Provider Perspectives: OCK Six Core Services

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Helping people live healthier lives by integrating and coordinating services and supports to treat the "whole-person" across the lifespan.

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Agenda

- Identify and define the six core services required by OCK
- Discuss potential activities for each core service
- Provider stories

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Core Services

OneCare Kansas members are eligible to receive six core services:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual & Family Supports
- Referral to Community & Social Support Services

These services are in addition to the services that members currently receive from their physical and behavioral health providers under Medicaid.

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Comprehensive Care Management : Critical Components

- Knowledge of the service delivery system
- Use of communication strategies that meet the member's skills and needs
- Ability to address other barriers to success
- Monitoring and follow-up to ensure that needed care and services are offered and accessed

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Comprehensive Care Management

Key Staff: Physician, Nurse Care Coordinator, Social Worker/Care Coordinator

- Develops and regularly updates a Health Action Plan
- Coordinates and collaborates with all team members

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Care Coordination: Critical Components

- Assists in the attainment of the member's goals in timely and relevant ways
- Engages members in chronic condition self-care to support treatment adherence
- Involves coordination and collaboration with other providers
- Engages members and their chosen supports in decision-making
- Monitoring progress

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Care Coordination

Key Staff: Nurse Care Coordinator, Social Worker/Care Coordinator

- Schedules and attends appointments with member (including transportation)
- Provides follow-up
- Shares information with the member and all members of the care team
- Monitors ED and Inpatient admissions
- Monitors progress

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Health Promotion: Critical Components

- Encourages and supports healthy ideas and behavior
- Places a strong emphasis on self-direction and skills development
- Ensures all health action goals are included in person centered care plans
- Provides health education and coaching
- Offers prevention education to members

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Health Promotion

Key Staff: Physician, Nurse Care Coordinator, Social Worker/Care Coordinator

- Assist in developing the skills and confidence to seek supports to manage their condition(s) and prevent other chronic conditions
- Assessment of member's understanding of their condition (including health literacy)
- Provide health education regarding chronic conditions
- Assist in the development of a self-management plan
- Conduct medication review and education
- Promote lifestyle interventions

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Comprehensive Transitional Care: Plan Elements

- Home visit(s) to determine safety at home, work, or the community
- Timeframes related to appointments and discharge paperwork
- Follow-up appointment information
- Medication list to allow providers to reconcile medications and make informed decisions about care
- Therapy needs, e.g., occupational, physical, speech, etc.
- Transportation needs
- Community supports needed post-discharge

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Comprehensive Transitional Care

Key Staff: Physician, Nurse Care Coordinator, Social Worker/Care Coordinator

- Specialized care coordination designed to facilitate transition of treatment plans from:
  - Hospitals
  - Emergency Departments
  - In-member units
- Assist in the development of a transition plan with the member and all relevant supports
- Address understanding of rehab activities, LTSS, self-management, and medication
- Appointment scheduling and follow-up

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Member and Family Support: Critical Components

- Involves ability to determine when members, and their support persons 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

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Member and Family Support: Critical Components

Key Staff: Nurse Care Coordinator, Social Worker/Care Coordinator, Peer Support Specialist/Peer Mentor

- Promotes engagement of members, family/support persons and guardians
- Promotes self-management capabilities of members
- Assistance with paperwork
- Member advocacy

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Referral to Community Supports & Services

- Determine services needed for the member to achieve the most successful outcome(s)
- Identify available community resources
- Identify natural supports

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Referral to Community Supports & Services: Critical Components

Key Staff: Nurse Care Coordinator, Social Worker/Care Coordinator, Peer Support Specialist/Peer Mentor

- Thorough knowledge of the service delivery system
- Engagement with community and social supports
- Establishing and maintaining relationships with community service providers
- Fostering communication and collaborating with social supports
- Knowledge of the eligibility criteria for services
- Identifying sources for comprehensive resource guide

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OCK Cores Services in Action

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