Using Health Plan Care Coordinators at Admission and Discharge

Health Plan Care Coordinators are health care professionals who are central members of the Interdisciplinary Care Teams (ICT). They:

- Coordinate patient's Medicare and Medicaid health and long-term care services
- 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

Every established Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs BasicCare (SNBC) patient has an assigned care coordinator who knows your patient's health history and social service needs.

Contact Health Plan Care Coordinator (or Care Navigator for SNBC) upon admission for info about services and providers in place.

Blue Plus	**651-662-5540 or 1-800-711-9868**
Medica	**952-992-2580 or 1-888-347-3630**
Metropolitan Health Plan	**1-888-562-8000**
UCare	**612-676-6622 or 1-866-242-2497 (MSHO, MSC+)** **612-676-3395 or 1-877-903-0061 (SNBC)**

Health Plan Care Coordinators can help you

ADMISSION *At time of admission and during stay at a hospital or interim care setting:*
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 the patient and/or family caregivers
Explain current formal and/or informal support in place for Activities of Daily Living (ADL) and Independent Activities of Daily Living (IADL)
Assist with benefits/covered services and eligibility requirements for ongoing care

DISCHARGE *At time of discharge and following discharge from a hospital or interim care setting:*
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
Coordinate transportation, as needed
Provide ongoing care coordination and interface with interdisciplinary care team
Assist with release of information and implementing physician orders for equipment and supportive services after discharge

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