Complex discharge planning

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As we begin 2020, we are adding utilization management complex discharge planning and case management complex discharge planning roles to our teams. We are excited to offer members, their families and caregivers someone to work with them while the member is inpatient and after discharge.

This team member will work with the facility to understand the member's needs, discharge plan and possible home needs. If your patient is sent to a post-acute setting, we will also work with that facility to understand any barriers to discharge and referrals to other Medicare programs.

If the member requires assistance after discharge, we will offer a team member to help the member receive necessary referrals to identified programs, help the member follow their discharge plan and assist in making any necessary appointments to see their doctors.

This is a collaborative program; we need your help to understand what your patients need to be successful upon discharge and to reach our common goal – avoidance of readmissions and ER utilization.

We look forward to working with you, and the acute and post-acute facilities that offer this value added program to our Medicare Advantage population.

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