Care Coordinator Role at Admission and Discharge

UCare Connect and Connect + Medicare members have a Care Coordinator who monitors and assists your patient's with hospital transition needs.

Care Coordinators:

- Are central members of the Interdisciplinary Care Team (ICT),
- Support patient in obtaining necessary and preferred resources, services, and informal supports,
- Complete comprehensive assessment, as indicated
- Work with ICT and patient to manage and coordinate patient care

At Admission, the Care Coordinator can:

Share patient's needs, preferences, and current care plan with facility's care team

Share consumer choice and outcomes, including successful and unsuccessful past interventions

Explain social/living environment and role of caregivers

Explain current formal and/or informal support in place for Activities of Daily Living and Independent Activities of Daily Living

Assist with benefits/covered services and eligibility requirements for ongoing care

At Discharge, the Care Coordinator can:

Review discharge instructions with patient and/or responsible party

Assess patient's understanding of current self-medication regimen, and who to call with questions or concerns

Schedule follow-up appointments, as needed and coordinate transportation.

Assist with implementing physician orders for equipment and supportive services after discharge

Provide ongoing care coordination and interface with interdisciplinary care team

Close communication with the patient's Care Coordinator can help to prevent hospital readmission. Contact the patient's Care Coordinator to coordinate the discharge process. If you aren't sure who the patient's UCare Care Coordinator is, contact UCare at 612-676-3395 or 1-877-903-0061.

Release of Information Statement:

Discussion of patient information meets HIPAA regulations under the contracts between hospitals and health plans, including health plan agents.

The Minnesota Department of Human Services (DHS) Minnesota Health Care Programs (MHCP) Medical Assistance Application for beneficiaries over the age of 65 (DHS Form 3876) authorizes sharing of medical information between health providers and health plan contractors to facilitate coordination of health care service.