OneCare Vermont

OneCare Vermont ("OneCare") is pleased to provide a status update on activities addressing childhood adversity through its Network.

Support of Local Initiatives through the Innovation Fund

OneCare has empowered local community initiatives addressing childhood adversity through the Innovation Fund. The Innovation Fund awards capital to applicants who present innovative ideas to improve the health of the community. The Innovation Fund awarded eight applicants funding over two cycles of applications in 2019. Two of these initiatives have the potential to mitigate adverse childhood events.

The Psychiatric Urgent Care for Kids (PUCK) program is an innovative concept in action in Bennington County. PUCK is a joint effort of United Counseling Service (UCS) and Southwestern Vermont Medical Center (SVMC) and is funded through the Innovation Fund grant from OneCare Vermont. PUCK was created to directly address the issue of increasing utilization of the emergency department by youth in crisis, and the negative consequences associated with this trend. Local schools in Bennington County observed a spike in the number of kids in crisis at school that were transferred to the ED. PUCK's primary goals are to be an alternative to the emergency department for elementary-aged children in psychological distress, to reduce the level of adverse experiences that children face by limiting law enforcement encounters and ED visits, to help free up resources (e.g., the time of the police, available beds in the emergency department,) to help children re-enter and to stay in school, and to create effective treatment plans. PUCK was selected in the first round of funding in 2019 for the Innovation Fund. It began serving elementary aged children (5-11yo) in the town of Bennington in September 2019, quickly expanded to accept all elementary aged children in Bennington County in October 2019, and expanded to middle school aged children (12-15yo) in February 2020.

The second initiative supported by the Innovation Fund that has the potential to mitigate childhood adversity is the Community Embedded Well Child Care for Refugee Communities. The University of Vermont Children's Hospital's Pediatric New American Clinic (PNAC) will spearhead a community-based clinic for 0 to 5 year-old well child care and will partner with Janet S. Munt Family Room in Burlington, VT to hire and train Family Strengthening Workers (FSWs) to increase families' overall wellbeing through group-based guidance on a range of topics. The PNAC, a nationally recognized model of care for refugees and immigrants, supports children and families to thrive through offering comprehensive, family-centered, medical care. By connecting FSWs to families struggling with poverty, employment, housing, and related stressors, medical providers essentially "wrap" the family within a holistic approach that aims to address not only acute needs but the root causes of medical conditions.

Identifying "At Risk" Pediatric Patients

The foundation of OneCare's care model is a strong, goal-oriented relationship developed between the patient/caregiver and his/her provider and care team members. Through risk stratification and segmentation, the care model seeks to identify potential patients and caregivers in need of a more comprehensive support system. In 2020, OneCare is risk stratifying the pediatric population separately from the adult population. This will allow a greater portion of pediatric population, the top 16%, to rise to the high and very high risk levels, better identifying those pediatric patients in need of complex care coordination for providers and care coordinators.

Another related area of focus is Developmental Understanding and Legal Collaboration for Everyone (DULCE). This is an intervention that takes place within a pediatric care office to address social determinants of health in infants, zero to 6 months, and provides support for their parents. A Family Specialists, trained in child development from the local Parent Child Center, attends the well child visits with families and medical providers. Together with the DULCE team, consisting of nurses, legal help, and pediatricians, the Family Specialist is able to help connect families with support systems to address the health disparities that often affect low-income families, families of color, and immigrants in particular.

As of December 2019, OneCare was able to exceed the goal of having three new DULCE locations by funding four DULCE models at pediatric practices statewide. These pediatric practices are Timber Lane Pediatrics in Milton, Timber Lane Pediatrics in South Burlington, The Mount Ascutney Hospital and Health Center in Windsor, and the Ottauquechee Health Center in Woodstock. All of these pediatric practices are using a DULCE family specialist.

Table 1. Metrics for DULCE progress at pediatric practices statewide.	
Percentage of well child visits attended by a Family Specialist	80% (138 of 172 visits)
Families that were offered DULCE services	73
Average number of staff trained in DULCE method at each site	Between 9 and 11 Staff
Percentage of patients screened	98%
Percentage of screened patients referred	75%
Percentage of patients accepting support when referred	56%
Number of families with mental health needs identified	8% (6 of 73 families)
Number of families with mental health needs referred	100%

The DULCE sites are working toward expanding the program and further integrating the program within the pediatric practices. The physicians have found the program extremely helpful and have increased the value of their visits with families. Parents have also found success because of DULCE. Below are some selected quotes from these parents:

“I think this program is great. I’m so glad I can have the extra help. Everyone should be offered this type of service. New parents need all the support they can get.” –Parent enrolled in DULCE
“The DULCE program has really helped our family to navigate the challenges that have come with the addition of a new baby to our family. I struggled with PPD/PPA after having [my son], and the resources and support of the DULCE program have tremendously helped prevent those issues from arising again with [my daughter]. Since becoming a mom I’ve often felt like I have the weight of the world on my shoulders and having someone to connect me with resources that can help us overcome the obstacles we face has been a lifesaver for me.” --Parent enrolled in DULCE

To further broaden the scope of early childhood adversity screening, OneCare is partnering with The Division of Maternal and Child Health (MCH) at the Vermont Department of Health, the Child Development Division (CDD) at the Department for Children and Families, Vermont Medicaid, Children’s Integrated Services, Building Bright Futures, and early program and planning agencies Help Me Grow Vermont and Strong Families Vermont through a Centers for Health Care Strategy Technical Assistance grant. Efforts focus on screening in settings including primary care, early education, and home visiting. Currently, organizations are being invited to participate, training programs established, and discussions about data sharing ongoing.

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Advancing Data-Driven Approaches

OneCare has partnered with Algorex Health since 2018 to build, test and validate three age-specific risk models to help social determinant of health risk. The result of this partnership is the Social Determinants of Health (SDOH) Composite Stress score that will be generated for all patients attributed to OneCare in 2020. The SDOH Composite Stress score is a trained model that predicts high medical expense and adverse utilization using only non-clinical factors, which allows this score to be a true complementary risk score to the Johns Hopkins' ACG Clinical Risk Score. The SDOH Composite Stress score will be displayed in Care Navigator this year to improve identification of individuals and families that may be at increased risk and benefit from additional care coordination supports.

Lastly, OneCare proposed to plan and develop a data and systems-driven collaboration with AHS and DVHA to integrate social needs data into OneCare's complex care coordination program. The objectives of this work will be to 1) Better identify individuals that could benefit from enhanced services and supports; 2) Develop collaborations across medical and human services providers that facilitate collaboration and information sharing; reduce duplication; and enhance individual's experience of care; and 3) Align and integrate health and human services and supports in local communities.

As healthcare and social programs continue to work in collaboration to achieve healthier populations, integration of health and social determinant data will become crucial in order to gain a complete view of an individual, especially those engaged in care management and falling into the high risk high need (HRHN) population. Merger of health and social determinant data into one accessible care management system, Care Navigator, would allow care coordination team members and the AHS social program teams a real-time snapshot of an individual's health data, as well as the social programs supports he or she is receiving; allowing for a more patient-centered, holistic approach to not only the care coordination, but allow for a more well-rounded social services support system, with the ability to identify duplication of services and to offer social programs the individual, and their family, may benefit from. Through identification of these HRHN individuals, and pairing them with the social supports they may benefit from, we can help to achieve a more equitable healthcare system in Vermont, with the most vulnerable receiving the utmost quality in care and social supports. OneCare and AHS will look to successes of the innovative work that has occurred in Oregon, where system-level medical and social complexity data is brought together to determine health risks in children, in the development of this project, but with plans to expand upon that model to the statewide population.

In the first phase of this project, OneCare will work with AHS to identify the social programs that would yield accurate data and best support HRHN individuals. For one example, incorporating social data for the Children with Special Health Needs (CSNH) program at AHS into the health data for these individuals into Care Navigator would allow a more holistic view of what social determinants to health children with special health needs are facing that are impacting the quality and the cost of their health care. The gathering of this data in one integrated data home, then combining that data with health care claims data would allow for OneCare and the State to better identify gaps, duplications, and also discover trends in health care and social program utilization. This integrated data system would support the missions of both OneCare's and AHS, would benefit Vermonters, especially those in HRHN categories, and lead to potential cost savings in both care and social programs costs.