



## Social Drivers of Health Provider Incentive Program (SDOHPIP) Provider Training

# SDOHPIP Objectives and Provider Expectations

## **SDOHPIP offers incentives to select Medicaid providers with the following objectives:**

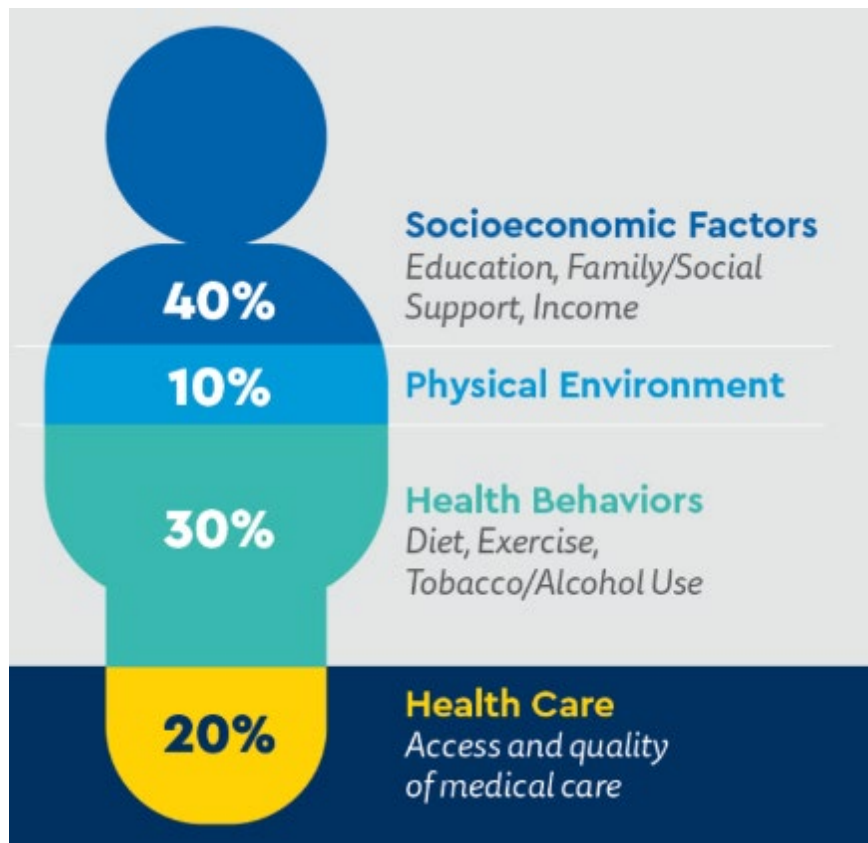
1. Obtaining a baseline of Social Drivers of Health (SDOH) needs and Adverse Childhood Experiences (ACEs) risk for Simply membership, to improve member health outcomes by addressing their SDOH needs
2. Increasing provider awareness and utilization of the SDOH vendor platform as a resource to refer members to community organizations that can help them with SDOH needs

## **Provider Expectations:**

1. Screen Members for ACEs risk, discuss score, and enter responses in findhelp.
2. Submit appropriate Dx Z codes on claims for members who have SDOH/ACEs needs.
3. Refer members with SDOH needs to CBOs, using the findhelp platform. Obtain Member authorization to share their PHI with CBOs. (We will provide an authorization form if needed.)
4. Outreach to members who have been previously referred to CBOs and update referral status field in the SDOH platform

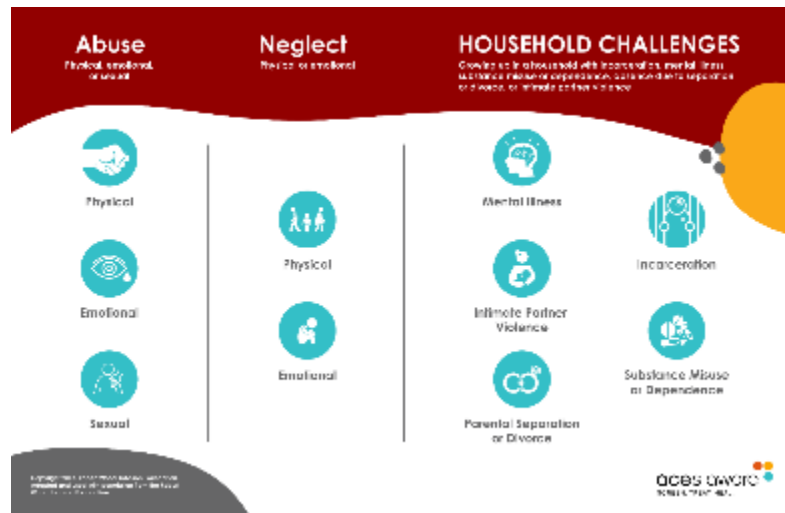
# What is SDOH and Why is it Important?

Per the World Health Organization (WHO), SDOH impact approximately 80% of patient health outcomes.



# What is ACEs?

- Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood. According to the CDC, ACEs can include violence, abuse, and growing up in a family with mental health or substance abuse problems. Toxic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood.



The life expectancy of individuals with six or more ACEs is 19 years shorter than that of individuals with none.

# What is an SDOH Social Care Platform?

- SDOH Social Care platforms are used for providers to connect patients to CBOs that offer food, health, housing, job training, education programs, and other social needs to get them through difficult times.
- These platforms allow users to find and refer patients with diverse needs to hundreds of available programs no matter where they live.
- Features include creating referrals electronically, sharing programs and notes with coworkers, closing the loop on referrals, and administering assessments.
- For the SDOHPIP program, we have partnered with findhelp and utilize their platform, where our Providers can conduct assessments for SDOH and ACEs, refer Members to CBOs, and close the referral loop.

# SDOHPIP Workflow Contents

- SDOHPIP Member Search
- Checking for Eligibility in a Member Profile
- Starting an Assessment
- Sending a Referral
- Closing the Referral Loop

# SDOHPIP Member Search

## 1 Log in

Use your standard email login information to access the SDOH Social Care Platform.

2 This is going to take you to the member search page. This is always where you will start your SDOHPIP workflow.

**Bookmark it!**

<https://sdohpip.findhelp.com/login>

### Member Search

**Provider Information:**

NPI 1245319599	TIN* 11-1111111
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LAURA SAMPLE MD

Auto-fill next time (my NPI and TIN do not change)

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**Member Information:**

Member Identifier*	State* ▼
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[Return to Home](#) [Search](#)

# SDOHPIP Member Search Process

- Enter your **National Provider Identifier (NPI)** and **taxpayer identification number (TIN)**. To save time on future searches, check the box to automatically fill in this information.
- Next, enter the **member's ID** and **state of residence**, then select **Search**.

**Member Search**

**Provider Information:**

NPI  
1245319599

TIN\*  
11-1111111

Auto-fill next time (my NPI and TIN do not change)

**Member Information:**

Member Identifier\*  
AHDS0710

State\*  
VA

[Return to Home](#) [Search](#)

# Continue Care

After searching, carefully review the results to ensure you've found the correct person. Once you've confirmed the member's identity, select Continue Care to access their shared care record.

**Important:** To be eligible for incentives on any actions you take, you must perform a member search first.

1 Result found

## Horne Michele

**Plan Type** MEDICAID

**Plan** VA Medallion 4.0 Expansion PP (SA) High Risk

**Member ID** AHDS0710

**Group ID** VAMCDWP0

**Source** elevance

**DOB** 06/06/1977

**Gender** female

**Phone** (747) 578-8153

**Alternative Phone**

**Street** 30222 Samantha Center

**City** Bena

**State** VA

**ZIP** 23018

[Continue Care](#)

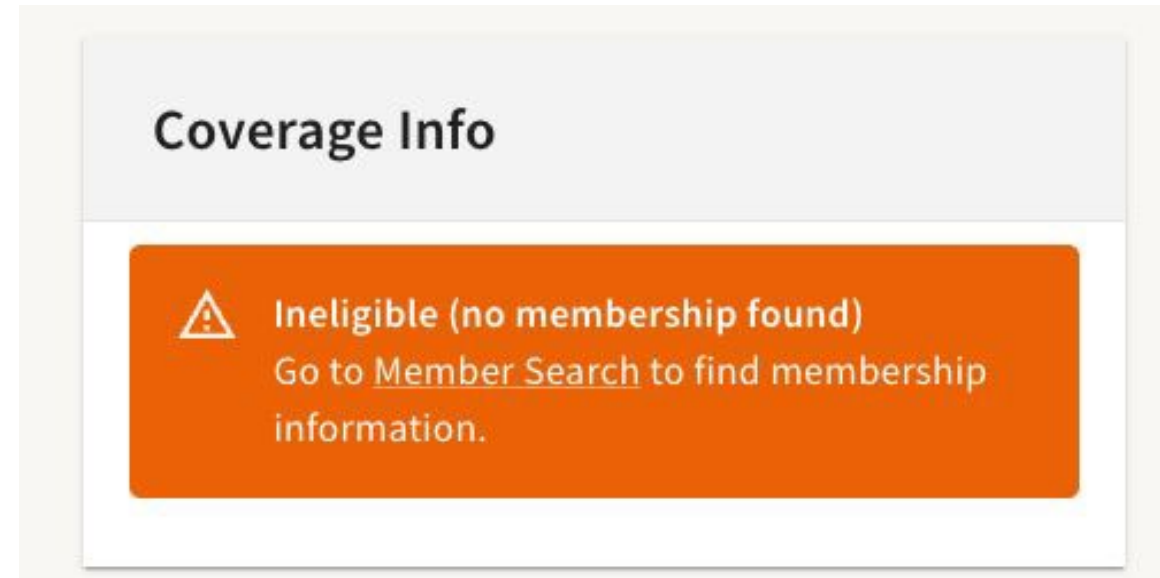
# Checking for Eligibility in a Member Profile

- When you're inside the member profile, the first thing you'll do is scroll down to see their coverage info.
- This tells you right away if they're eligible.

Coverage Info	
<b>Member ID</b>	AHDT50710
<b>Coverage Plan</b>	VA Medallion 4.0 Expansion PP (SA) High Risk
<b>Coverage Type</b>	MEDICAID
<b>Member Eligibility End Date</b>	2039-12- 31T23:59:59+00:00

# Checking for Eligibility in a Member Profile (cont.)

- If they're ineligible, you will see this in the coverage section.



For ineligible members, go to the top of the screen and select End session. This workflow supports eligible members.

People I'm Helping / Price Manuel

End Session

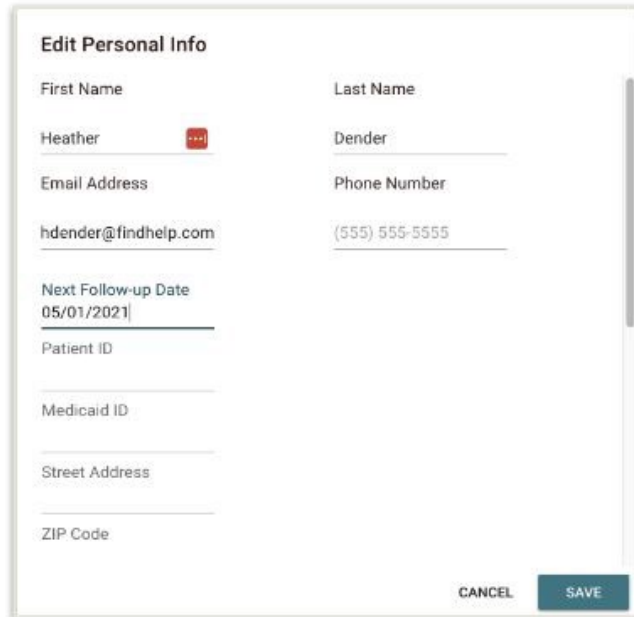
# The Member Profile

The screenshot displays a user interface for a member profile titled "People I'm Helping / Heather Dender". The page is organized into several sections:

- Personal Info:** Displays the name "Heather Dender" and email address "hdender@findhelp.com". An "Edit Personal Info" button is located below.
- Assignment:** Features an "Assign To Me" button.
- Household:** States "Household information has not been added" and includes a "Create" button.
- Forms:** Indicates "No forms have been submitted for this user" and has a "Start A Form" button.
- Documents:** Shows a document titled "Care Plan.png" dated "Sep 9, 2024" with an "Upload" button.
- Goals:** Shows "Heather has 1 goal." with an "Add Goal" button. The goal is "Getting ID Replacing a Missing ID" with a due date of "9/09/24" and a status of "In progress".
- Navigation History:** States "You have referred Heather to 1 programs." and includes "Start a Referral" and "Add Note" buttons.
- Referrals and Notes:** Displays a referral for "Mitch Food Pantry" with a status of "Needs client action". It includes a list of notes and actions:
  - 9/09/24: "Heather needs to replace her ID to qualify for this program" (Action: Add Note)
  - 9/09/24: Status set to 'needs client action' (Action: Add/Remove Goals)
  - 7/31/24: Status set to 'not updated' (Action: Add/Remove Goals)
  - 7/31/24: Referred by Heather D (Findhelp Learning and Development)

The member profile helps your team track and coordinate care by storing member information, referral history, and statuses in one place.

# Member Profile Info and Navigator Assignment



The 'Edit Personal Info' form contains the following fields:

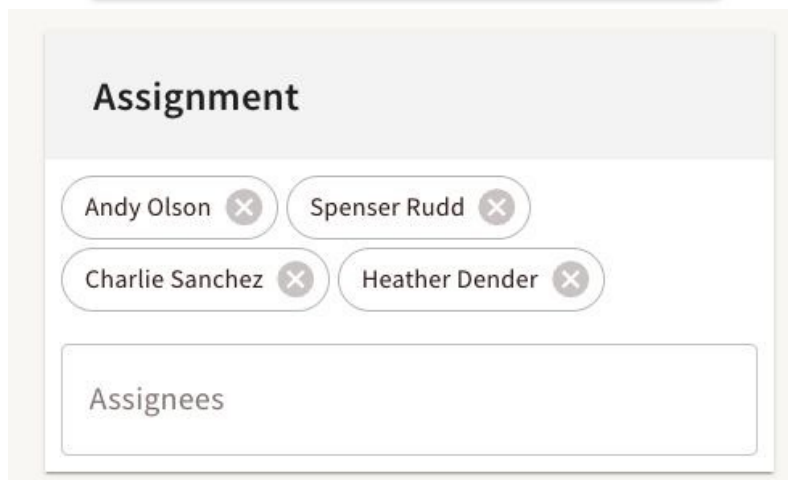
- First Name: Heather
- Last Name: Dender
- Email Address: hdender@findhelp.com
- Phone Number: (555) 555-5555
- Next Follow-up Date: 05/01/2021
- Patient ID: (empty)
- Medicaid ID: (empty)
- Street Address: (empty)
- ZIP Code: (empty)

Buttons: CANCEL, SAVE

You can set a follow-up date in personal info, which you can use later in your *People I'm Helping* dashboard to keep track of who you need to check in with.

You can assign yourself or a teammate to a member profile. This makes it easier to filter by navigator in the *People I'm Helping* dashboard and helps your team see who's working with each member.

Multiple navigators can be assigned if they're in the same group.



The 'Assignment' section displays the following assigned navigators:

- Andy Olson
- Spenser Rudd
- Charlie Sanchez
- Heather Dender

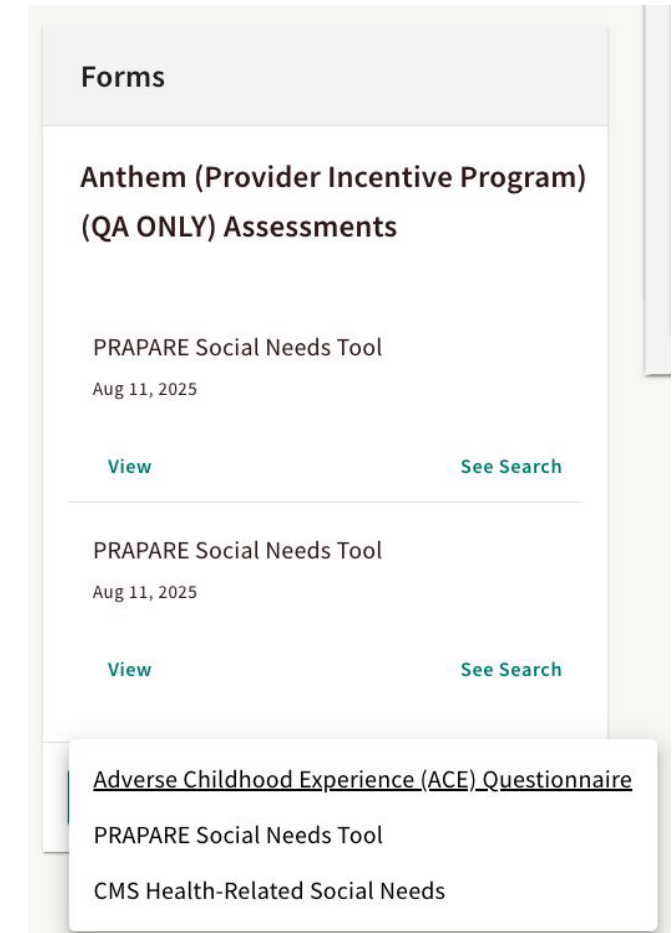
Below the list is a text input field labeled 'Assignees'.

# Starting a Member Assessment

If they are eligible, you can review information in the member's profile. In the *Forms* section, you can view previous assessments completed for this member.

To start a new assessment, select **Start a Form** and choose either an ACE or PRAPARE or CMS assessment. This will depend on the member you are helping. **Note: ACEs forms are only available in select markets.**

This is a key step in our incentivized workflow.



# Assessment Auto-Populated Fields

Currently Helping **Michele Horne**  
StateRID (Indiana): None  
Subscriber ID: AHDS0710

**END SESSION**

## PRAPARE

Select Language

It can be hard to know where to go when you need a little extra help. Using this screener will provide a customized list of organizations that can help connect you with resources you may need, like food, housing, work, transportation and more. Fill out our Social Needs Tool and get your list.

### PRAPARE

Zip code \*  
23018

If you don't have a stable home, use any zipcode in your city.

First Name \*  
Michele

Inside the form, information from the member's profile will auto populate, making this easy to fill out.

# Assessment Button: Review Form

REVIEW FORM

When you select **Review Form**, you can see the answers provided and make any necessary edits.

## Use of this Platform

Do you have appropriate consent from this person or their guardian (if under 18) for The Community Resource Link for Providers (QA ONLY) to collect and store this profile information? By consenting they agree to the The Community Resource Link for Providers (QA ONLY) platform's [Terms](#) and [Privacy Policy](#).

Let them know...

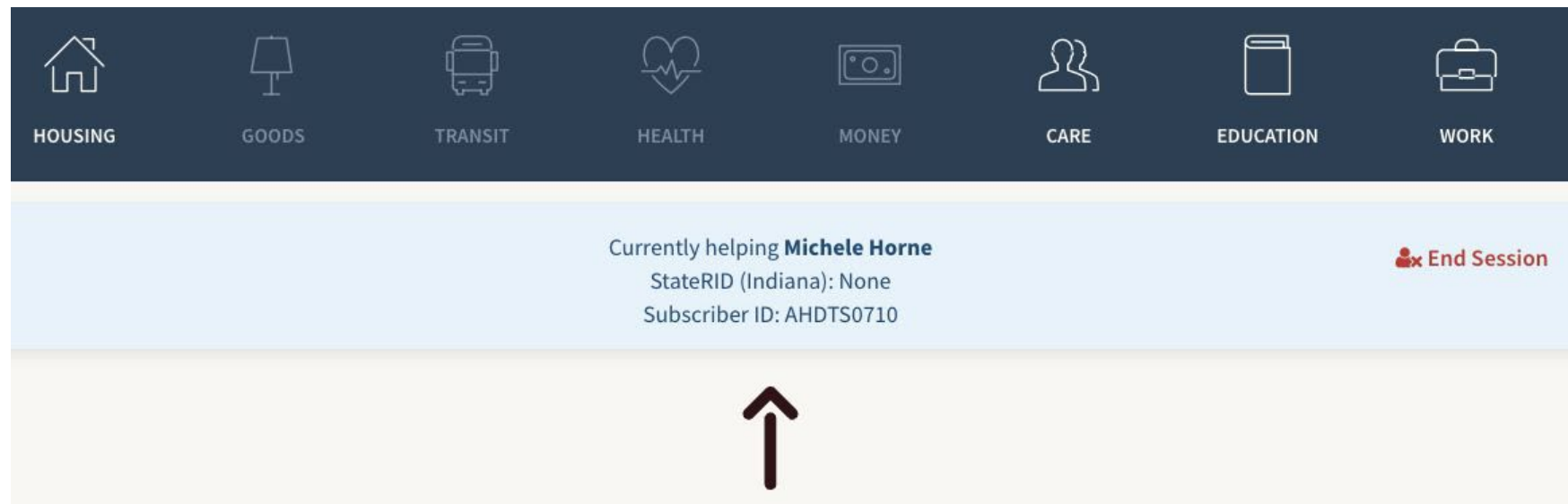
1. If they don't yet have an account for The Community Resource Link for Providers (QA ONLY), we will create one for them and email them the details.
2. We will also email them a link to return to their highlighted program search results (based on their answers on this form).

Yes, I consent

You will also gain the member's consent for this information to save to their profile.

# Search Results

Submitting takes you to a search screen. You will see an indicator that you are in their member profile. All actions you do will be saved to that profile. You will also see highlighted categories that you can select to find a relevant program result.



The member also gets a link to this same search, so they can find resources on their own.

# Email Sent to Member

The member you completed the assessment for will receive an email with a link to the same set of personalized search results.

Hi there,

Thank you for taking the time to fill out a form on The Community Resource Link for Providers.

We created [a custom search](#), so you can browse programs that might serve your needs

Note: this is an automatic message, which is unable to receive replies. If you need emergency help, please call 911.

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# Sending a Referral

Support Site Tools My Program Tools Michele's Profile

Navigation History

You have referred Michele to 3 programs.

Referrals and Notes Start a Referral Add Note

- From the assessment highlighted search, you can find and send a program referral.
- You can also start a referral directly from the *Navigation History* section of their member profile.
- Just select **Start a Referral** to go to a search screen.

# Referrals: Keyword Search

- The search will automatically use the ZIP code from their profile, but, if you need to change it, just type a new one into the keyword search bar and select enter.

Keyword Search



ZIP or keyword or program name

Select Language English

Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost help starts here:

FOOD HOUSING GOODS TRANSIT HEALTH MONEY CARE EDUCATION WORK LEGAL

Currently helping **Michele Horne**  
StateRID (Indiana): None  
Subscriber ID: AHDT50710

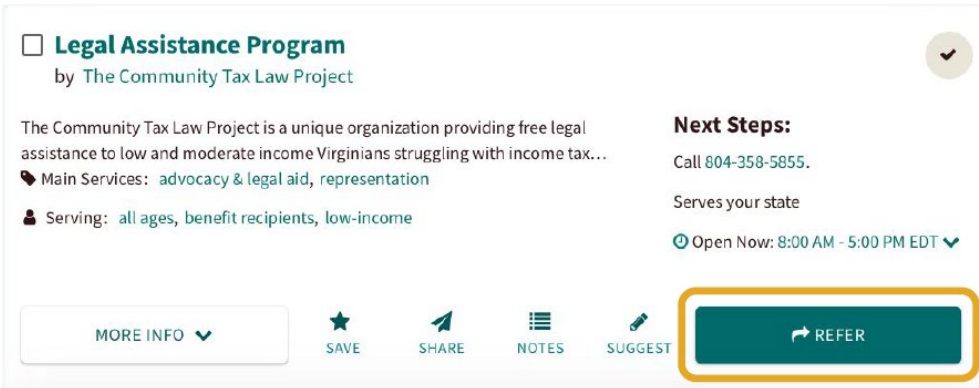
End Session

↑

**424 programs**  
in the Bena, VA 23018 area

Profile ZIP code

# The Live Referral Form



**Legal Assistance Program**  
by The Community Tax Law Project

The Community Tax Law Project is a unique organization providing free legal assistance to low and moderate income Virginians struggling with income tax...

Main Services: advocacy & legal aid, representation

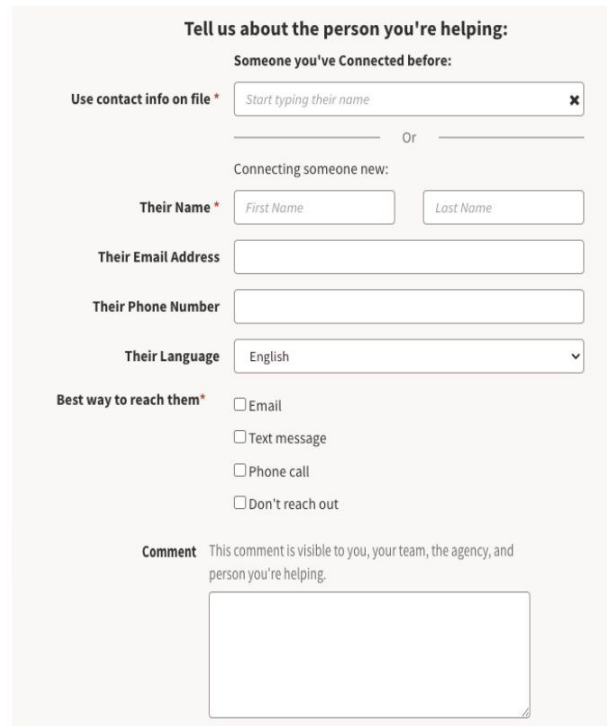
Serving: all ages, benefit recipients, low-income

**Next Steps:**  
Call 804-358-5855.  
Serves your state  
Open Now: 8:00 AM - 5:00 PM EDT

MORE INFO ▾ SAVE SHARE NOTES SUGGEST REFER

When you select the **Connect** button, you will see a referral form. This information in this form will go to the organization supporting the program:

- **Auto Populate Info:** The form will pull info from the member's profile.
- **Select their preferred language** to translate the notification.
- **Choose their contact method:** This applies to both notifications and how the organization will follow up. Options include: phone, text, or email. Select **Do not reach out if the member doesn't have any of these methods available or is in an unsafe situation.**
- **Add a note:** The comment will be visible in the member's notification, as well as to the CBO provider and any navigators in your group. Since it's shared, do not include any PII or PHI.



**Tell us about the person you're helping:**

Someone you've Connected before:

Use contact info on file \*  x

Or

Connecting someone new:

Their Name \*

Their Email Address

Their Phone Number

Their Language

Best way to reach them\*  Email  
 Text message  
 Phone call  
 Don't reach out

**Comment** This comment is visible to you, your team, the agency, and person you're helping.

# The Logged Referral Form

😊 **Best way to connect!**  
Call 877-548-7838 to get more info.

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Helping someone else? [LOG A REFERRAL](#)

I'm referring someone else

Your Name \*

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**Tell us about the person you're helping:**

Someone you've Connected before:

Use contact info on file \*  x

Or

Connecting someone new:

Their Name \*

Their Email Address

Their Phone Number

Their Language

Best way to reach them\*  Email  
 Text message  
 Phone call  
 Don't reach out

**Comment** This comment is visible to you, your team, and person you're helping.

When you select the **Connect** button, you will see the next steps to share with the member. Select **Log a Referral** and complete the form. The referral won't be sent to the organization, but it will be saved to the member's shared care record:


- **Auto Populate Info:** The form will pull info from the member's profile.
- **Select their preferred language** to translate the notification.
- **Choose their contact method:** This is just for notifying them, not the organization.
- **Add a note:** It will be visible in the member notification and to navigators who are a part of your group.

# Gaining Consent

Because we are sending the member's information to another organization, we have a consent checkbox built into the form to confirm before the referral is sent.

## Confirm Consent \*

- I have appropriate consent from the person or their guardian (if under 18) to:
- Send their contact info and additional info through this system to this agency, and
  - Send them info **about this program** through the LinkU platform (including any responses sent to them by the program).

 SEND

**Important!** We'll do our best to send them your information, but it's possible that we may not be able to reach the agency or get a quick response. *If you are in an emergency situation, call 911.*

# Next Steps: After the Referral is Submitted

## Live Referrals



The member can receive a notification about the program and next steps, **based on their preferred method of contact.**



The **CBO will receive** a notification that a new referral has been made. They will reach out to the member directly to provide help.



You can **check the status** of the referral you made in the People I'm Helping dashboard.

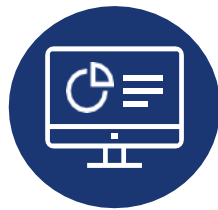
## Logged Referrals



The member can receive a notification about the program and next steps, **based on their preferred method of contact.**



The CBO **does not** get a notification of the referral. The member reaches out to the organization to start the process.



You will **update the status** of the referral you made in the People I'm Helping dashboard.

# How Can I Update the Status of a Member's Referral?

Referrals status can be updated on the *Member Profile*, in the *Navigation History* section:

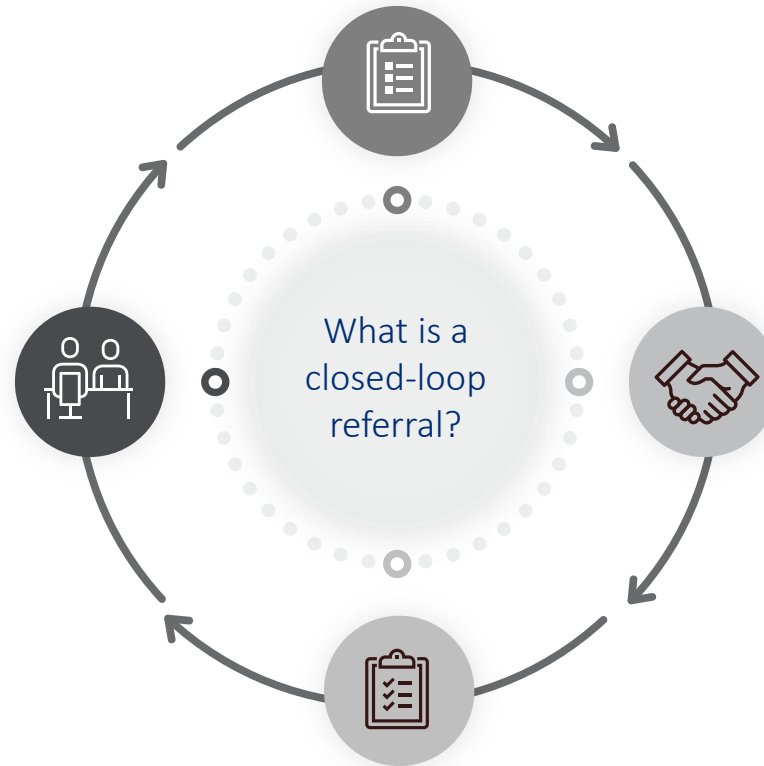
- 1 Review status update history.
- 2 Update the status of a referral to Got help to close the loop.
- 3 Add any relevant notes.

The screenshot displays a web interface for managing referrals. The main heading is "Referral to Bertha Grows: Community Gardens by Aunt Bertha Community Foundation". Below this, the status is "not updated". A dropdown menu is open, showing various status options: "Not updated", "Needs client action", "Pending", "Referred elsewhere", "Got help", "Eligible", "Couldn't get help", "Couldn't contact", "Not eligible", "No capacity", and "No longer interested". The "Got help" option is highlighted with a yellow border. A blue circle with the number "2" is placed over the "Got help" option. Another blue circle with the number "1" is in the top right corner, and a third blue circle with the number "3" is in the bottom right corner. The interface also shows a table of referrals with columns for status and date, and a section for adding notes.

# What Does Closing the Loop Mean?

The referral is transmitted electronically to a Community-Based Organization (CBO) that can provide assistance.

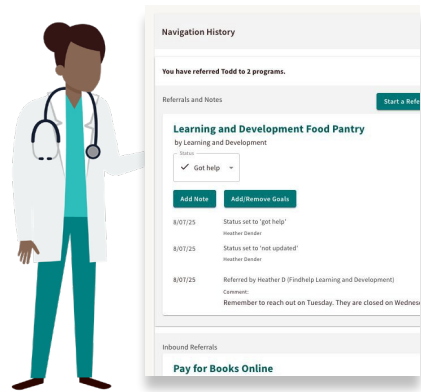
A navigator (like a social worker at a non-HIPAA covered organization) makes a referral for service on behalf of someone who needs help.



A CBO provides the assistance they need.

The CBO replies to the navigator electronically to let them know they provided the assistance.

# How is a Logged Referral Loop Closed?



When you submit a logged referral, you will see it at the top of member's navigation history.



The member will reach out to the provider to get the service.



You will need to follow up with the member to confirm they received the resource or service.




Then, you will update the status to Got Help to close the loop.


## **Billing Appropriate SDOH/ACEs — Related Diagnosis Z Codes**

# SDOH/ACEs diagnosis Z code mapping


The Z-Code Crosswalk Spreadsheet lists incentive eligible Z-codes for positive SDOH needs.



Provider will bill the most appropriate diagnosis Z code listed for each category. (Must use one of the diagnosis Z codes listed on the crosswalk to qualify for the incentive.)



The Provider does not need to take action with diagnosis Z codes in the SDOH platform.



A diagnosis Z code crosswalk will be made available for reference. Note: This crosswalk is the source of truth. See next slide for an excerpt.

# Diagnosis Z code crosswalk (excerpt)

Category	Findhelp*#	PRAPARE #	Question	Response options	Positive result indicator	ICD-10 codes and descriptions
Family and home	1	7	What is your housing situation today?	I have housing.	N/A	[N/A]
				I do not have housing (staying with others, in a hotel, in a shelter, living on the street, on a beach, in a car, or in a park).	Housing	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 Z59.2 Discord with neighbors, lodgers, and/or landlord Z59.5 Extreme Poverty (100% FPL or below) Z59.6 Low income (200% FPL or below) Z59.8 Other problems related to housing and economic circumstances Z59.81 Housing instability, housed (foreclosure, past due rent) Z59.811 Housing instability, house, with risk of homelessness (imminent risk of homelessness) Z59.812 Housing instability, housing, homelessness in the past 12 months Z59.819 Housing instability, housing unspecified Z59.86 Financial insecurity, not elsewhere classified Z59.87 Marital hardship, not elsewhere classified Z59.89 Other problems related to housing and economic circumstances Z59.9 Problem related to housing and economic circumstances, unspecified
				Patient chooses not to answer	N/A	N/A
Family and home	2	8	Are you worried about losing your housing?	Yes	Housing	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 Z59.2 Discord with neighbors, lodgers, and/or landlord Z59.5 Extreme Poverty (100% FPL or below) Z59.6 Low income (200% FPL or below) Z59.8 Other problems related to housing and economic circumstances Z59.81 Housing instability, housed (foreclosure, past due rent) Z59.811 Housing instability, house, with risk of homelessness (imminent risk of homelessness)

# Training Requirements and Continued Learning

# ACEs Screeners training requirements

Clinical team members who plan to conduct one of the ACEs Screeners must complete a certified ACEs Aware core training and attest to completing the training to qualify for the incentive payment. Below is a list of approved, certified core trainings:

- [Pediatric Resiliency | Home \(pedsresiliency.org\)](https://pedsresiliency.org): Providers must complete all four sections to receive AMA PRA Category 1 credits.
- [ACEs Aware — Futures Without Violence](#): Provider must complete all three sections and the evaluation in order to receive CE credits.
- [Adverse Childhood Experiences and Trauma Informed Pediatric Care | UCSF Child and Adolescent Psychiatry Portal](#): Providers must complete all four sections and complete an evaluation to receive AMA PRA Category 1 Credits or AMA MOC Part 2 credits.

**Do you attest that you have completed one of the Certified Core Adverse Childhood Experiences (ACEs) Provider Trainings listed above?**

YES

# SDOHPIP Platform Training Link

- [SDOHPIP Training Video](#)

# Thank you

<https://provider.simplyhealthcareplans.com>

Simply Healthcare Plans, Inc. is a Managed Care Plan with a Florida Healthy Kids contract.

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