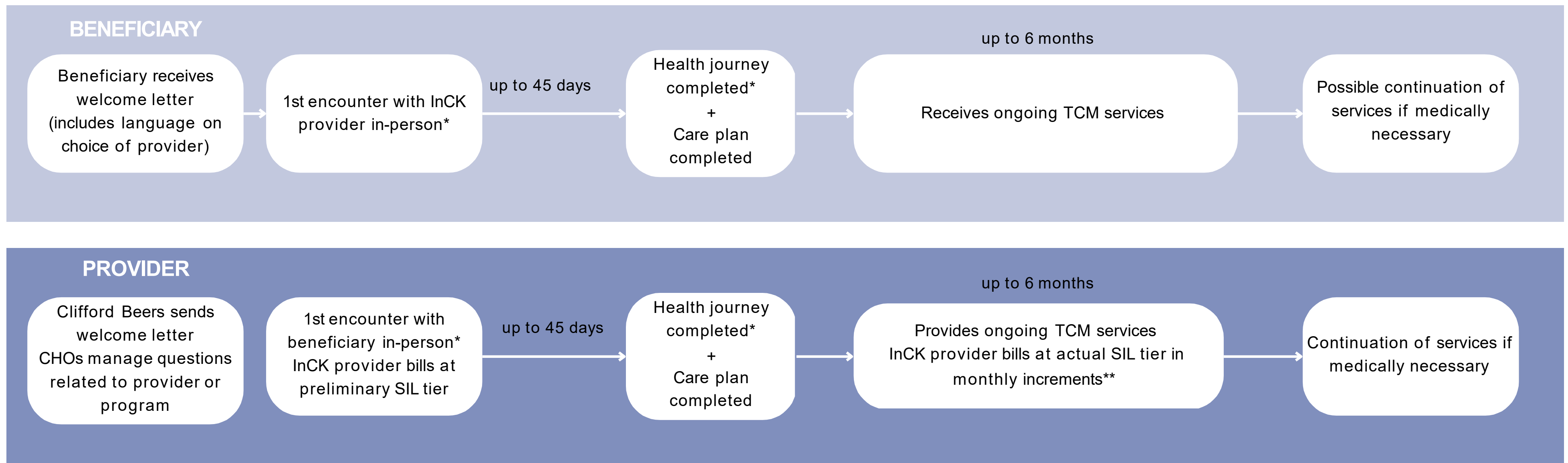
Appendix A: Service Flow - Pilot Phase



*encounter and health journey with SIL 1 may be conducted virtually

**Manual reviews of care plans to determine if:
(1) cases are resolved or
(2) if services need to continue before the 6 months

Appendix B: InCK Overview

Domain	No Claims	SIL 1	SIL 2
HealthJourney	Annually	Annually	Annually
Goal of CT InCK Intervention	Focus on outreach to enroll in CT InCK: verify contact and demographics, consent/opt out, refer to ASO Member Engagement to id PCP, HealthJourney, refer v Unite Us	Focuses on basic, preventive care and active surveillance for developing needs and functional impairments	The CT InCK Intervention Overview outlines elements of the InCK Model and identifies required and suggested guidelines by Service Integration Level (SIL) for aspects of the CT InCK model that InCK provider organizations and Intensive Care Coordinators need to follow. Items in red signify what is required by CMS and the CT InCK Model and the responibiilty of the InCK Provider and ICC. Items in black identify guidelines, estimates and recommndations for the InCK Provider.
Assignment of Member to InCK Provider	CHO	If member stratified as a SIL 1 is part of a family unit with an individual stratified at a SIL 2 or SIL 3 assigned to an ICC, that ICC will be responsible for completing HealthJourney for SIL 1 members	InCK Provider/ICC
SIL Criteria	All members without claims for previous 12 months	Includes entire target population stratified at a SIL 1 until otherwise stratified higher	Includes members with needs involving ***more than one service type*** and who exhibit a ***functional symptom or impairment***
InCK Provider Role	None	HealthJourney only for SIL 1's within a family unit assigned to an ICC	Single Point of Contact/Outreach & engagement/Legal/ HealthJourney Assessment/care plans/closed-loop referrals/care coordination/care planning team meetings and any other ICC services
CHOs Role	Single Point of Contact for member	If SIL 1 is within a family unit assigned to an ICC, CHO will be Single Point of Contact for ICC. If member is stratified at a SIL 1 and not part of a family unit, assignment to be determined	Single Point of Contact for ICC
Caseload **(specific caseload sizes are to be determined during demonstration: numbers in table are for illustrative purposes only)**	400 members/year/CHO (7 CHOs)	35 annually	13 annually
Intervention	Community Health Organizer acts as the connector to services and resources	x	Intensive Care Coordination
	Outreach via Phone only	Outreach via Phone only	Initial Outreach via Phone, required to complete initial face-to-face visit
	HealthJourney	HealthJourney only	HealthJourney
	Crisis/Safety Plan - urgent/emergent needs	Crisis/Safety Plan - urgent/emergent needs	Crisis/Safety Plan - urgent/emergent needs
	Warm Transfer to CHN to identify a PCP	Warm Transfer to CHN to identify a PCP	Shared Care Plans (Tailored plan specific to individual need and includes family vision, needs statements, care plan needs and benchmarks (which include strategies), team meeting materials and documentation, transition plans, etc.
	BH referral if needed	BH referral if needed	Care Planning Team Meetings with member, family and care team within 60 days of care plan development
	N/A	N/A	Engage existing PCP, Bx Health Practioner, OBGyn, Dentist. If member does not have existing providers, provide warm-transfer to CHN to identify a PCP; warm-transfer to Benecare to identify a dentist, if needed conduct referral for BH and ObGYN care provider.
	N/A	N/A	Engage school personnel
	Warm Transfer to Benecare to identify a dentist	Warm Transfer to Benecare to identify a dentist	Referrals and/or Engagement to SDoH agencies based on identified needs
	Referrals via Unite Us	Referals via Unite Us	Referrals via Unite Us
Dose and Intensity of Intervention	HealthJourney (via portal sent electronically)	HealthJourney 1x/annually (via portal sent electronically), no face- to-face required, no care coordination required	Encounters = 11 hours/month (includes face-to-face, telephonic, consultation, care planning team meetings, cross-organization care coordination and documentation (per member)). Estimated 2 face-to-face visits per month.
Documentation	Document warm transfers and referrals as needed	Document warm transfers and referrals as needed	Document each instance of face-to-face, telehealth, telephonic encounter, consultation, care planning team meetings, and cross- organization care coordination in Zane Care Home platform
APM Performance Measures			1) Successful Completion of Needs Conversations: This measure is met if an InCK Provider completes Needs Conversations with 60% or greater of its attributed population. This measure is calculated by dividing the total number of completed Needs Conversations by the total number of attributed members for an InCK Provider. 2) Comprehensive Collection of Race, Ethnicity, and Language Data: This measure is met if an InCK Provider collects race, ethnicity, and language data in 75% or greater of its completed Needs Conversations. This measure is calculated by dividing the total number of InCK members with completed race, ethnicity, and preferred language demographic data by the total number of InCK members with completed Needs Conversations by an individual InCK Provider. 3) Referral Efficacy: This measure is met if 50% or greater of referrals made by an InCK Provider for attributed patients are closed. This measure is calculated by dividing the total number of closed referrals by the total number of referrals made (in aggregate across
Payment	No Payment	No Payment	PMPM based on monthly report of total SIL2 & SIL3. Initial monthly payment based on preliminary risk score (claims data and DCF data). An ICC is required to cmplete an initial face-to-face visit and complete a Health Journey and subsequent care plan within 45 days of the initial face-to-face in order to secure second monthly payment for SIL and SIL 3 members.

red text=requirement

SIL 3
Every 6 months
Focuses on child-centered care planning, intensive care coordination, and home and community-based services
InCK Provider/ICC
Includes children who meet **Level 2** criteria who are ***currently*** , or are at ***imminent risk*** *of being, placed* ***outside the home*** .
Single Point of Contact/Outreach & engagement/Legal/ HealthJourney Assessment/care plans/closed-loop referrals/care coordination/care planning team meetings and any other ICC services
Single Point of Contact for ICC
6 annually
Intensive Care Coordination
Initial Outreach via Phone, required to complete initial face-to-face visit
HealthJourney
Crisis/Safety Plan - urgent/emergent needs
Shared Care Plans (Tailored plan specific to individual need and includes family vision, needs statements, care plan needs and benchmarks (which include strategies), team meeting materials and documentation, transition plans, etc.
Care Planning Team Meetings with member, family and care team within 60 days of care plan development
Engage existing PCP, Bx Health Practioner, OBGyn, Dentist. If member does not have existing providers, provide warm-transfer to CHN to identify a PCP; warm-transfer to Benecare to identify a dentist, if needed conduct referral for BH and ObGYN care provider.
Engage school personnel
Referrals and/or Engagement to SDoH agencies based on identified needs
Referrals via Unite Us
Encounters = 16 hours/month (includes face-to-face, telephonic, consultation, care planning team meetings, cross-organization care coordination and documentation (per member)). Estimated 3 face-to-face visits per month
Document each instance of face-to-face, telehealth, telephonic encounter, consultation, care planning team meetings, and cross- organization care coordination in Zane Care Home platform
1) Successful Completion of Needs Conversations: This measure is met if an InCK Provider completes Needs Conversations with 60% or greater of its attributed population. This measure is calculated by dividing the total number of completed Needs Conversations by the total number of attributed members for an InCK Provider. 2) Comprehensive Collection of Race, Ethnicity, and Language Data: This measure is met if an InCK Provider collects race, ethnicity, and language data in 75% or greater of its completed Needs Conversations. This measure is calculated by dividing the total number of InCK members with completed race, ethnicity, and preferred language demographic data by the total number of InCK members with completed Needs Conversations by an individual InCK Provider. 3) Referral Efficacy: This measure is met if 50% or greater of referrals made by an InCK Provider for attributed patients are closed. This measure is calculated by dividing the total number of closed referrals by the total number of referrals made (in aggregate across
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