OneCare Kansas Services

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Comprehensive care management involves Identifying members with high risk environmental and/or medical factors, and complex health care needs who may benefit from OneCare Kansas (OCK), and coordinating and collaborating with all team members to promote continuity and consistency of care and minimize duplication. Comprehensive care management includes a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs, and the development of a health action plan (HAP) with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), OneCare Kansas Partner (OCKP), member, family/support persons/guardian, and health services and social service staff. Critical components of comprehensive care management include: • Knowledge of the medical and non-medical service delivery system within and outside of the member's area • Effective cultural, linguistic, and disability appropriate communication with the member, family members/support persons, guardians, and service providers • Ability to address other barriers to success, such as low income, housing, transportation, academic and functional achievement, social supports, understanding of health conditions, etc. • Monitoring and follow-up to ensure that needed care and services are offered and accessed • Routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintaining health status, and other circumstances
Care coordination is the implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports. A dedicated Care Coordinator is responsible for overall management of the member's HAP, including referring, scheduling appointments, following-up, sharing information with all involved parties including the member, monitoring Emergency Department (ED) and in-patient admissions to ensure coordinated care transitions, communicating with all parties during transitions of care/hospital discharge, referring for LTSS, locating non-Medicaid resources including natural and other supports, monitoring a member's progress towards achievement of goals, and revising the HAP as necessary to reflect the member's needs. Care coordination: • Is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals • Supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in OCK • Involves coordination and collaboration with other providers to monitor the member's conditions, health status, and medications and side effects • Engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports • Implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact • Creates and promotes linkages to other agencies, services, and supports

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Health promotion involves engaging members in OCK by phone, letter, HIT and community “in reach” and outreach, assessing members understanding of health condition/health literacy and motivation to engage in self-management, e.g., how important is the person’s health status to the member, how confident the member feels to change health behaviors, etc., assisting members in the development of recovery plans, including self-management and/or relapse prevention plans, linking members to resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on member needs and preferences, and assisting members to develop the skills and confidence that will enable them to independently identify, seek out and access resources that will assist in managing and mitigating their conditions, and in preventing the development of secondary or other chronic conditions. Health promotion: • Encourages and supports healthy ideas and behavior, with the goal of motivating members to successfully monitor and manage their health • Places a strong emphasis on self-direction and skills development, engaging members, family members/support persons, and guardians in making health services decisions using decision-aids or other methods that assist the member to evaluate the risks and benefits of recommended treatment • Ensures all health action goals are included in person centered care plans • Provides health education and coaching to members, family members/support persons, guardians about chronic conditions and ways to manage health conditions based upon the member’s preference • Offers prevention education to members, family members/support persons, guardians about proper nutrition, health screening, and immunizations.
Comprehensive transitional care is specialized care coordination designed to facilitate transition of treatment plans from hospitals, ED, and in-member units, to home, LTSS providers, rehab facilities, and other health services systems, thereby streamlining POCs, interrupting patterns of frequent ED use, and reducing avoidable hospital stays. It may also involve identifying members not participating who could benefit from OCK. Comprehensive transitional care involves developing a transition plan with the member, family/support persons or guardians, and other providers, and transmitting the comprehensive transition/discharge plan to all involved. For each OCK member transferred from one caregiver or site of care to another, OCK coordinates transitions, ensures proper and timely follow-up care, and provides medication information and reconciliation. Comprehensive transitional care involves collaboration, communication and coordination with members, families/support persons/guardians, hospital ED, LTSS, physicians, nurses, social workers, discharge planners, and service providers. It is designed to ease transition by addressing the members understanding of rehab activities, LTSS, self-management, and medications. It includes scheduling appointments scheduling and reaching out if appointments are missed. It may also include evaluating the need to revise the HAP. The transition/discharge plan includes, but is not limited to, the following elements: • timeframes related to appointments and discharge paperwork • follow-up appointment information • medication information to allow providers to reconcile medications and make informed decisions about care • medication education • therapy needs, e.g., occupational, physical, speech, etc. • transportation needs • community supports needed post-discharge • determination of environmental (home, community, workplace) safety

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Member and family support involves identifying supports needed for members, family/support persons/guardians need to manage member's conditions and assisting them to access these supports. It includes assessing strengths and needs of members, family/support persons/guardians, identifying barriers to member's highest level of health and success, locating resources to eliminate these barriers, and advocating on behalf of members, family/support persons/ guardians, to ensure that they have supports necessary for improved health. Included in this service is assistance to complete paperwork, provision of information and assistance to access self-help and peer support services, and consideration of the family/support persons/guardians need for services such as respite care. To promote inclusion, consideration is given to accommodating work schedules of families, providing flexibility in terms of hours of service, and teleconferencing. The goal of providing member and family support is to Increase member's, family/support persons and guardians understanding of effect(s) of the condition on the member's life, and improve adherence to an agreed upon treatment plan, with the ultimate goal of improved overall health and quality of life. Member and family support: • Is contingent on effective communication with member, family, guardian, other support persons, or caregivers • Involves accommodations related to culture, disability, language, race, socio-economic background, and non-traditional family relationships • Promotes engagement of members, family/support persons and guardians • Promotes self-management capabilities of members • Involves ability to determine when members, families/support persons, and guardians are ready to receive and act upon information provided, and assist them with making informed choices • Involves an awareness of complexities of family dynamics, and an ability to respond to member needs when complex relationships come into play
Referral to community supports and services includes determining the services needed for the member to achieve the most successful outcome(s), identifying available resources in the community, assisting the member in advocating for access to care, assisting in the completion of paper work, identifying natural supports if services providers are unavailable in the member's community, following through until the member has access to needed services, and considering the family/support persons/guardian preferences when possible. Community supports and services include long-term care, mental health and substance use services, housing, transportation, and other community and social services needed by the member. Referral to community and social support services involves: • A thorough knowledge of the medical and non-medical service delivery system within and outside of the member's area • Engagement with community and social supports • Establishing and maintaining relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, the Aging & Disability Resource Center (ADRC), faith-based organizations, etc. • Fostering communication and collaborating with social supports • Knowledge of the eligibility criteria for services • Identifying sources for comprehensive resource guides, or development of a comprehensive resource guide if necessary