OneCare Kansas Partner Professional Process Flow

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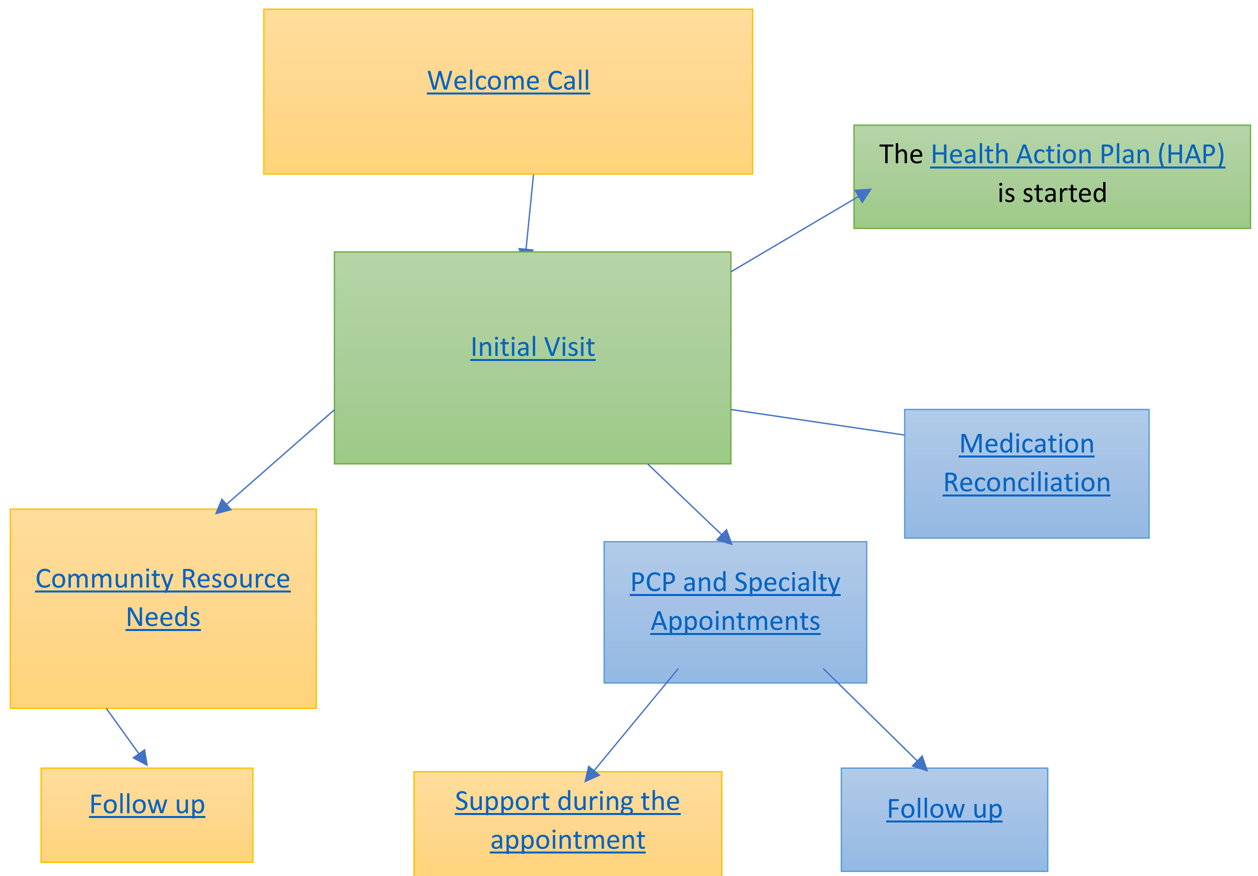
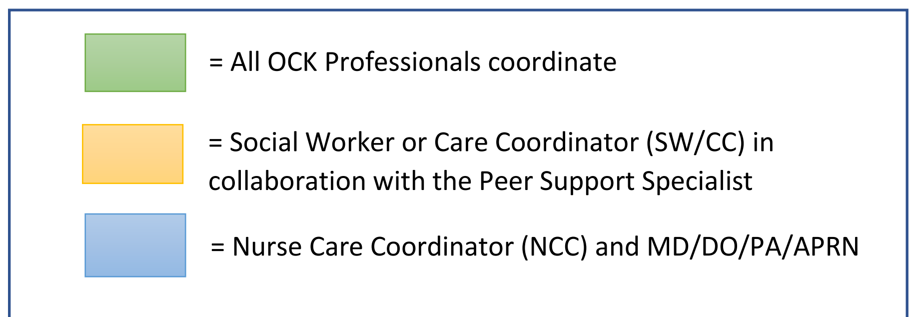
Newly Assigned Member

The member has opted into OneCare Kansas (OCK) and is assigned to the OCK Partner. In the diagram below outlines the possible delegation of activities to each professional within the OCK Partner. By clicking any of the links below, you can access more information on the topics.





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Welcome Call:

Social Worker or Care Coordinator or Peer Support Specialist or Nurse Care Coordinator

- The Social Worker/ Care Coordinator calls the newly assigned member to introduce them to the OCK Partner.
- The SW/CC will coordinate with the member and the NCC to schedule the Initial Visit
    - If needed, 2 separate appointments are made: one for the member to meet with the Social Worker and one to meet with the Nurse Care Coordinator and Physician/Mid-level.
- Discuss the HAP and the process for it to be completed.
- The Welcome call can also be completed by the receptionist of the facility.

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Initial Visit:

Introducing the member to the OCK Partner's team of professionals and starting the HAP are the critical components of the Initial Visit. Also, a brief overview of the services offered through the OCK program may be needed.

Social Worker or Care Coordinator:

- Identify social needs of the member (such as food security, housing, etc.)
- Coordinate with Nurse Care Coordinator to complete Health Action Plan (HAP)

Peer Support Specialist

- Coordinate with the Social Worker to identify any Community Resource needs

Nurse Care Coordinator:

- Start the Health Action Plan (HAP) and coordinate with the Social Worker/CC to address all the components of the HAP
- Identify health needs of the member (such as wellness visit or vaccine schedule needs)
- Complete the Medication Reconciliation form for the member.
- Identify appointments already scheduled with PCP or Specialties Physicians

Physician, PA or APRN:

- Identify any health concerns that may need follow-up

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Health Action Plan

Social Worker or Care Coordinator:

- Download the Health Action Plan (HAP) Document and instructions from the OCK Website
- Compiles information for the following sections of the HAP, in coordination with NCC:
    - Section I: Demographic Information
    - Section II: Additional Contact Information
    - Section VI: Goals and Steps to Achieve
    - Section VII: Signatures
- Submits completed HAP, as well as any updates, to the HAP Data Hub
    - The initial HAP is due no later than 90 days after the member is enrolled into OneCare Kansas
- Coordinates with the NCC to monitors the HAP for the required quarterly updates or as needed for the following reasons:
    - Changes in health status
    - Hospitalizations
    - Emergency Room use
    - Milestones reached with the Member's goals

Nurse Care Coordinator:

- Completes the following sections of the HAP, in coordination with the SW/CC and MD/PA/APRN:
    - Section III: Physical, Behavioral Health
    - Section IV: Existing HCBS Waiver Plan of Care (If applicable)
    - Section V: Advanced Directives
    - Section VI: Goals and Steps to Achieve
    - Section VII: Signatures
- Update the HAP quarterly, or as needed for any of the following reasons:
    - Changes in health status
    - Hospitalizations
    - Emergency Room use
    - Milestones reached with the Member's goals

Physician, PA or APRN:

- Review the HAP
- Sign the Section VII: Signatures Section of the HAP

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Back to Admission to Hospital or Nursing Home

Identifying Appointments

Nurse Care Coordinator:

- Ask the member for a list of upcoming Medical appointments and document in chart
- Coordinate with SW/CC for any needs for appointment such as transportation, attendance, etc.
- Ask the member of Primary Care Physician (PCP) assignment and last Wellness check. Schedule as needed.
- Follow up with the provider's office after each appointment for any changes in care and/or medications
- Follow up with the member for any questions related to the appointment to ensure that the member understands all instructions given.
- Update the Medication Reconciliation, as needed

Social Worker or Care Coordinator:

- Schedule transportation, if needed for the member.
- Attend any appointment with the member, as needed.
- Help the member formulate questions to ask the provider prior to each appointment.
- Follow-up with the member after each appointment to assess for any questions and understanding of instructions from the provider

Peer Support Specialist

- Coordinate with the SW/CC to help schedule transportation to appointments for the member
- Attend appointments with the member, as needed.

Physician, PA or APRN

- If any health concerns are identified, refer to PCP or specialists, as needed. Coordinate with NCC or SW/CC to schedule appointments.
- Peer-to-Peer communication and coordination with member's other providers, as needed.

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Medication Reconciliation

Nurse Care Coordinator:

- Ask the member, at each appointment, for their medication list, including supplements.
    - Document on the Medication Reconciliation Form on the OCK Website
    - Update the Medication Reconciliation Form with any changes to the member's medications
- Submit the Medication Reconciliation Form onto the HAP Data Hub

Physician, PA or APRN

- Review the Medication Reconciliation Form and assess for any interactions
    - If potential interactions are identified, contact prescribing provider to discuss.

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Back to Admission to Hospital or Nursing Home

Community Resource Needs

Social Worker or Care Coordinator:

- Identify any Social Determinants of Health and Independence issues and resources in the community that could help the member address them. This could include:
    - Housing
    - Food Security
    - Transportation issues
    - Counseling needs
- The Aunt Bertha website can be used to help find resources for the member
- **Follow-up** with the member and community partners to ensure that the member understood the instructions.

Peer Support Specialist

- Work with the SW/CC with linking the member with Community Recourses to address SDOH/I needs that could include:
    - Housing
    - Food Security
    - Transportation issues
    - Counseling needs
- The Aunt Bertha website can be used to help find resources for the member
- Work with the SW/CC to follow-up with the member

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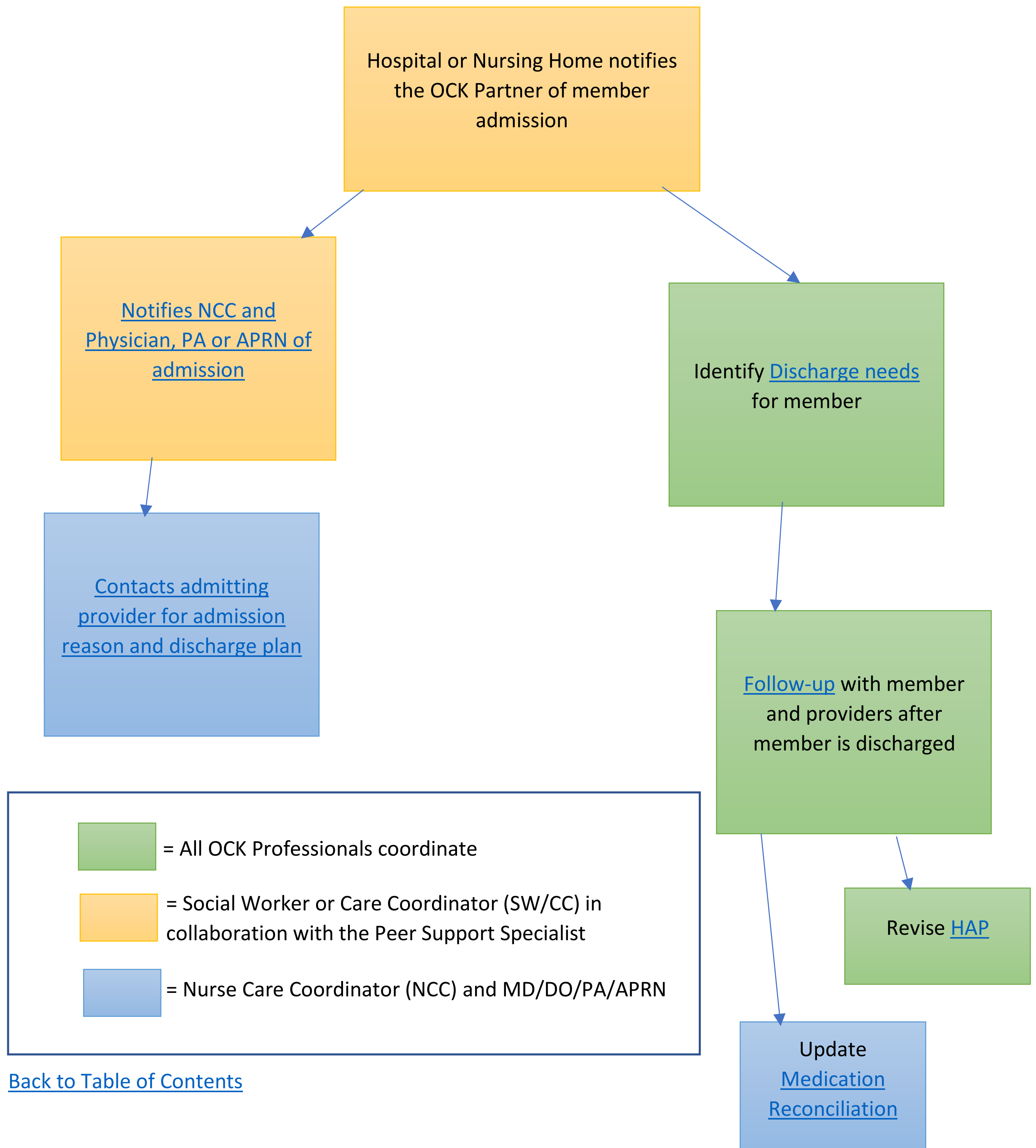
Discharge from Hospital or Nursing Home

The OCK member is admitted to the hospital or nursing home. The SW/CC is listed as the OCK Partner main point of contact for community partners. Transitional Care is a Core Service in OneCare Kansas. This scenario is meant to be an example, but not all inclusive. Transitional Care may be appropriately billed for any transition out of intuitions back to the community.



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After a Hospital or Nursing Home Admission

Social Worker or Care Coordinator

- Is notified from the facility and/or the member that member has been admitted
- Coordinates with the NCC for discharge needs
- Visits the member in the facility to assess for any needs while hospitalized
- Identify any needs after discharge, such as:
  - Meal delivery services
  - Transportation needs
- Coordinate with NCC to revise the HAP, as needed, and submit to HAP DATA HUB

Peer Support Specialist

- Coordinate with the SW/CC to determine member and family support needs as well as Community resources that the member needs after discharge.

Nurse Care Coordinator

- Coordinate with SW/CC for discharge needs.
- Identify needs after discharge, including discharge orders, such as:
  - Follow-up appointments
  - Referrals made to Home Health care
  - Medication changes
- Coordinate with the SW/CC to revise the HAP, as needed
- Revise the Medication Reconciliation as needed
- Schedule appointment for member to meet with OCK Team, as needed

Physician, PA or APRN

- Reviews member’s chart, as needed, for any healthcare needs

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Follow-up with Member and Providers, after discharge

Social Worker or Care Coordinator

- Contact the member to ensure that discharge instructions are understood and followed
- Identify any Community Resource needs and refer as appropriate
- Coordinate with NCC for any changes to HAP
- Submit revised HAP to HAP Data Hub, as needed

Peer Support Specialist

- Work with the SW/CC to identify any Community Resources needs and help connect the member to those resources.

Nurse Care Coordinator

- Follow-up with Member to ensure that discharge instructions were understood
- Update the member's Medication Reconciliation

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