OneCare Vermont

Care Coordination Survey 2020

Q1. First and Last Name
Q2. Name of organization or practice for which you are providing care coordination.
Q3. What is your position/ title? (please spell out)
Q4. How many years of experience do you have in care coordination?
Answer Choices
1 year or less
>1 year to 5 years
6 or more years
Q5. Check all of the barriers for conducting care coordination for OneCare patients in your region.
Answer Choices
Difficulty communicating with care coordinators and/or providers at primary care practices
Difficulty communicating with community-based organizations (Home Health, DA, AAA, SASH)
Challenges with engaging patients
Caseload is too high
HIPAA/Privacy regulations
Insufficient time to coordinate care
Technology Issues: Specify below
Not understanding what is expected
Need more education and training about care coordination
Other (please specify)
Q6. Check all of the tools that are included in your process for identifying OneCare patients who might benefit from care coordination services.
Answer Choices
Care Coordination Process Metrics Application
Care Navigator: Utilization Metrics including ER Visit, Hospital Admissions/Readmissions
Care Navigator: Risk Stratification Level (Very High, High, Medium, Low)
Care Navigator: Social Risk Score
COVID-19 Application
Team Conferences/Huddles
Electronic Medical Record review
Patient Prioritization Application (monthly change in ACG risk score)
Other (please specify)
Q7. How do you decide which patients to include in your care coordination program?

Q8. How do you decide when to transition a patient out of care coordination?
Q9. What are the short-term (1 year or less) outcomes or improvements you would expect from your care coordination intervention?
Answer Choices
Reduce ED utilization
Reduce hospital readmission
Reduce total cost of care
Increase engagement in self-management program
Increase engagement with primary care/patient-centered medical home
Other (please specify)
Q10. What are the long-term (over a year) outcomes or improvements you would expect from your care coordination intervention?
Answer Choices
Reduce ED utilization
Reduce hospital readmission
Reduce total cost of care
Increase engagement in self-management program
Increase engagement with primary care/patient-centered medical home
Other (please specify)
Q11. What do you think is the most impactful thing you do for your patients as a care coordinator?
Q12. The Social Risk Score is a risk adjustment method that uses non-medical claims data to inform a score of 1 to 4 that is associated with the level of social stressors a patient may be experiencing. Do you use the social risk score in Care Navigator? If so, how do you use it? If you don't use it, why?
Q13. How often are you using Care Navigator?
Answer Choices
Daily
Weekly
Monthly
Quarterly
Yearly
Never

Q14. We are interested in gathering information about improving Care Navigator. Below are fields that care coordinators are expected to use. Please share suggested improvements for visualizing this information in Care Navigator.
Answer Choices
Adding Care Team Members
Viewing Care Team Members
Care Team Notifications
Shared care plan content, including goals and tasks
If patient/family is able to access Care Navigator, what information do you suggest they have access to?
What type of reports, lists or views would be useful? Please Describe
Q15. Choose the clinical assessments you would like to have available in fill-able format on Care Navigator.
Answer Choices
Self Sufficiency Outcomes Matrix (SSOM)
Social Determinants of Health (SDoH) screening
Suicide Screening
Beck Depression Inventory (BDI)
Patient Health Questionnaire (PHQ-9)
Patient Health Questionnaire (PHQ-2)
Quality of Life (QoL) Assessment
Other (please specify)
Q16. What else would you like to share about enhancing Care Navigator? Please be specific about how this would enhance your experience.
Q17. Would you like to see the Northern and Southern Core Team meetings continue?
Answer Choices
Yes- Monthly
Yes- Every other month
Yes- Quarterly
Yes- Twice per year
Yes- Annually
No, please explain below
I do not participate in the Core Team Meetings
Other (please specify)
Q18. Check the topics you would like to see covered during the Core Team meetings.
Answer Choices
Health Service Area specific information
Updates from OneCare
Care Coordination training and education
Subject Matter Expert speaker
I do not participate in the Core Team meetings
Other (please specify)

Q19. There is a newly launched 'Care Coordination Corner' on Vermont Health Learn. Check the boxes of the topics that are of interest to you.
Answer Choices
Patient Engagement
Transitional Care
Increasing Adherence to Self Management
Navigation and Closing the Loop
Medication Reconciliation
Formalizing processes between organizations that are caring for mutual patients.
Other (please specify)
Q20. The Care Coordination team provides technical assistance (TA) and education for Health Service Area groups focusing on care coordination of the OneCare population. List the TA topics that would be most helpful to improve your provisioning of care coordination.
Q21. Please note anything else you would like to share specific to the Care Coordination Program at OneCare.