



Care Coordination Services

Care Coordination activities promote holistic and person-centered care to ensure that an individual's needs and goals are understood and shared among providers, patients, families, and team members. The ultimate aim is to improve the quality of care, the patient experience of care and the patient engagement in their plan of care as they interact with health care providers. OneCare supports a community-based care coordination program for all attributed beneficiaries. Care coordination services are guided by the use of assessments that evaluate the individual's physical health, mental health, and social needs and desires to support attainment of optimal health. OneCare's care coordination model actively promotes a holistic and person-centered approach to care delivery, ensuring that all team members participating in an individual care team can identify and support the individual's preferences and needs. Care coordination streamlines care for the patient by reducing the redundancy in visits, facilitating access to specialty care and services, and allowing team members to share information about the patient. These supports allow the patient to focus on achievement of health care goals knowing that all team members are informed.

OneCare follows the definition of Case Management outlined by the State of Vermont Care Models Care Management Workgroup:

"programs that apply systems, science, incentives, and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social, and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence-based or promising innovative and non-duplicative services. It is understood that in order to support individuals and to strengthen community support systems, care management services need to be culturally competent, accessible, and personalized to meet the needs of each individual served."

OneCare supports community-based care coordination services and enhanced communication and collaboration across care team members by providing the network with the technology of Care Navigator software. The Care Navigator software is a common platform in which all members of the care team, including the patient, can communicate regarding updates and needs, and a place where all team members can access the patients shared plan of care.

- **Care Navigator:**
 - <https://login.mycarenav.com/adfs/ls/?wa=wsignin1.0&wtrealm=https%3a%2f%2fonecare.mycarenav.com%2f&wctx=rm%3d1%26id%3d7223607e-9bcf-4713-8280->

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