Case Management and Care Coordination

Molina Healthcare's Case Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining best possible care outcomes to meet the member's needs so they receive the right care, at the right time, and in the right setting.

The Molina case managers are licensed professionals and are educated, trained and experienced in the care coordination process to empower the member to understand and access quality, efficient and cost effective health care.

Molina Case Managers use information from the assessment process to develop and implement Individualized Care Plans (ICP) with the member in a timely manner based on member's own identification of primary health concern and analysis of available data on the member's medical condition(s) and history. The Molina Case Managers stratify the individual members into appropriate risk and intervention levels. Based on the level of case management needed, outreach is made to the member to determine the best plan to achieve short and long-term goals.

Members with the following conditions may qualify for CM and should be referred to the Molina CM Program for evaluation:

- High-risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately
- Children with special health care needs
- Sickle Cell
- BH Concerns

Referrals to the CM Program may be made by contacting Molina at:
Phone: (855) 237-6178
Fax: (843) 740-1773