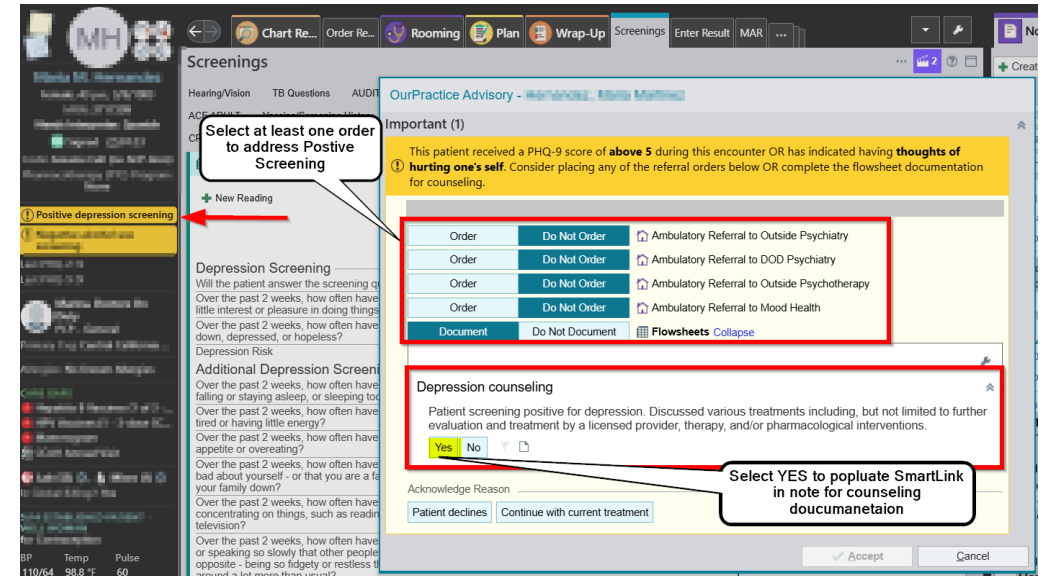
Who Does What

Population Health
Completes PVP

MA
Administers screening tools during intake (if not completed by pop health)

Providers
Reviews results, assesses interventions / referrals

Referral Coordinators
Tracks referrals and documents outcomes



What Our Data Is Telling Us

Building the foundation takes time – and data reflects that.

WHAT WE OBSERVED

Screening and follow-up workflows became more standardized across clinics. Confirmed follow-up within 30 days after a positive depression screen increased from 19.60% to 47.06%. Spanish-speaking follow-up rates improved from 43% to 52.38%.

WHAT WE LEARNED

Workflow improvements exposed gaps in reporting logic. Internal follow-up visits routed through Epic workqueues were not captured as formal 'linked to services' or 'close the loop' referrals. We also learned that reporting guideline changes significantly impacted baseline comparisons.

HOW WE'RE BUILDING FROM IT

We are optimizing Epic reporting to better capture internal behavioral health follow-up workflows, strengthening referral tracking and continuing targeted outreach for high-risk and Spanish-speaking populations.

Lessons Learned

THE CHALLENGE

What was hard? What broke down or threatened to?

- Changes to screening guidelines
- Staffing limitations
- Provider variability
- EHR reporting gaps

HOW WE WORKED THROUGH IT

What got you through? What would you do differently?

We built Epic workqueues, standardized OPAs, retrained staff and increased collaboration between Population Health, operations and Epic teams.

Frequent audits and workflow reviews helped us identify gaps quickly and refine processes in real time.

Still On Our Mind

One thing to steal — and one thing that still keeps us up at night.

ONE THING TO STEAL

Build dedicated follow-up work queues tied to positive behavioral health screenings.

This created accountability, standardized outreach, and significantly improved follow-up completion rates.

WHAT WE'RE STILL WORKING ON

Aligning operational workflows with quality reporting logic remains a challenge.

We are continuing to refine how internal behavioral health follow-up visits are captured within linkage-to-services and closed-loop referral metrics.

Question & Answers

Doctors on Duty just named something a lot of practices are wrestling with.

*Who else is in the middle of that **same challenge?***

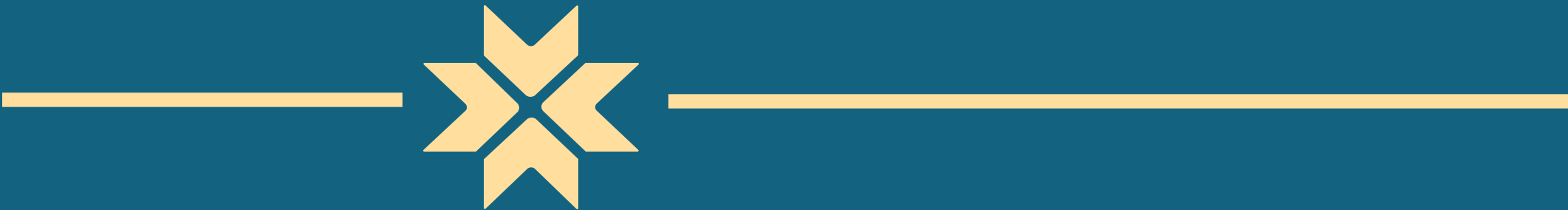
UNMUTE

Have a question for Doctors on Duty? Unmute and ask – there are no wrong questions here.

DROP IN CHAT

Prefer to type? Drop your question in the chat and we'll read it aloud.

Social Health Bridge: Transferable Skills



The Foundation you built with BH already works for HRSN.

SCREENING APPROACHES

Empathetic, non-judgmental, trauma-informed approaches apply across both BH and social needs screening. The clinical stance is the same regardless of what you're asking.

REFERRAL COORDINATION

Discuss the referral before generating it — self-determination is key. Facilitate a warm handoff. Embed this in your referral tracking and training protocol. Works for both BH and HRSN.

CaAIM INTEGRATION

Addresses BH and complex social needs together through patient-centered partners and warm handoffs. Improves closed-loop linkage across both domains — the infrastructure is shared.

What this looks like in the actual work you're already doing.

The same template areas appear in both BH and HRSN submissions.

	BH Template	HRSN Template
Training	How staff are trained on BH screening, stigma, and response protocols — including who receives training and how often it's updated.	How staff are trained on SDOH conversations, social needs screening, and referral processes — the same training infrastructure applies.
Tracking Referrals	How positive BH screens are tracked from identification through warm handoff, referral, and closed-loop follow-up confirmation.	How social needs flags are tracked from screening through resource referral and confirmation that the patient connected — same logic, same fields.
CaAIM Integration	How are warm hand-offs to ECM documented in the protocol, referral tracking and closed loop referral outcomes	How are practices using CaAIM service lines (ECM, CS, CHWs) to develop social need partnerships, warm hand-offs, referral tracking & closed loop referral outcomes

What it looks like when a practice goes deep on one social need.

North East Medical Services

HRSN Focus: Food insecurity

Our 2025 UDS data shows very high need:

- 59.2% of patients at or below 100% FPL
- 56.6% on Medi-Cal
- Predominantly low-income Asian immigrant families who often prioritize housing stability over food due to cultural norms and limited resources
- We chose to go deep on one high-impact need rather than spreading thin.

The Lesson: You can screen broadly but focus deeply on one high-impact need to build sustainable, patient-centered systems.

WHAT THEIR COMPREHENSIVE APPROACH INCLUDES

Screening:	Primary screening by Member Services at registration & annual renewal
Response protocol:	Modified PRAPARE with immediate actionable triage. Secondary path via clinical staff, health ed.
Community partners:	Mapped food resources with referral tracking Same Day CalFresh Assistance +Food Bank Referrals
Closed-loop follow-up:	Confirmation that patient connected
Staff training:	How to have the conversation — not just screen
One need, done right:	Depth before breadth — a replicable model

North East Medical Services

HRSN focus: Food insecurity · FQHC · 90,000 pts

WHAT WE BUILT

- Primary screening owned by Member Services during new registration and annual renewal (~90,000 patients)
- Uses modified PRAPARE tool with specific food insecurity questions
- Positive screen → Immediate eligibility pre-screening + same-day CalFresh application assistance via BenefitsCal
- Additional pathway: Referral to San Francisco-Marin Food Bank for SF County patients
- Secondary referrals from PCPs, MAs, Behavioral Health, and Health Education

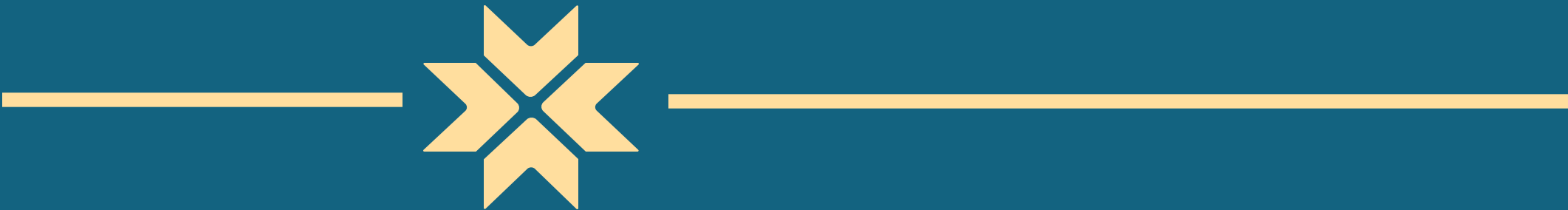
ONE THING TO STEAL

- Involve frontline staff + leadership early
- Bring Operations & IT in early to operationalize
- Protect clinical time while building culturally sensitive workflows

WHAT WE'RE STILL WORKING ON

- True closed-loop verification of benefit receipt
- Limitations with BenefitsCal

Live Troubleshooting



We heard you at the start. Here's what came up

THEME 1

Closing the BH Referral Loop

Practices across the board are still working on confirming that BH referrals – especially those sent outside the clinic – result in completed care, and that status is tracked and documented in a closed loop.

THEME 2

Patient Follow-Through & Unreachability

Even when referrals are made, patients miss follow-up appointments or can't be reached – creating a persistent gap in completing the BH care cycle and confirming warm handoffs.

THEME 3

Documentation, Data Capture & Tracking

Practices are navigating how to consistently document BH and SDOH referral outcomes – including proactive care coordination before visits – in ways that satisfy reporting requirements and support care team visibility.

We heard you at the start. Here's what came up

THEME 1

Workflow Standardization & Documentation

Practices struggle to create consistent, written protocols for BH screening including MA administration, score thresholds, tiered response levels, and role clarity across the care team.

THEME 2

Closed-loop referral tracking & follow-up

Once a positive screen is identified lack reliable systems to confirm referrals were received, appointments kept, and follow-up completed – especially for external BH referrals where visibility ends at the practice boundary.

THEME 3

Data capture, extraction & structured documentation

Screening data is inconsistently entered into structured EHR fields – or is difficult to export – making it hard to run reports, demonstrate compliance, or identify trends at a population level.

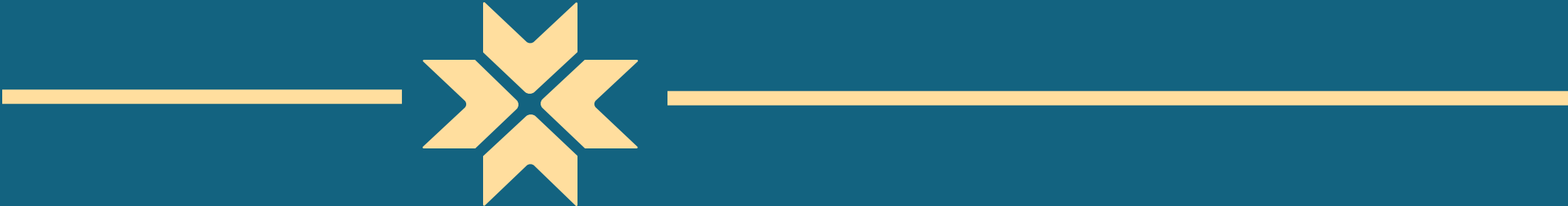
Drop in the chat:

What's one concrete step your practice will take before November to move your BH and/or HRSN work forward?

NO WRONG ANSWERS. NO ONE'S COLLECTING THIS FORMALLY.

This is for you – a moment to name something concrete before you leave.

Close & Next Steps



Evaluation

Please fill out the evaluation - chose June 1st or June 2nd as the date.

If you would like CEC's, you will need to click "Yes" on Question 9 and fill out the appropriate information.

The link will be posted in the chat and shared in the follow up email.



Key reminders and where to find what you need

01 Follow Up Email and Newsletter

Resource sharing, information updates, and more to be able to move forward in EPT.

02 KPI and PhmCAT Submissions

If your organization has been contacted to complete your KPI submissions and/or PhmCAT, please submit before the deadline!

03 Submission Cycle Timeline

Use this session's materials to strengthen your submission when you either receive feedback by June 5th or submit next cycle.

04 June Learning Session - Part 2

Sustainability in a Changing Landscape — VBP, post-program readiness, and what holds your gains when EPT ends.

Sustainability in a Changing Landscape

Value-based payment and post-program readiness.

What you built today — safe protocols, operational workflows, and data that tells the truth — is the foundation for what comes next.

See you in Part 2.