Case Management & Transition of Care Training

Molina Healthcare of South Carolina

Provider Training Module

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Training Objectives

- Understand Molina SC Case Management goals and scope
- Learn provider roles in Case Management and Transition of Care
- Review referral processes and required forms
- Access key Molina resources and contacts

Case Management Overview

Molina's Case Management is a comprehensive program aimed at helping members with complex health needs achieve optimal health outcomes through coordinated care. The program is offered at no cost to members and is voluntary (members may choose to participate or opt out).

Key aspects of Molina's Case Management program

- **Member-Centric Support:** A team of nurses, social workers, and case managers works one-on-one with members and their caregivers to address medical, behavioral, and social needs. The approach is **whole-person and person-centered**, focusing on what each member needs to live their healthiest life.
- **Care Coordination:** Case managers help members **coordinate services across the continuum of care** – from primary care and specialists to community resources. They arrange needed appointments or tests, assist with transportation, and help close any gaps in care. The goal is to ensure members get **the right care at the right time** without duplication of services.
- **Resource Connection:** Molina's case management can connect members with resources beyond standard benefits, such as community programs (e.g., "Meals on Wheels", WIC, local support groups) to address social needs. Case managers also help set up in-home services or equipment (DME) if needed, and ensure members have a *Primary Care Provider (PCP)* and other providers appropriate to their needs.

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Goals and Functions of Case Management

The goals of Molina's Case Management program are to improve health outcomes, enhance member quality of life and reduce unnecessary hospital utilization by providing proactive support and education.

Core functions of Case Management

- **Comprehensive Assessment & Care Planning:** Upon referral and member consent, a Molina care manager conducts a thorough assessment of the member's health status and risks. They work with the member (and family as appropriate) to develop an **Individualized Care Plan (ICP)** with measurable goals, aligned with the member's personal health objectives.
- **Care Coordination & Advocacy:** The care manager serves as the member's advocate and care coordinator. They help arrange services such as home health, rehabilitation, or preventive care, and coordinate across providers (including physical health, behavioral health, and social services) . They also facilitate transitions between care settings (e.g., hospital to home) to ensure continuity.
- **Member Education & Self-Management Support:** Case managers educate members about their health conditions and treatments in plain language, empowering them to manage their conditions and medications. They use evidence-based guidelines and motivational interviewing to encourage healthy behaviors and adherence to care plans. For example, a case manager may help a member with diabetes understand how to monitor blood sugar and diet.

Core functions of Case Management (continued)

- **Monitoring Progress:** The case management team regularly monitors the member's progress against care plan goals (e.g., improved A1c for a diabetic member, or completion of prenatal visits for a high-risk pregnancy). They adjust the care plan as needed and ensure follow-up appointments are kept. If a member is not making expected progress or new issues arise, the case manager intervenes (and may involve additional resources like a Transition of Care coach or community health worker).
- **Interdisciplinary Care Team (ICT) Collaboration:** Molina's philosophy is team-based. The case manager often coordinates an ICT, which can include the member's PCP, specialists, behavioral health providers, pharmacists, community connectors, and the member/caregiver, to review the care plan and progress. This ensures all providers are on the same page and contributing to the member's goals. For complex cases, Molina may hold ICT meetings or case conferences involving the provider network.

Member Eligibility and Identification for Case Management

All Molina Medicaid members are eligible for Case Management, but the program prioritizes those with high-risk or special healthcare needs. Common criteria and scenarios for identifying or referring a member to Case Management include:

- Chronic and Complex Conditions: Members with co-morbid chronic illnesses (for example, asthma, COPD, diabetes, CHF, etc.) or catastrophic conditions (e.g., advanced cancers, organ transplant candidates) should be considered for case management. These members often benefit from extra coordination to manage multiple providers and treatments.

- High-Risk Pregnancy: Pregnant members with high-risk factors – such as a history of preterm labor or delivery, multiple gestation, or medical complications – qualify for case management support. Case managers and Molina's perinatal programs help ensure these members get appropriate prenatal care, education, and support services. High-risk obstetric cases (e.g., incompetent cervix, substance use in pregnancy) are specifically listed on Molina's referral form.

- Frequent Hospital or ER Use: Members with repeated hospitalizations or emergency department visits (e.g., 3 or more admissions in 6 months) are identified for case management. Frequent utilization may indicate uncontrolled conditions or barriers to care that the case manager can help address (such as medication adherence or access to primary care).

- Children with Special Health Care Needs: Pediatric members with special needs (for example, those with developmental disabilities, complex congenital conditions, or technology dependencies) are eligible for Molina's case management for pediatric care coordination. The program can help families navigate pediatric specialists, therapy services, and community support programs.

- Serious Mental Illness or Substance Use Disorder: Members living with serious mental illness(SMI) or substance use disorder can benefit from case management to coordinate behavioral health services with physical health care. Molina's case managers collaborate with behavioral health providers and can connect members to counseling, social supports, or Medication-Assisted Treatment programs as needed.

- Member/Caregiver Request or Provider Referral: Importantly, any member or provider can request case management if they feel extra support is needed. Molina allows self-referrals and provider referrals, even if the member doesn't fit a standard high-risk category. For instance, if a caregiver is overwhelmed or a member is struggling to follow their treatment plan, a referral can be made. All Molina members are eligible for case management upon request, underscoring the program's broad availability.

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Referral Process

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Referral Process

1. **Identify the Member's Need:** During patient encounters, consider if the member meets any criteria or has needs as described above. If a patient is struggling with their health goals or you feel they'd benefit from care coordination, prepare to refer. Members currently "failing to meet care plan milestones" despite treatment are strong candidates.

2. **Submit a Referral to Molina:** Providers can refer a member by phone or fax.

3. **Phone:** Call Molina's Health Management (Care Management) Department at (866) 891-2320 (TTY 711) to provide a referral over the phone. Alternatively, you can call Provider Services at (855) 237-6178. The representative can route your referral to the care management team. Molina's Member Services (855) 882-3901 can also direct member self-referrals to the Care Management team.

4. **Fax Referral Form:** Molina provides a Health Management Referral Form (also called Disease Management/Case Management Referral Form) on the provider website. Fill out the member's information and check the relevant risk factors (the form includes checkboxes for high-risk OB, transplant, chronic conditions, etc., as well as continuity-of-care needs). Fax the completed form to (843) 740-1773, Molina's Case Management Department fax line. This written referral ensures all pertinent details (diagnoses, recent events, specific concerns) are communicated.

5. **Acknowledgment and Outreach:** Once Molina receives a referral (phone or fax), a Case Manager will review the information. If the member is not already enrolled in case management, the team will reach out to the member, usually by phone, to introduce the program and obtain the member's consent to participate. Remember that the program is voluntary, so member agreement is needed. Molina will make multiple contact attempts if necessary.

Referral Process (continued)

6. **Member Assessment and ICP Development:** After the member agrees, the assigned Care Manager conducts a comprehensive assessment (covering medical, behavioral, social, and functional needs). Based on this, the Care Manager develops an Individualized Care Plan in collaboration with the member and often notifies the PCP that the member has been enrolled in case management. Providers may receive a Provider Collaboration Form or other communication summarizing the care plan or requesting input.

7. **Engagement and Follow-Up:** The Care Manager will provide ongoing support, scheduling follow-up calls or visits (telephonic case management is common, and in some cases, in-person visits can be arranged, such as home visits by Molina's Community Connectors or TOC Coaches). The provider who referred the member (or the PCP) will be kept in the loop regarding significant updates, especially if any changes to the treatment plan are recommended. Providers are encouraged to collaborate with the case manager, for example, by reviewing the care plan or participating in case conferences for complex cases.

8. **Referral Outcomes:** If you referred a member, expect feedback. Molina may confirm the member's enrollment or if the member declined participation. You might be asked to provide additional clinical information to the case manager or to incorporate certain recommendations into the member's care (e.g., scheduling a follow-up in 7 days post-discharge). Providers can always contact the Health Management Dept. to check status or update information on a referred member.

Transition of Care (TOC) Program

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Transition of Care (TOC) Program

Healthcare transitions, such as moving from a hospital back home or switching from another health plan to Molina, are high-risk moments for patients. Molina has a dedicated TOC program to ensure members experience smooth, safe, and coordinated transitions in their care. The TOC program is closely tied to case management and is a critical component of Molina's continuity-of-care obligations under Medicaid.

Transition of Care (TOC) Program Roles and Team Structure

Transition Coordinator: This is a specially designated staff member at Molina who oversees plan-level transitions. The Transition Coordinator acts as a single point of contact when members are transitioning between health plans or major programs (e.g., from another MCO into Molina or from Medicaid FFS into Molina).

Transition of Care (TOC) Coaches

- These are Molina's frontline staff for transition support, typically Registered Nurses or licensed social workers with expertise in care transitions. Molina SC employs several TOC Coaches who work under the Transition Coordinator's guidance. TOC Coach core functions:

- **Hospital Outreach and Discharge Planning:** TOC Coaches closely monitor Molina members who are hospitalized. They may conduct inpatient visits or assessments and collaborate with hospital discharge planners from day one of an admission. Their goal is to ensure a solid discharge plan is in place to meet the member's medical and social needs (e.g., equipment, home health, follow-up appointments).

- **Post-Discharge Follow-Up:** After a member leaves the hospital, a TOC Coach will reach out within a few days (often within 5 business days of discharge for most cases). They perform a Transition of Care assessment via phone or face-to-face, evaluating the member's current status, understanding of discharge instructions, medication needs, and any pending issues. Based on risk level, the Coach will follow a specific contact schedule (detailed in a later section on workflows).

- **Care Coordination & Coaching:** TOC Coaches act as bridges between the hospital and outpatient care. They ensure the member has a timely follow-up visit scheduled with their PCP or specialist (ideally within 7 days of discharge for medical admissions) and assist with arranging transportation if needed. They also review medications (often a pharmacist is involved for medication reconciliation), check that the member has obtained new prescriptions, and educate the member on signs and symptoms to monitor. They use coaching techniques to reinforce the discharge plan such as making sure the member knows how to use new inhalers or the importance of keeping a wound clean.

Transition of Care (TOC) Coaches (continued)

- **Interdisciplinary Collaboration:** TOC Coaches work with a wide range of professionals to execute a transition plan. They might coordinate with DME providers to deliver equipment (oxygen, hospital bed, etc.) before the member gets home. They connect with home health agencies or community services to set up in-home nursing, Meals on Wheels, or other supports. They also communicate with the member's PCP and specialists such as sending over the hospital discharge summary or making sure the PCP is aware of the hospitalization. If the member has behavioral health needs, the TOC Coach may involve Molina's behavioral health case managers or ensure follow-up with therapists is arranged.

- **Short-Term Intensive Support:** The TOC program is generally a short-term, intensive intervention (around 30 days post-discharge for high-risk members). During this period, TOC Coaches might call or visit the member weekly (or more frequently for critical issues). They focus on stabilizing the member's condition, addressing any barriers (like confusion about medications or lack of family support), and preventing readmission. If, after 30 days, the member still has significant needs, the TOC Coach can transition the member into long-term Case Management for ongoing support. TOC Coaches often work together with Molina's case managers. The member's primary Case Manager remains the main point of contact for the member throughout, while the TOC Coach provides extra help during the immediate transition period.

- **Care Managers and Community Connectors:** Molina's existing care managers (from the case management program) and Community Connectors (local field staff who can do community outreach) are part of the Transition Team as needed. For example, a Community Connector might accompany a member to their first doctor visit after discharge or deliver a portable phone to a member with no contact method. Molina also has a Care Connections team of nurse practitioners in SC who can make home visits for members who need primary care follow-up but face access barriers. The Transition Coordinator can deploy these resources in a coordinated way.

Transition of Care (TOC) Team Summary

Overall, Molina's TOC team functions as an interdisciplinary unit that pulls in the right expertise for each situation such as medical, behavioral, pharmacy, social services, and more. For providers, this means you may interact with different Molina staff: a Transition Coordinator for plan-level issues, a TOC Coach for a hospital discharge case, or a case manager for ongoing care. Molina will strive to make this seamless, often having one person be your primary liaison for a given member's transition.

Common TOC Triggers

- Hospital or Facility Discharge (Inpatient to Home/Lower Level of Care)
- New Member Transitioning into Molina (Continuity of Care for New Enrollees)
- Provider Termination or Change (Provider leaves network)
- Emergency Department (ED) Visits

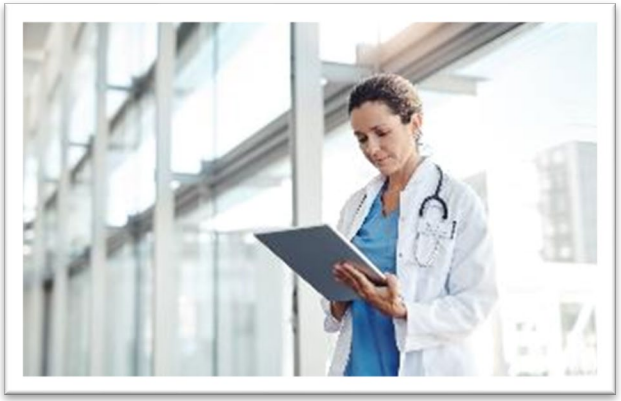
Case Management Contract info

- Molina's Provider Services department at (855) 237-6178
- Health Education Referral Form Here
- Case Management Referral Form Here

Molina Provider Training Survey

The Molina Provider Relations Team hopes you have found this training session beneficial.

Please share your feedback with us so we can continue to provide you with excellent customer service!



Please take a few minutes to complete the Molina Provider Training survey to provide feedback on this session. The survey is located on the You Matter to Molina Page of our Provider Website, under the "Communications" tab.

Molina of South Carolina Provider Relations Contact Information

Molina has designated email addresses based on provider types to help get your questions answered more efficiently or to connect you to training opportunities:

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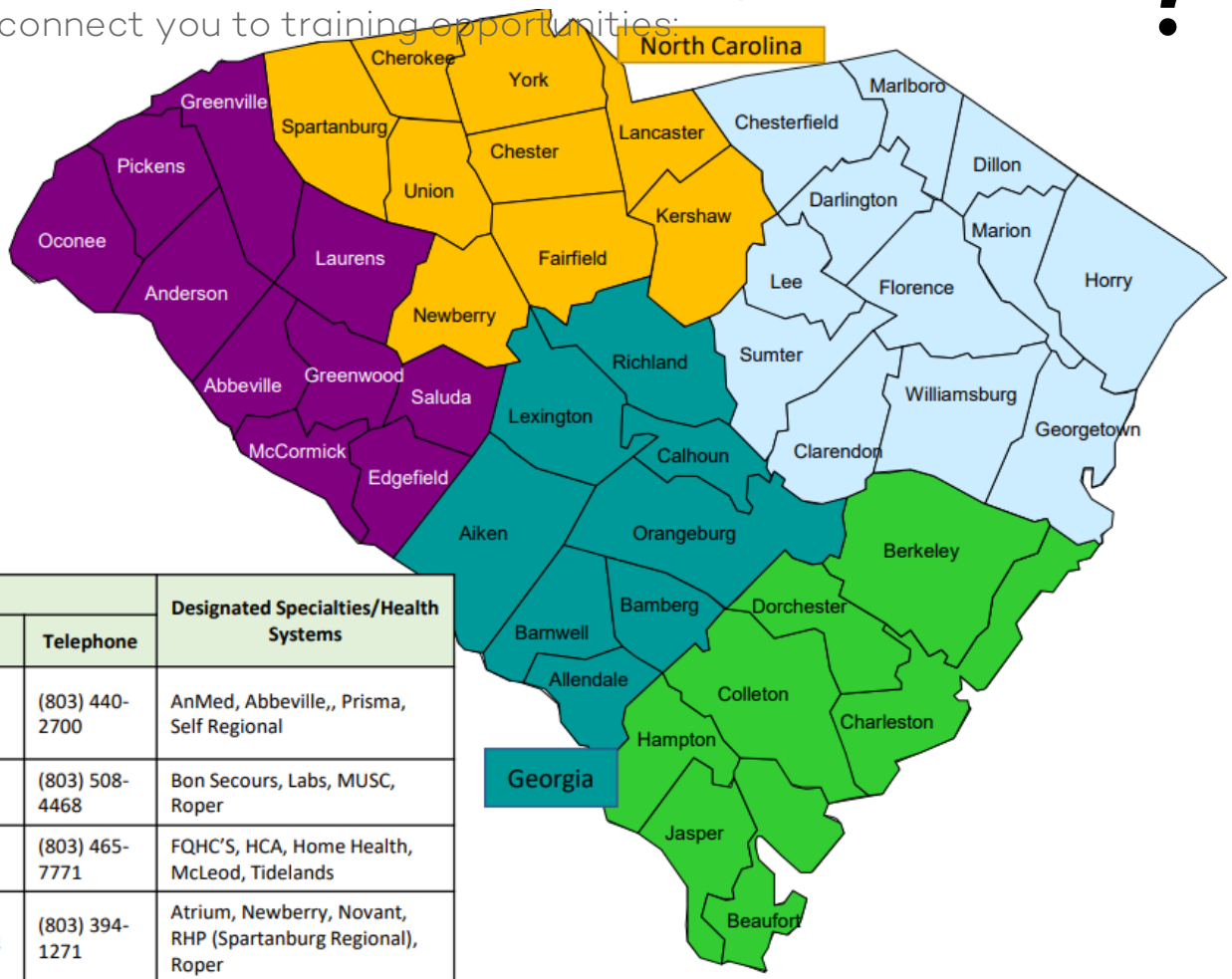

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Thank You

Questions

Open Discussion

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