CT HCBS User Guide

Last update: February 20, 2025

The Connecticut Department of Social Services (DSS) has implemented value-based care initiative for home and community-based service (HCBS) providers. To improve Medicaid member health outcomes, the program aims to create and sustain a value-based fee-for-service delivery model by providing whole-person care through incentive payments to HCBS providers based on defined outcomes. The initiative includes HCBS organizations access to their clients' HCBS program related data through Connie. The purpose is to leverage Connie to better provide whole-person care to:

- decrease avoidable hospitalizations
- increase in probability of members going home after being discharged from the hospital
- increase the number of members meeting their personal goals
- decrease health inequities among members served by participating organizations

For more information regarding requirements for participating in the DSS HCBS Program, visit the Connecticut DSS website at https://portal.ct.gov/dss/common-elements/home-and-community-based-services/value-based-payments.

This document outlines the features of the CT HCBS Program tool and serves as a user guide for its basic functions. It offers an overview of the platform features, including explanations of their purposes and potential uses.

User Support
Phone: 1-866-987-5514
Email: help@ConnieCT.org

What's Inside

User Stories

As a home health nurse, I am responsible for administering medications and ensuring my client is making progress where they are able to. I can log into the HCBS Program tool through the Connie portal, see if there are any updates on my patients' goals and hospitalizations. I can also use Connie to conduct a patient search to check for additional clinical information for my patient, including medications prescribed and diagnosis that may not have been detailed in their referral.

As a care coordinator for a homemaker and companion program, I can log in to the HCBS Program tool in the Connie portal, see if any of our clients have been admitted to or discharged from the hospital in preparation for the week. I then look for flags that highlight clients who may be in need of more attention and look at the Snapshot view to understand where they might be struggling to help me identify actions our staff can take during visits to support their client's progress.

As an HCBS program director, I want to monitor my organization's progress related to the HCBS program goals, to see if we are on track to meeting Value Base Payment benchmarks. I can use the CT HCBS Program tool Dashboard to see how my organization did during the previous assessment cycle, our current score, and how we are doing month over month in relation to the goal benchmarks.

Sources of Data

Connie receives data from hospitals, the Department of Social Services (DSS) and their business associates to support the features included in the CT HCBS Program tool.

Data types include:

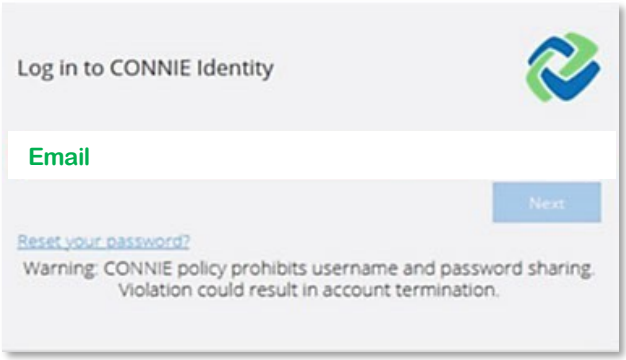
- Hospital admission and discharge information, which can include patient demographic, patient class, location, date/time, and diagnosis.
- Care Team Prior Authorization and Electronic Visit Verification extract files
- The Universal Assessment
- Member Person Centered Goals

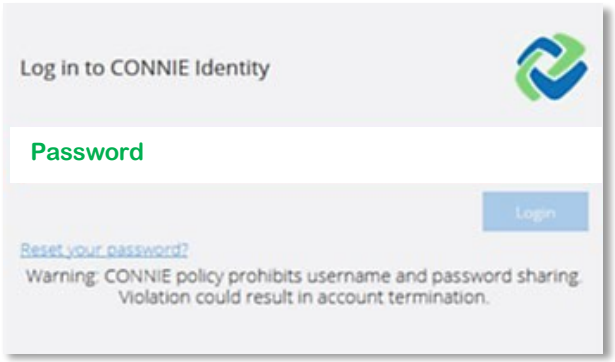
For more details regarding the data used for the CT HCBS tool, see *the HCBS Implementation Guide.*

NOTE: Not all data sources are available during the initial launch of the HCBS program tool. Although this User Guide describes all functionality, early users may experience some missing features. As data becomes available additional features described below will populate with the relevant information.

Accessing the Portal

1. Navigate to portal.conniect.org
2. Login with email and password





Don't Have a Login? Contact Connie Customer Support at help@conniect.org or 866.987.5514 to request access. Resetting a Password - Click on the "Reset your password?" link and follow the onscreen instructions.

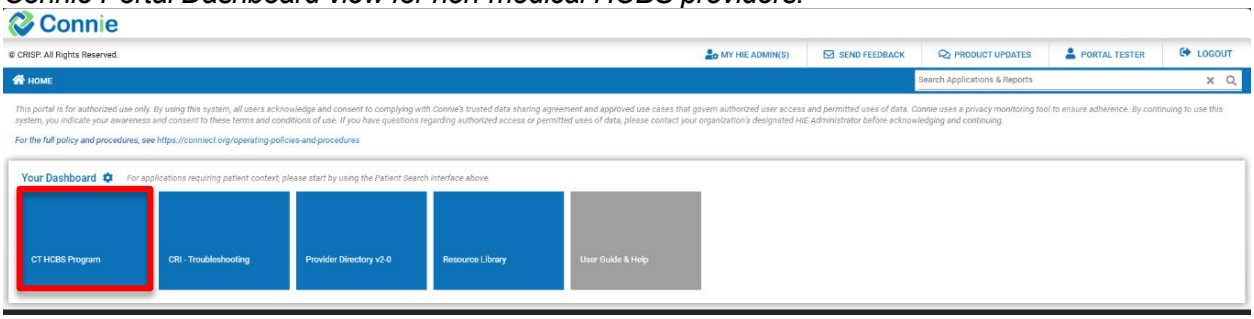
Two-Factor Authentication

To keep patient data confidential and secure, Connie requires that you set up Two-Factor Authentication (2FA) for your portal account. For more information about setting up 2FA, see **Connie Portal Two-Factor Authentication Guide.**

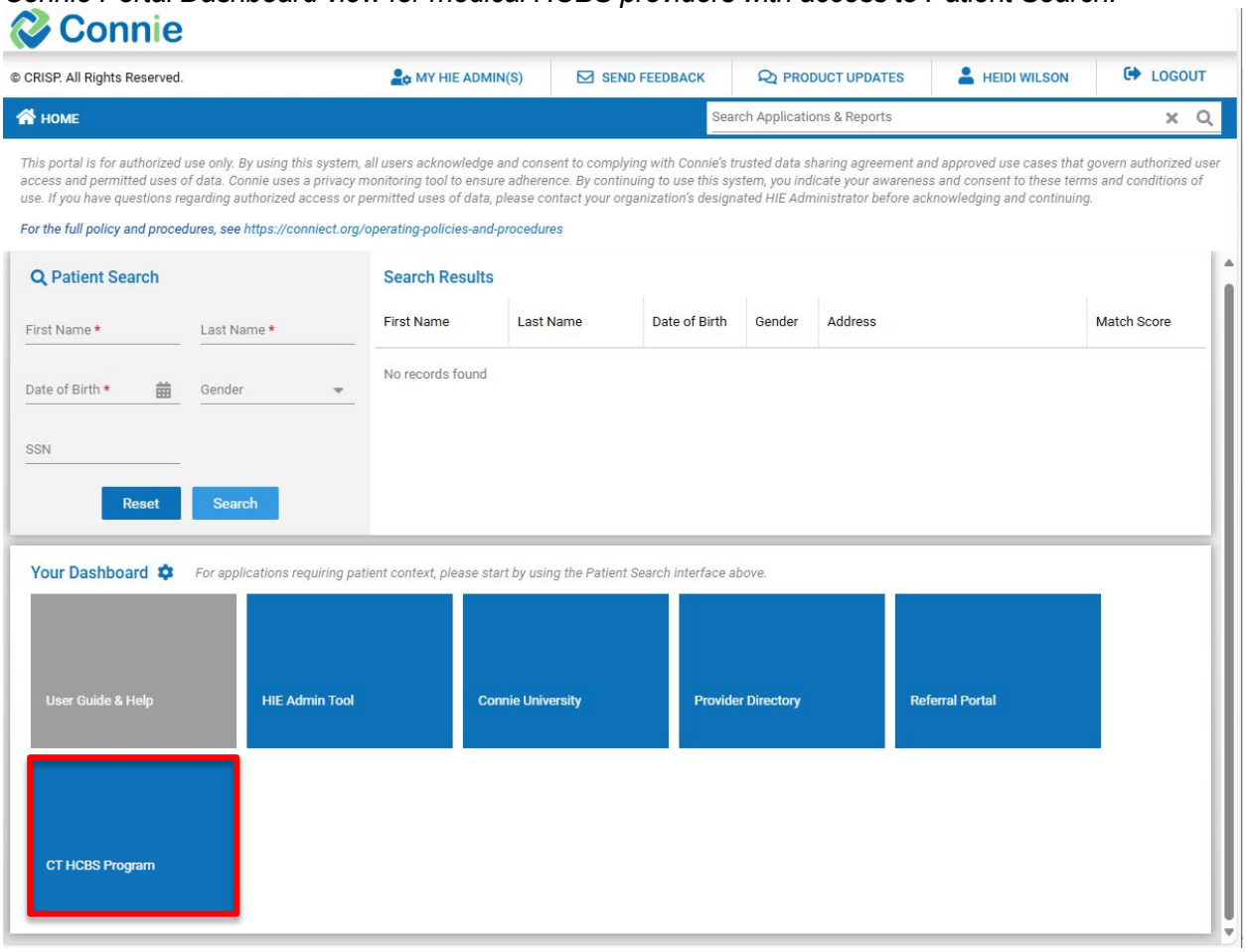
Connie Landing Page

The Connie landing page consists of a Patient Search section and Dashboard. Please note, only healthcare providers that are authorized and have signed the Clinical Data and Empanelment Use Case Exhibits will be able to execute a patient search.

Connie Portal Dashboard view for non-medical HCBS providers.



Connie Portal Dashboard view for medical HCBS providers with access to Patient Search.



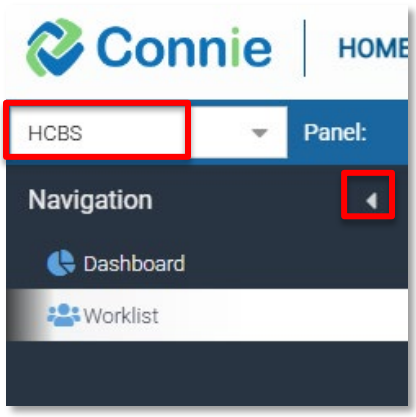
On launch, general applications will appear in the Dashboard beneath 'Patient Search.' For CT HCBS Program participants that have only signed the HCBS Use Case Exhibit, dashboard features will be limited to applications that do not require a patient search.

Launching the CT HCBS Program Application

To access the HCBS program application, select the CT HCBS Program tile on the dashboard.

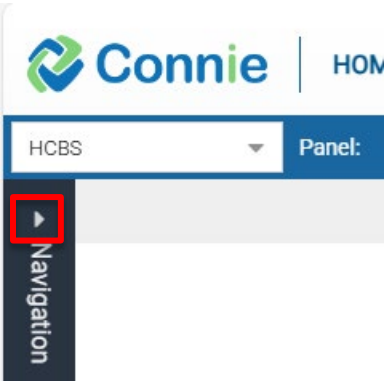
Navigation

On the left side of the screen is the Navigation section. There are two features of the HCBS Program tool that can be accessed through Navigation:



The **Worklist** provides access to a list of your clients and key indicators of how they are doing. From the worklist you can navigate to a detailed snapshot of your client's information by selecting their name.

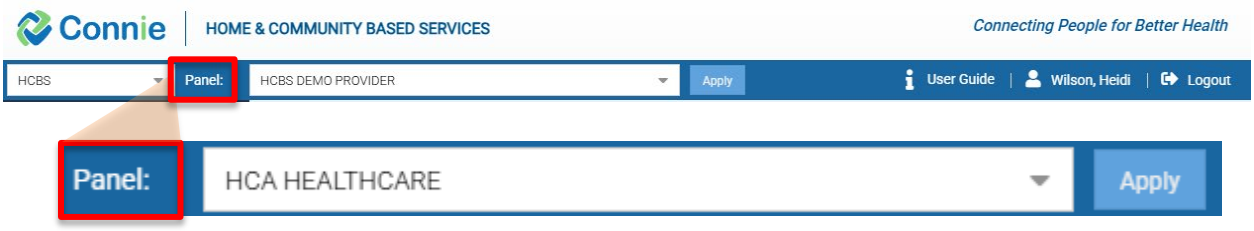
The **Dashboard** provides an overview of how your organization's panel of Medicaid member clients are doing in relation to the goals of the DSS HCBS program.



Launching the CT HCBS Program tool defaults to the Worklist. To navigate between these two features, select your desired feature under the "Navigation" heading on the right side of your screen. To collapse the Navigation column, select the right facing arrow next to "Navigation". To expand navigation, select the left facing arrow.

Service Support Bar

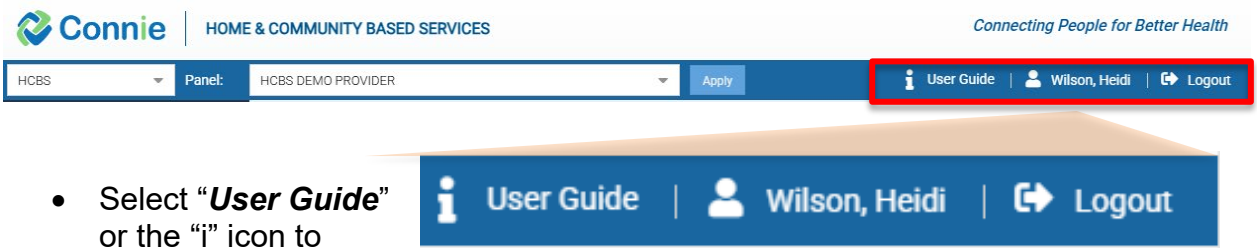
The blue bar across the top of the screen includes a few services to provide support described below beginning left to right.



Panel: The name of your organization's panel of patients will be listed. If your organization has multiple panels, you can switch between panels using the drop-down arrow, and then selecting "Apply". Note, the default is for participating organizations to only have one panel.

Your Panel is a list of your Medicaid member clients created from prior authorization data, and/or Electronic Visit Verification data. Your panel of clients are then listed in the Worklist feature (see Worklist section below for details).

On the upper right side of the screen include the following features:



- Select "***User Guide***" or the "i" icon to download this HCBS Tool user guide.
- ***Your name***, as the user, will be listed between the "Help" and "Logout" links when you are logged into the site.
- Select "***Logout***" to end your session and securely lock access to the CT HCBS Program application.

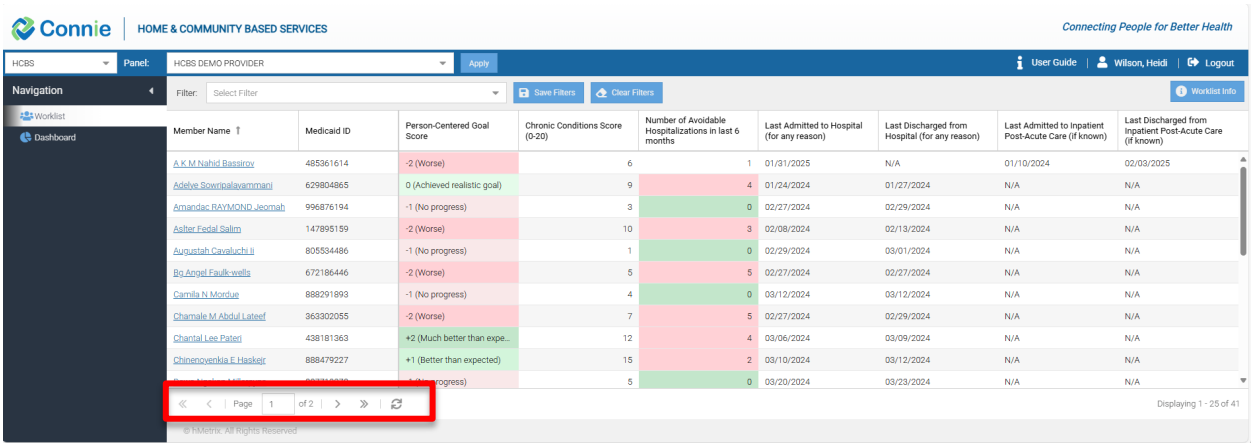
HCBS Program Features

Worklist

The Worklist provides you with a list of your Medicaid member clients and includes their name, Medicaid ID, Person-Centered Goal Score, Chronic Conditions Score, Number of Avoidable Hospitalizations in the last 6 months, the last date they were admitted to the hospital for any reason, the last date they were discharged from the hospital for any reason, the last date they were admitted to an inpatient post-acute care facility (like a skilled nursing facility) if that information is known, and the last date they were discharged from an inpatient post-acute care facility if that information is known.

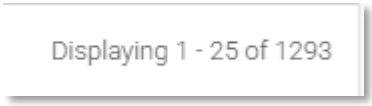
The purpose of the worklist is to provide you with an overview of your clients' status, enabling you to quickly identify clients with higher needs. Note that only up to 25 clients are listed at a time. If you have more than 25 Medicaid members as clients, you will have multiple pages to your worklist

At the bottom left of the Worklist screen, you can navigate between worklist pages.



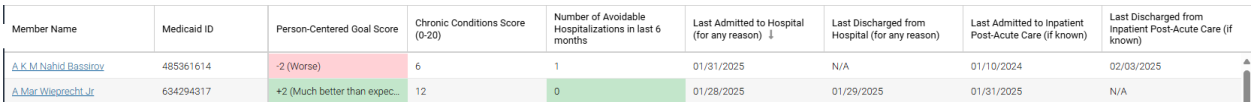
- Selecting the double arrow on the left will take you to the first set of 25 clients.
- Selecting the single arrow on the left will take you to the previous set of 25 clients.
- Selecting the double arrow on the right will take you to the last set of 25 clients.
- Selecting the single arrow on the right will take you to the subsequent set of 25 clients.
- Select the number in the box and type a number between 1 and the maximum page number to jump to another page of clients within your worklist.

The bottom right of your screen will tell you the number of members on your panel, and which count is currently displaying from that list



Column Categories

There are nine column categories that can be independently ordered and filtered. Click on the column heading to order A-Z or oldest to newest. Click a second time to order Z-A or newest to oldest. For more information on filtering and undoing the order, see the "filter" section of this User Guide below.



Member Name – The worklist defaults to ordering your clients alphabetically by your client's first name. Select the client's name to open a more detailed "Snapshot" of your client's conditions.

Medicaid ID – DSS issued Medicaid ID number for the Medicaid member.

Person-Centered Goal Score – Only members receiving homecare services have Person-Centered Goals. When goals are established, they are scored at a -1. Any

member with a -1 score means they have not progressed nor regressed from where they started. A score of -2 means they have regressed. For members with a score of 0, +1, or +2 means they have improved. Members at 0 or above during the performance period are counted towards your organization meeting the Person-Centered Goals benchmark.

Chronic Conditions Score - The Chronic Conditions Score is based on a combination of the Charlson Comorbidity Index (CCI) and the Elixhauser Comorbidity Index (ECI), two very common indices, which help to predict whether the patient is experiencing conditions that increase their likelihood for a hospitalization. The score range is 0 to 20 with a higher score associated with worse health. The score is a weighted count based on the number of the following conditions the patient experiences:

Alcohol abuse	Deficiency anemias	Metastatic cancer
Any tumor	Dementia	Peripheral vascular disorder
Cardiac arrhythmias	Fluid and electrolyte disorders	Psychosis (inc. depression)
Chronic pulmonary disease	HIV/AIDS	Pulmonary circulation disorders
Coagulopathy	Hemiplegia	Renal failure
Complicated diabetes	Hypertension	Weight loss
Congestive heart failure	Liver disease	

Number of Avoidable Hospitalizations in the last 6 months - Number of Avoidable Hospitalization indicates a count of hospitalizations the member has had in the last six months that are defined by Centers for Medicare and Medicaid Services (CMS) as avoidable hospitalizations. The avoidable hospitalization categories with relevant diagnosis are listed below:

- Inadequate Injury Prevention: Fractures, Head injuries
- Inadequate Management of Chronic Conditions: Adult Asthma, Chronic obstructive pulmonary disease (COPD), Congestive heart failure (CHF), Diabetes short-term complications, Hypotension/ Hypertension
- Inadequate Management of Infections: Bacterial pneumonia, C. difficile infection, Influenza, Septicemia (except in labor), Skin and subcutaneous tissue infections, Urinary tract infection / Kidney infection
- Inadequate Management of other Unplanned Events: Acute kidney failure, Arrhythmia, Aspiration pneumonitis; food/vomitus, Deficiency and other anemia, Dehydration/ Electrolyte imbalance, Intestinal impaction, Pressure ulcers, Thromboses and embolisms

Last Admitted to the Hospital (for any reason) – Provides a date for when your client was last admitted to the hospital for any reason (not only for avoidable hospitalizations). Clients admitted in the last 7 days will be highlighted in pink.

Last Discharged from the Hospital (for any reason) - Provides a date for when your client was last discharged from the hospital for any reason (not only for avoidable hospitalizations). Clients discharged in the last 7 days will be highlighted in pink.

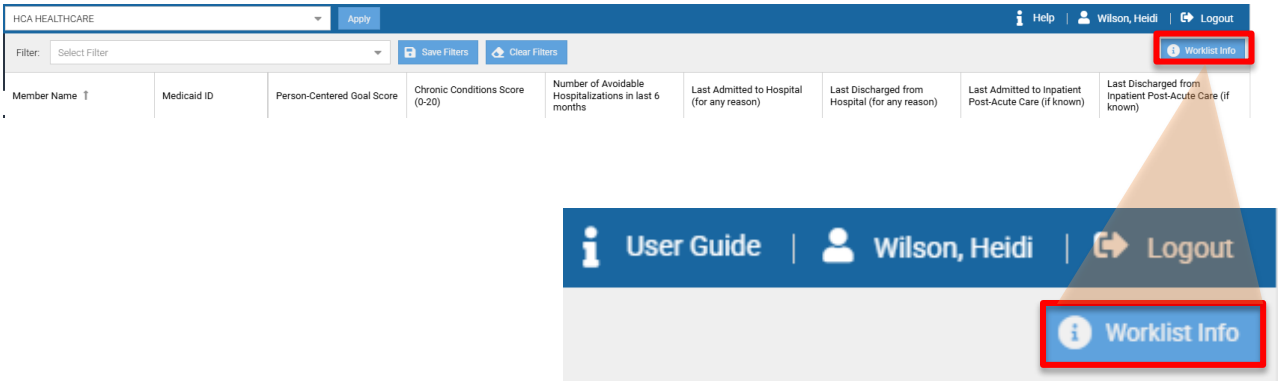
Last Admitted to Inpatient Post-Acute Care (if known) – If Connie has received data

from a Post-Acute Care facility indicated that the patient has been admitted to an inpatient post-Acute Care facility, the date they were last admitted will be included. N/A means either that the patient was not admitted, or that Connie did not receive admission information.

Last Discharged from Inpatient Post-Acute Care (if known) – If Connie has received data from a Post-Acute Care facility indicated that the patient has been discharged from an inpatient post-Acute Care facility, the date they were last discharged will be included. N/A means that the patient was not discharged, or that Connie did not receive discharge information.

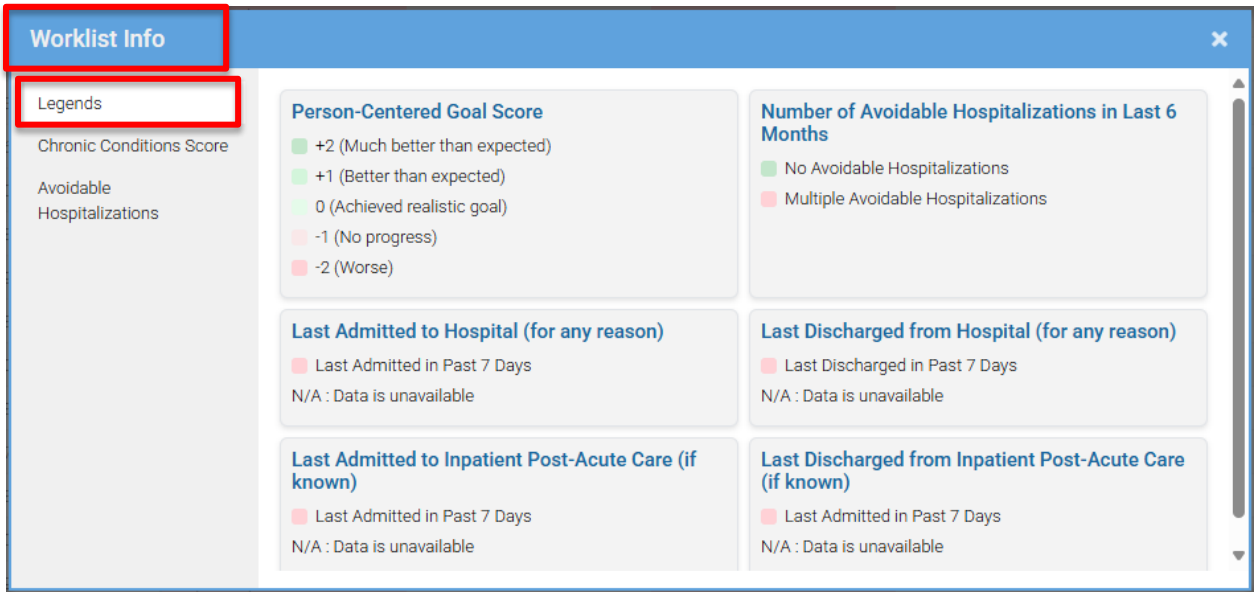
Worklist Info

The Worklist Info button in the upper right corner above the columns provides a legend and definitions of the Chronic Conditions Score and Avoidable Hospitalizations.

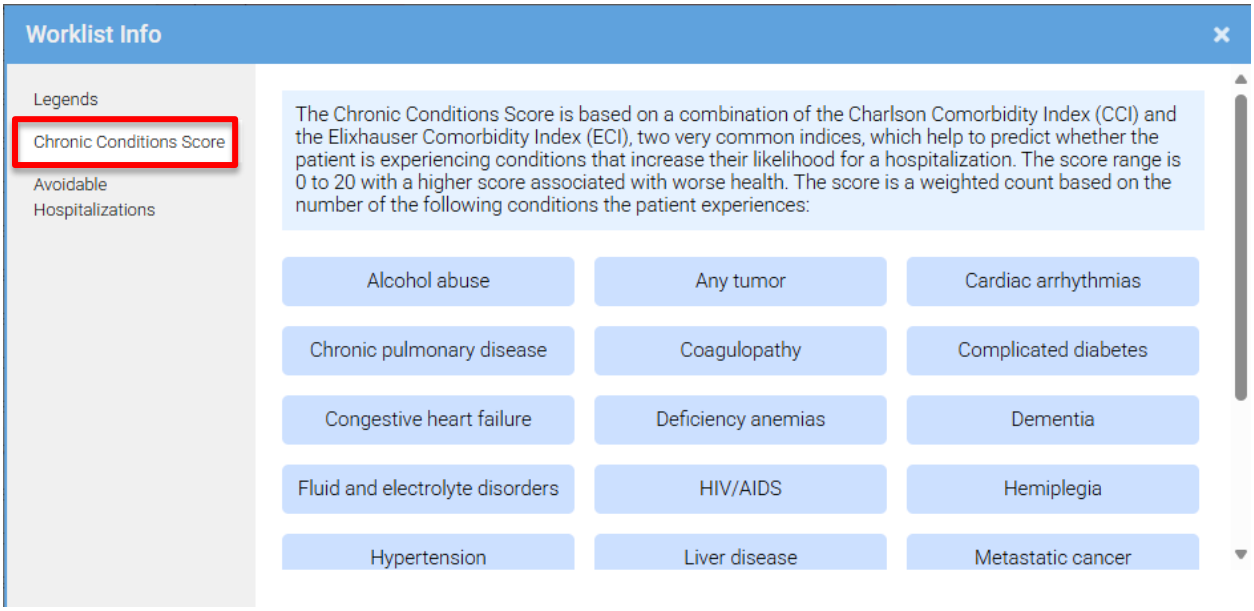


Select the Worklist Info button. A pop out window will open. You can resize the popout window to make it larger or smaller. Close the widow by selecting the “x” in the upper right corner.

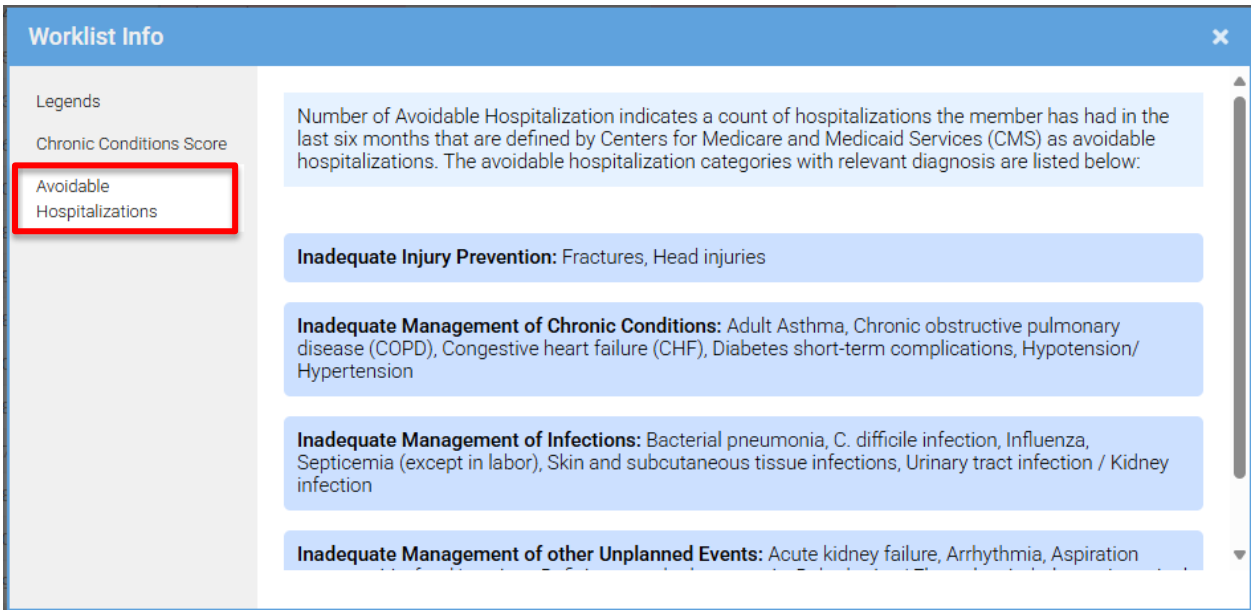
The Worklist Info defaults to opening onto the Legends section. Here you will have access to the description for when the color coding is used for each of the columns.



For the Chronic Conditions definition, select the “Chronic Conditions” section on the left side navigation.

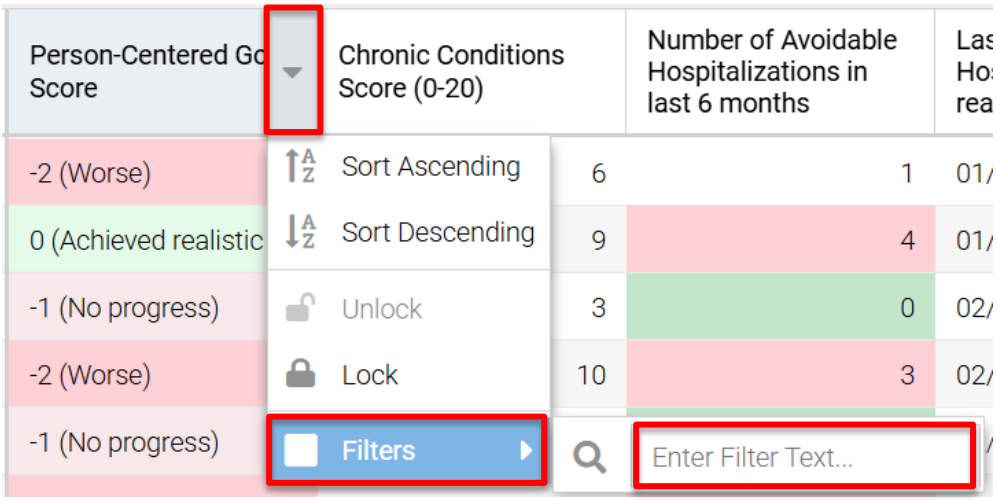


For the Avoidable Hospitalizations definition, select the “Avoidable Hospitalization” section on the left side navigation.



Worklist Filter

Each column in the worklist has a filter function. You can create a filter by hovering over the column header to reveal a downward facing triangle.

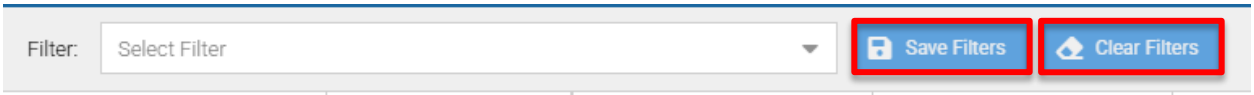


Click the triangle, and then select “filter” at the bottom of the dialogue box. Type the word or range you want to filter.

Once a filter has been applied to the column, the column header will be bold and italics.

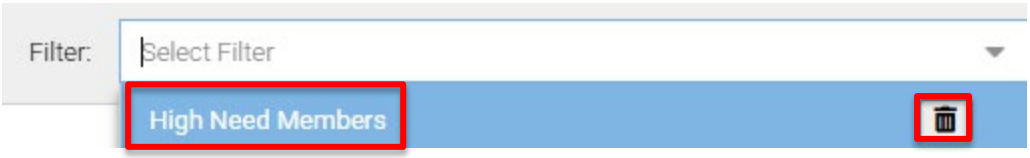
You can filter multiple columns to create a unique sub list of your clients. For example, under Person Centered Goals type "-" (negative) to only view your clients with a negative score. Then filter the number of Avoidable Hospitalizations to include hospitalization greater than 2.

To clear your filters, select the "Clear Filters" button at the top of the widow.



To save your filter to use in subsequent sessions, select the Save Filter button at the top of the window and enter a filter name.

Now your filter will be available in the Filter dropdown menu. Click on the down arrow, then select your previously saved filter. To delete a previously saved filter, select the trash can icon to the left of the filter name you wish to delete.

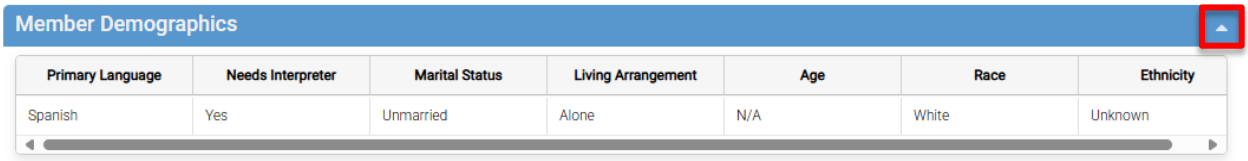


Member Snapshot

For a more information about your client's situation, select your client's name in the Worklist. The Member Snapshot feature will display as a pop out window. You can resize the window by selecting the lower left corner. Close Snapshot for the selected patient by clicking on the "x" in the upper right corner of the snapshot view. Only one client can be viewed in Member Snapshot at a time.

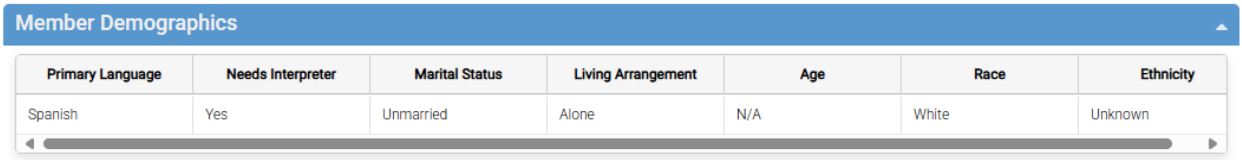
Member Snapshot defaults to the collapsed view. To expand the sections, select the downward facing arrow next to the Snapshot section.

To collapse an expanded section, select the upward facing arrow at the header of the expanded section.



Member Demographics

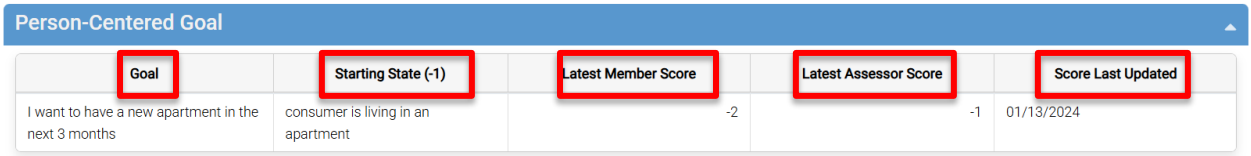
Member Demographics information is primarily provided by the Universal Assessment, administered by Access Agencies.



Person-Centered Goals

Person-Centered Goals are developed between Access Agency staff and your client. In this section you will find the specific goal language, your client's condition or ability at the time the goal was set (starting state), the score your client gave themselves the last time the Access Agency checked your client's progress in relation to the goal (Latest Member Score), the score the Access Agency gave your client the last time they

checked your client's progress in relation to the goal (Latest Assessor's Score), and the date of the last time the score was assessed (Score Last Updated).



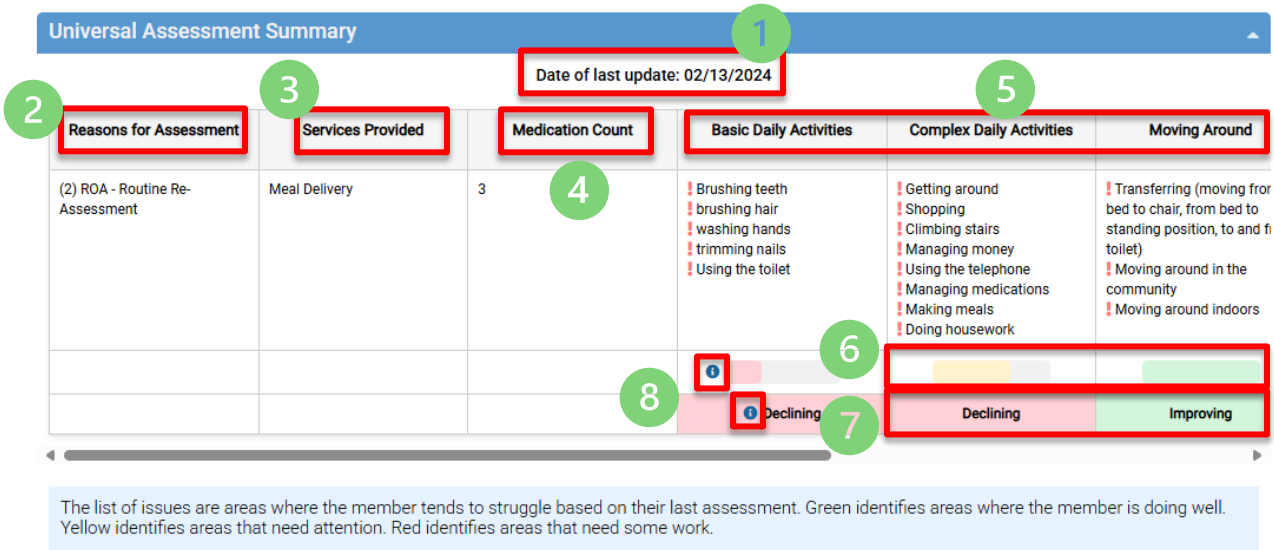
Care Team

The care team primarily includes data on other HCBS organizations, including the Access Agency, that provide services to your clients. If a specific provider is available, their name will be included under Provider Name. The organization name will be included as well as any information available on the type of provider and a phone number for that organization or program.

Universal Assessment Summary

The CT Universal Assessment was designed to standardize assessments across waivers and other Medicaid programs, improve reliability of assessments, and reduce redundancy of multiple assessments. Access Agencies administer the assessment before services begin and typically annually after the initial assessment for eligibility determinations and service planning. This section provides a summary of the results of the last assessment completed for your client.

1. The data of your clients last Universal Assessment is provided at the top of this section.
2. The first column provides the reason the assessment was completed on this date.
3. Services Provided will include a list of the services your client is receiving.
4. Medication Count is the number of medications your client was known to be taking as of the assessment date.
5. Each of the subsequent columns provide a category of activities and a list of activities your client has difficulty doing within that category.



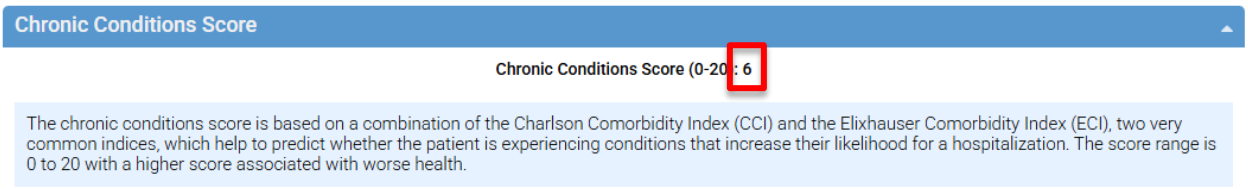
6. The row under the list of activities indicates if your client is overall doing well in that category (green), doing moderately in that category (yellow), or having a lot of challenges (red).
7. The final row in the table indicates whether your client has improved, declined, or stayed the same as compared to the previous assessment.
8. The “i" in the 2nd and 3rd rows provide an explanation of the color coding for reference.

Chronic Conditions Score

The Chronic Conditions Score section includes a definition of the score, the potential score range, and your member’s score. You will not be provided detailed information

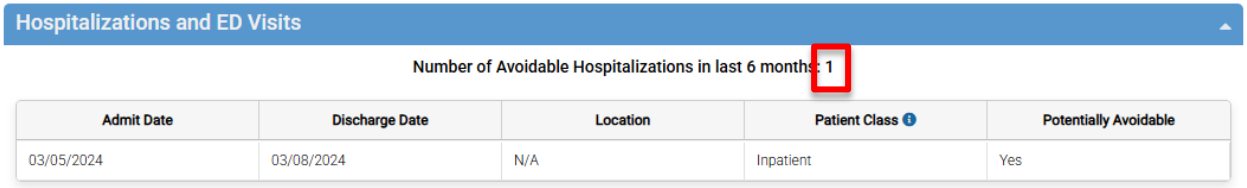
about the nature of your clients' health conditions that contribute their score, as that is protected health information.

NOTE: For HCBS program participants that are legally allowed access to your patient's protected health information, you can find more information about your patient's condition under the Clinical Information Application after Patient Search from the Connie Portal Dashboard. This feature is only available to healthcare professionals.



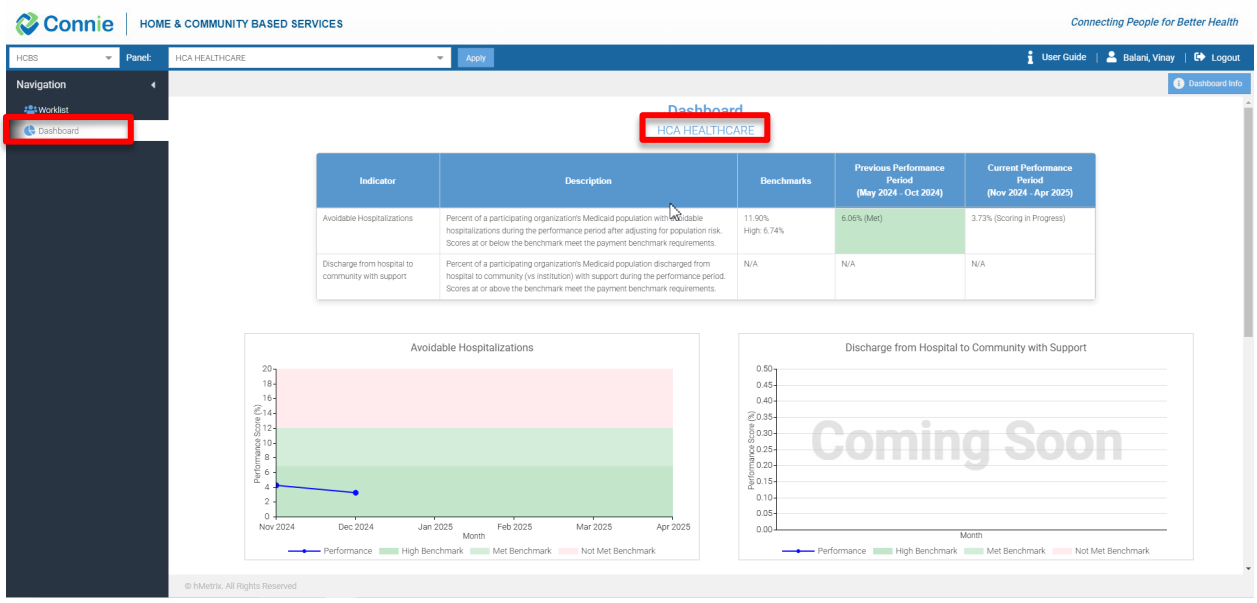
Hospitalizations and ED Visits

A count of your client's avoidable hospitalizations over the last six months is provided at the top of this section. Below the count is a list of your client's previous hospitalizations within the last 6 months. The list includes the date your client was hospitalized (Admit Date); the date they were discharged (Discharge Date), where they were seen (Location); if the stay was an inpatient, outpatient, ED visit, or just for observation (Patient Class); and whether the visit met the definition of an avoidable hospitalization (Potentially Avoidable). See Worklist Info above for the definition of Avoidable Hospitalizations.



Dashboard

Access to the Dashboard is available by selecting “Dashboard” under the left had Navigation. Once selected, the name of the organization’s panel that is represented in the dashboard will be listed at the top of the Dashboard page.



The Dashboard includes 4 sections:

1. A table that provides an overview of your organization’s progress related to Outcome Measure 1: Avoidable Hospitalizations and Outcome Measure 2: Discharges from Hospital to Community with Support.
2. Two graphs, one for Outcome Measure 1 and the other for Outcome Measure 2
3. A second table that provides an overview of your organization’s progress related the three Person-Centered Goals outcome measures
4. A single graph for Person-Centered Goals.

Outcome Measures: Table

The Table View provides a description for each outcome measure, the benchmark for the measure, your organization’s score during the previous performance period, and your organization’s score during the current performance period.

Indicator	Description	Benchmarks	Previous Performance Period (May 2024 - Oct 2024)	Current Performance Period (Nov 2024 - Apr 2025)
Avoidable Hospitalizations	Percent of a participating organization's Medicaid population with avoidable hospitalizations during the performance period after adjusting for population risk. Scores at or below the benchmark meet the payment benchmark requirements.	11.90% High: 6.74%	6.06% (Met)	3.73% (Scoring in Progress)
Discharge from hospital to community with support	Percent of a participating organization's Medicaid population discharged from hospital to community (vs institution) with support during the performance period. Scores at or above the benchmark meet the payment benchmark requirements.	30.00% High: 60.00%	14.50% (Not Met)	27.00% (Scoring in Progress)

Outcome Measure – Identifies the title of the outcome measure.

Description – Provides a description of the outcome measure as well as whether a score above or below the benchmark meets the benchmark.

Benchmarks - For Goal 1 and Goal 2, DSS has established high and low benchmarks. The low benchmark is listed at the top of each row. The High benchmark is the second percent listed in the field. The second benchmark listed in the table cell specifies “high”.

For outcome measure 1, meeting the low benchmarks means that your organization has had LESS avoidable hospitalizations among your panel of clients than low benchmark. To meet the high benchmark, your organization has had LESS avoidable hospitalizations among your panel of clients than the high benchmark percent listed. For outcome measure 2, your organization must have MORE discharges to the community with support among your panel of clients than the low and high benchmarks listed.

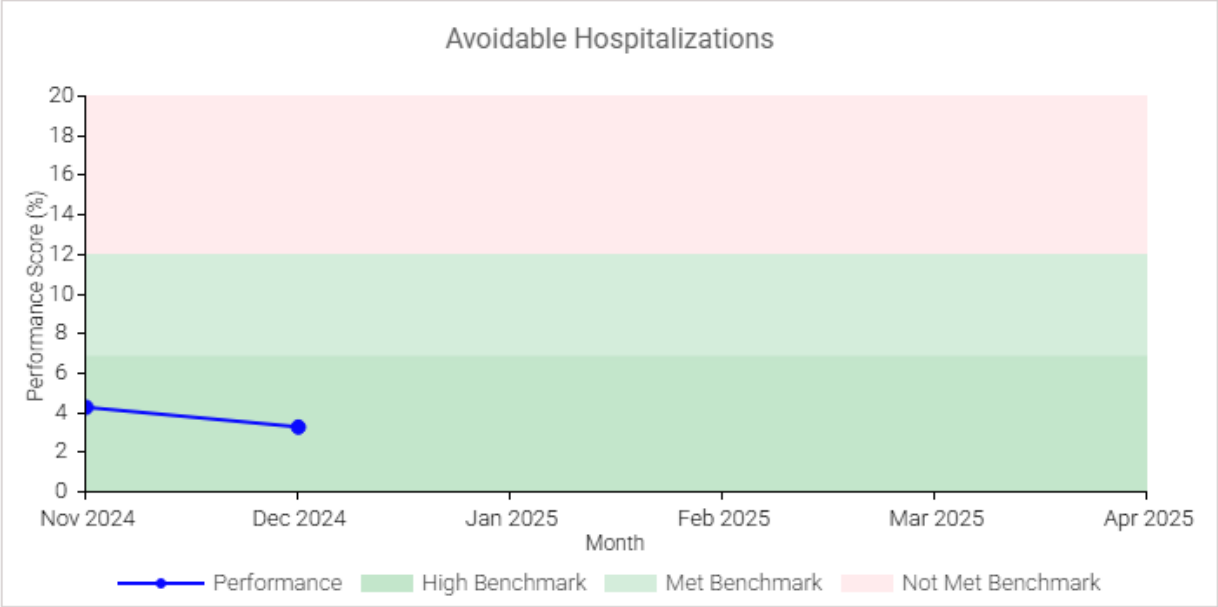
Previous Performance Period - The previous performance period shows the final score given at the end of the performance period compared against the benchmark. A Previous Performance Period score highlighted in green indicates that the score met at least the lower benchmark. A score highlighted in red indicates that neither high nor low benchmarks were met.

Final scores are risk adjusted based on the Chronic Condition Scores of your panel of Medicaid member clients. If your panel of clients have more health issues than another organization (or a different time period for your own organization), your score is adjusted to take this into account. In this way, a riskier panel of clients does not put you at a disadvantage for meeting the benchmark.

Current Performance Period - The Current Performance Period score is accumulative, meaning that it provides your current score today from the beginning of the performance period.

Outcome Measures: Graphs

The graph view shows your organization's progress month over month during the current performance period only. The Graph view is not accumulative. it shows how your organization's panel of clients scored for each month independently against the benchmark.



Your organization monthly score is indicated by the blue trend line. The darker green band indicates scores that would reflect meeting the high benchmark. The lighter green band indicates scores that would reflect meet the low benchmark. The pink band indicates scores that would not meet either benchmark.

Person-Centered Goals

The Person-Centered Goals have three measures: Goal Identification, Goal Assessment, and Goal Attainment. The table and associated graph provide an overview of how your organization's panel of Medicaid members are doing in relations to these three measures.

Table

The Table provides a description for each outcome measure, the benchmark for the measure, your organization's score during the previous performance period, and your organization's score during the current performance period.

Indicator	Description	Benchmarks	Previous Performance Period (Jan 2024 - Jun 2024)	Current Performance Period (Jul 2024 - Dec 2024)
Person-Centered Goals: Identification	Percent of a participating organization's Medicaid population who (a) had a goal identified during the performance period.	90.00%	92.50% (Met)	92.50% (Met)
Person-Centered Goals: Follow-up	Percent of a participating organization's Medicaid population who (b) had a follow-up within 180 days.	50.00%	49.50% (Not Met)	49.00% (Not Met)
Person-Centered Goals: Attainment	Percent of a participating organization's Medicaid population who (c) met or exceeded their primary person-centered goal during the performance period.	40.00%	41.50% (Low member count, not scored)	41.50% (Low member count, not scored)

Outcome Measure – Identifies the title of the Measure

Description – Provides a description of the Measure, defined by NCQA

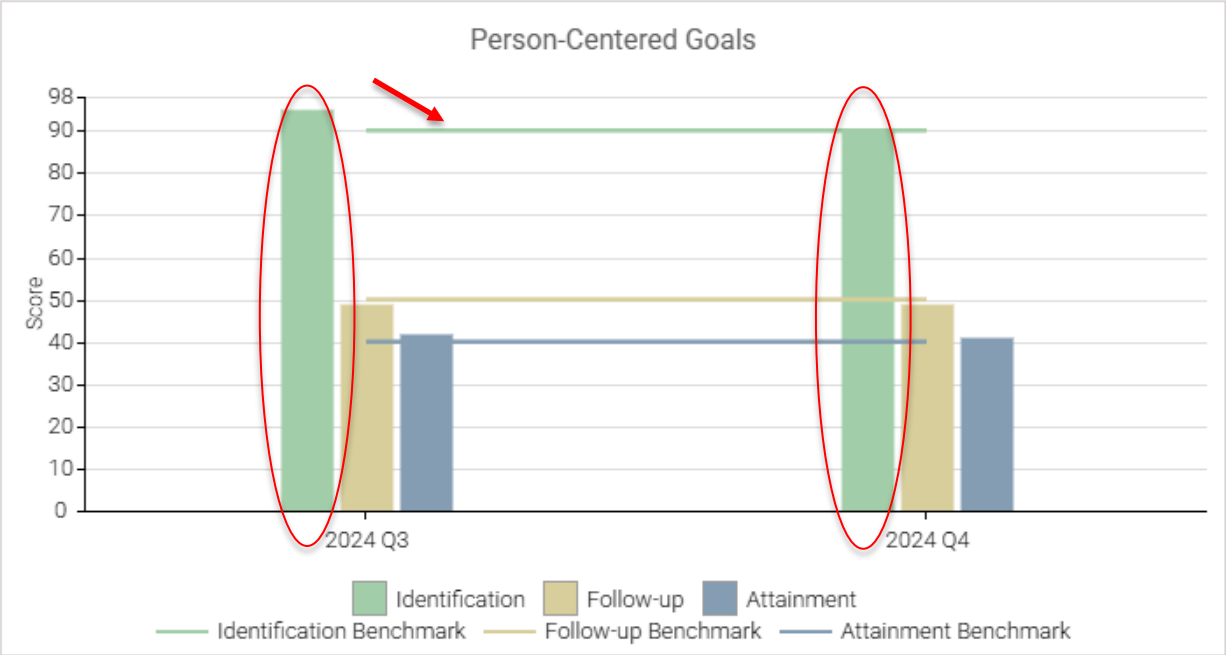
Benchmarks – NCQA identified one benchmark for each measure of the Person-Centered Goal area. Meeting the benchmarks means that your organization's score is GREATER THAN the benchmark.

Previous Performance Period - The previous performance period shows the final score given at the end of the performance period compared against the benchmark. A Previous Performance Period score highlighted in green indicates that the score met the benchmark. A score highlighted in red indicates that the benchmark was not met. If there was not a sufficient number of eligible clients, you will receive a score for the clients that were eligible, but your score will not measure goal performance.

Current Performance Period - The Current Performance Period score is accumulative, meaning that it provides your current score today from the beginning of the performance period.

Graph

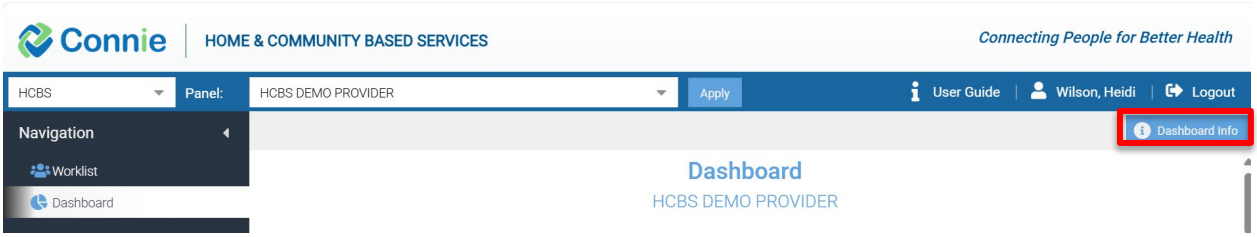
The graph view shows your organization's progress quarter over quarter during the current performance period only. The Graph view is not accumulative. it shows how your organization's panel of clients scored for each quarter independently against the benchmark.



For each quarter, there are three bars and three lines. The bars represent your organization's score for that month for each measure. The lines represent the benchmark for each measure. Bars and lines with the same color reflect the same measure. For example, the first green bar represents your organization's score for the "identification" measure in 2024 Q3 (July – September). The second green bar represents your organization's score for the "identification" measure in 2024 Q4 (October – December). The green line represents the benchmark score needed to meet the "identification" measure.

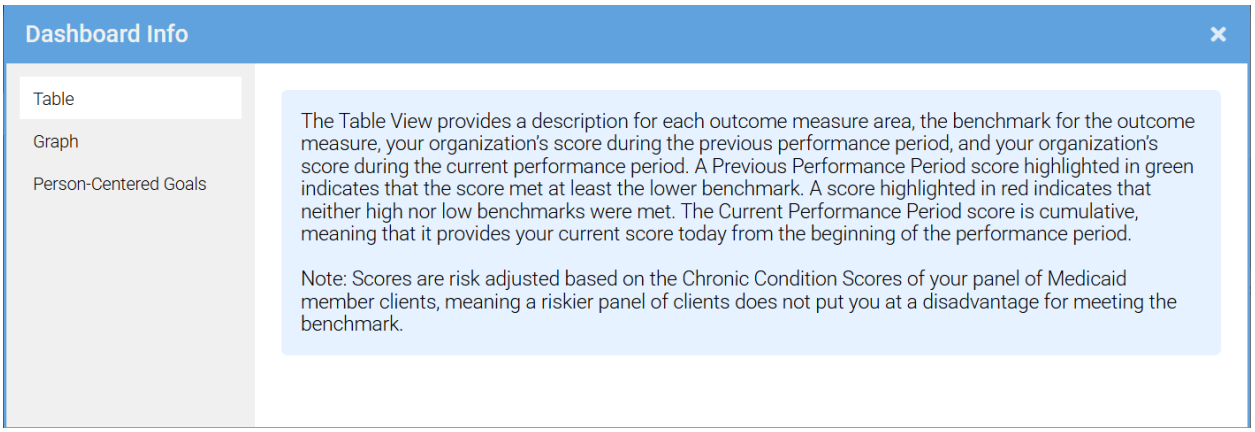
Dashboard Info

The dashboard info provides more detailed descriptions of the definitions of the goals and measures. To access Dashboard Info, select the “Dashboard Info” button on the upper right side of the screen, under “logout”.

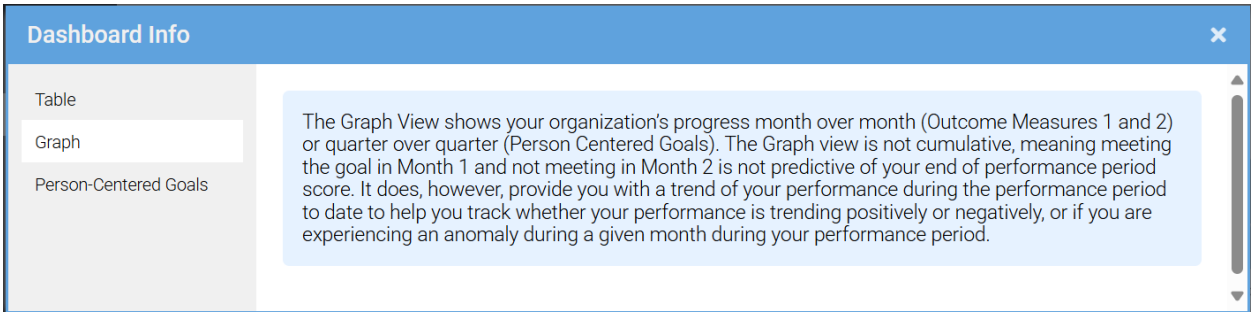


A pop out window will appear. There are three sections. Dashboard Info includes descriptions of the Table View, Graphs, and Person-Centered Goals. The pop out will default to the Table section.

Table View describes the Current Performance Period score, and eligibility criteria.



Graph describes the monthly performance measure.



Person-Centered Goals provides details about meeting the benchmark and eligibility requirements for each measure.