CHCS Center for Health Care Strategies, Inc.

TRANSFORMING COMPLEX CARE PROFILE

OneCare Vermont

Investing in data and clinical strategies to support complex care across a statewide accountable care organization

OneCare Vermont is a statewide accountable care organization (ACO) founded by the University of Vermont Medical Center and Dartmouth-Hitchcock Medical Center in 2012. Building on the strengths of the state's patient-centered medical home model, OneCare is developing a provider-driven, integrated health care delivery system to serve the small cities and rural areas of Vermont. OneCare recently became part of Vermont's All-Payer Accountable Care Organization Model, a new delivery system reform initiative of the state and the Centers for Medicare & Medicaid Services.

Pilot Focus

OneCare Vermont is building on its existing health system reform efforts, including the statewide Integrated Communities Care Management Learning Collaborative and Vermont Blueprint for Health primary care model, to standardize care coordination approaches for patients with complex care needs. OneCare Vermont's pilot effort is also supporting four Vermont communities — Bennington, Berlin, Burlington, and St. Albans — to test care coordination software and facilitate communication through shared care plans accessible to all care team members and providers. The care team includes nurses, social workers, health coaches, and medical assistants as well as behavioral health providers and representatives from local social service agencies. The software is populated with claims data and includes patient demographics, health conditions and key health care utilization metrics. The Johns Hopkins ACG (Adjusted Clinical Groups) risk score is used to stratify the population and determine interventions. The pilot will inform future enhancements and spread of the system statewide.

Pilot Patient Population

OneCare Vermont patients, including Medicaid, Medicare, and commercially insured individuals, who are targeted for care coordination are identified by risk scores based on: recent inpatient hospitalizations, number of chronic conditions, number of specialty visits, gaps in care, polypharmacy, and diagnosis codes. The care coordination software will eventually be used statewide — for the more than 114,000 individuals served by the program.

About Transforming Complex Care

These profiles feature participants in *Transforming Complex Care*, a national initiative made possible with support from the Robert Wood Johnson Foundation. The Center for Health Care Strategies is directing this multi-site demonstration to support the development of highly replicable care models for individuals with complex medical and social needs. For more information, visit **www.chcs.org.**

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Key Program Partnerships

- **Health Care Providers**: Primary care, specialists, home health care, hospice, skilled nursing facilities, and Critical Access Hospitals.
- **Behavioral Health Care Providers**: Behavioral health specialty hospitals and designated community mental health centers.
- **Social Service Providers**: Agencies on aging and support and service providers.

Select Features of OneCare's Program

Data and Analytics

- Testing Care Navigator software as a "one-stop shop" for a shared plan of care.
- Connecting the shared care plan to the data warehouse for EHR and other data.

Workforce Development

- Examining opportunities to train and employ community health workers as part of care teams.

Policy and Advocacy

- Exploring new ways to finance health care through an all-payer ACO delivery model that includes requirements to identify patients with complex medical and social needs and coordinate their care. Payment mechanisms, quality measures, financial targets, risk arrangements, and beneficiary attribution will be aligned across Medicare, Medicaid, and commercial payers.

*SOURCE: Complex Care Domains, from *Supporting a Culture of Health for High-Need, High-Cost Populations: Opportunities to Improve Models of Care for People with Complex Needs*. Robert Wood Johnson Foundation and CHCS. October 2015.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.