



Your Extended Family.

## Molina Healthcare of Florida Community Connector Program

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# Our Mission

To provide quality health care to people receiving government assistance

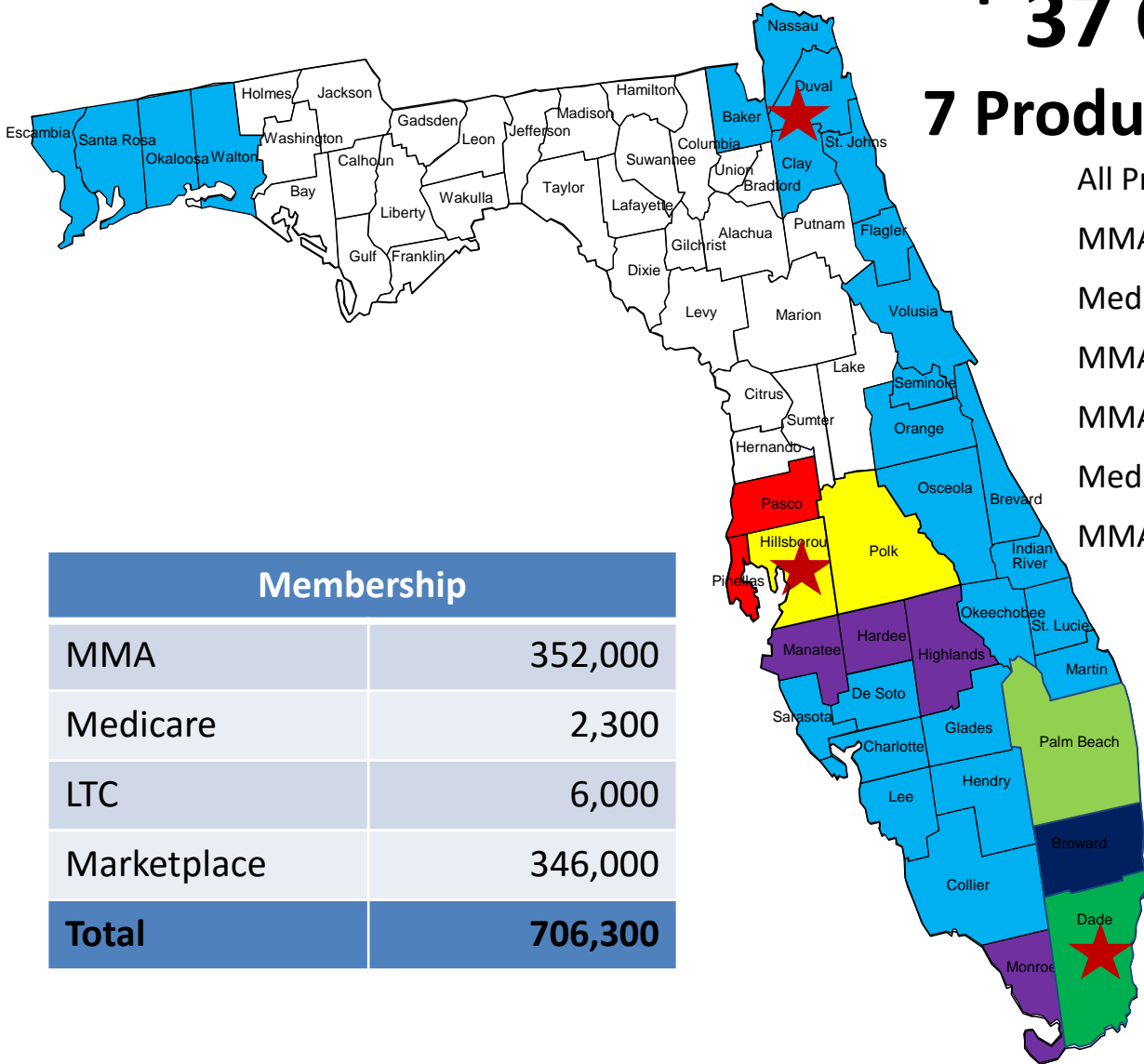


# MHFL Snapshot

## 37 COUNTIES

### 7 Product Combinations

- All Products
- MMA & LTC
- Medicare & MP
- MMA, Medicare & MP
- MMA
- Medicare & LTC
- MMA, Medicare & LTC



Membership	
MMA	352,000
Medicare	2,300
LTC	6,000
Marketplace	346,000
<b>Total</b>	<b>706,300</b>

 Molina Office Location

# Model of Care Overview

The Model of Care is person-centered and maintains the connection to family, caregivers and an interdisciplinary care team to ensure appropriate delivery use of healthcare services.

- High touch
- Focus on care transitions
- Prevention of hospital admissions/readmissions
- Appropriate ER utilization
- Preventive care & self-management

# Care Coordination

## Integrated Care Management & Coordination Model



### CONCURRENT REVIEW:

- Inpatient admission / continued stay review
- Discharge planning



### COMMUNITY CONNECTORS:

- Supportive care coordination
- Member liaison to the plan
- Community based support

### CARE ACCESS & MANAGEMENT (UM):

- Clinical review
- Medical necessity
- Care coordination



### TRANSITION OF CARE:

- Discharge support & coordination
- Post discharge home visits
- Hospital readmission prevention



### CASE MANAGEMENT:

- Health risk assessment
- Comprehensive individualized care plan
- Targeted outcomes & goals

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# Care Coordination

## Characteristics of Community Connectors



### COMMUNITY CONNECTORS:

- Supportive care coordination
- Member liaison to the plan
- Community based support

- Non-licensed / Non-clinical staff with community based knowledge or experience and/or healthcare experience

- Experience ranges from:
  - Community members,
  - Counselors,
  - Case workers

- Live in the community being served
- Speak the language(s) of the community being served

# Care Coordination

## Community Connector Functions & Roles



### COMMUNITY CONNECTORS:

- Supportive care coordination
- Member liaison to the plan
- Community based support

### Education:

- Health plan services & benefits
- Community Services & resources<sup>(1)</sup>
- Connections to health education & self-management

### Member Outreach:

- Locating hard to reach or unable to contact members
- Coordinating communication from community to plan

### Coordination:

- Benefits (Provider appointments, transportation)
- Delivery of services (pick up Rx)

(1) Molina maintains relationships with a network of over 200 CBOs throughout the state.



# Care Coordination

## Community Connector Success Stories



### The Dog Ate My Hearing Aid!

During a campaign for well-child visits, a CC found member T (minor) was having difficulty in school; he could not hear. This also affected his social activities. An external part of his cochlear implant device had been eaten by the family pet. T and mom needed assistance replacing the eaten equipment. The CC assisted with the documentation, and attended a provider appointment with T and his mother. CC supported T and his mother while they presented to an Interdisciplinary Care Team to override any limits. T received a new device, returned to school and got back a healthy childhood as well!

# Care Coordination

## Community Connector Success Stories



### See You at Your Place on Saturday

Telephonic welcome calls and assessments were unsuccessful for 58 members who all lived in the same building complex. The 2 CCs working that area coordinated with the complex to arrange a one-day Saturday outreach to meet the members. They prepared educational materials, self-assessments and even had Case Managers on standby. In addition to meeting with members that were pre-scheduled, the CCs were able to arrange sessions with members on-the-fly. Overall, the CCs were successful in educating new enrollees, proactively identifying issues or concerns and coordinating assistance.

# Care Coordination

## Community Connector Success Stories



### No Cell Minutes, No Cell Service, No Problem!

Member O delivered a healthy baby boy, but could not be reached on the phone to coordinate her postpartum visit. CC visited the member at home to discover that O has limited cellular minutes and very poor reception where she lives. “Can you help me via text”, she says. CC returned to where cellular reception was improved, set up an appointment for O, and sent O a text with the appointment information. Her response text read: “thank you so much! Can we always text?”. After the appointment CC confirmed that O attended her postpartum visit. O texts pics of the baby now!

# Care Coordination



Questions?