Updated 7/1/2021

Medica Enhanced Care Coordination (ECC) Recommendations*
Applies to All Institutional & Community Members

Timeline for assessments, care plans and other requirements remain the same. Regardless of care level, care plan should be monitored and updated as needed when care coordinator has contact with member and/or with changes in member's condition.

Care Level	1	2	3 & 4
	New enrollment and members missing from the report will be defaulted to a Care Level 3.		
Additional Telephonic Contacts for Community Members based on level	Every other month	Monthly	Every 6 months
Additional Telephonic Contacts for institutional members	Every 6 months		
Members in an inpatient Hospitalization	Current transition process and follow up telephonically with member within 2 weeks post notification of discharge.	Current transition process and after discharge to home CC must attempt face to face visit within 5 business days and if feasible attend post hospital PCP visit. *For MSHO only, LSS readmission benefit if eligible	Current transition process and follow up telephonically with member within 2 weeks post notification of discharge.
ER 3 or > in 6 months, 10 or > in last year, or IP 4 or > in last year	**Suggested for members who have had multiple Emergency Room (ER) visits or Inpatient (IP) hospitalization, regardless of care level:** -During call or face to face visit with the member, discuss ER or IP reasons/utilization with member. -Provide education on *When and Where to Get Care* , document found on Care Coordinator website -Facilitate PCP visit if no preventive health visit in last year or no PCP visit post hospitalization -Assist member in establishing care with a PCP if needed **Suggested support for Level 1& 2 Members** -Attend PCP visit with member. If member is not interested, communicate to PCP re: member's ER and/or IP utilzation		
Available Resources to Consider	-Clinical Liaison consult -Clinical consult requested through Clinical Liaison (telephonic review of complex cases) -Interdisciplinary Team Consult, sign up in Sharefile (multidisciplinary team review of complex cases) -Referral to Complex Case Mgmt, Disease Management,and/or Tobacco Cessation, see referral form on Care Coordinator website titled *Complex Case Management/Health Support Referral Form*		

Definition: Institutional members are defined as members residing in SNF, customized living memory care unit, an ICF/DD, or a group home with on site 24 hour staffing. Community members are defined as all members not residing in an institution, regardless of waiver