COORDINATION OF CARE

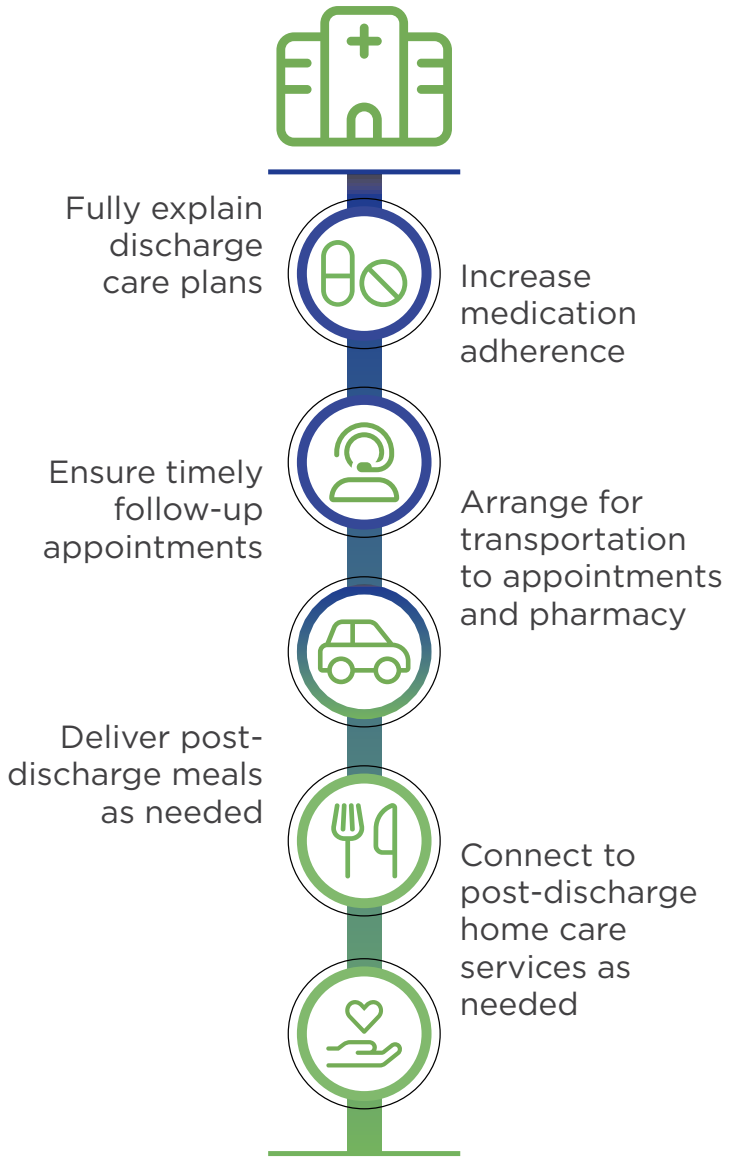
MASS ADVANTAGE
A Medicare Advantage Plan

Mass Advantage members with complex needs are identified and stratified for care management programs to improve health outcomes. Members engage with these wraparound programs after and between acute care episodes. Mass Advantage care managers collaborate with providers, vendors, and community resources to keep members living safely at home.

TRANSITIONS OF CARE PROGRAM

Transitions from hospital, emergency department, or post-acute facilities to home are often fraught with care plan risks. Mass Advantage care coordinators improve adherence to discharge plans, follow-up appointments, and medication changes. New home services and unmet caregiving needs are addressed. They also survey social determinations of health with proactive referrals to plan benefits and community-based resources.

Lorene's Transition from Hospital/SNF to Home



POST-ACUTE COORDINATION PROGRAM

Mass Advantage care managers follow every member arriving into a post-acute facility (e.g. skilled nursing home, inpatient rehabilitation facility, long term acute care hospital). They will collaborate with the facility's staff to optimize the recovery process and preparation towards a safe and successful transition home.

CHRONIC COMPLEX MANAGEMENT PROGRAM

Some members have significant care gaps that are challenging to address through a traditional health system experience. Mass Advantage care managers deliver high-touch interventions over several weeks to holistically address their biopsychosocial needs. Comprehensive evaluations increase attention to social determinants of health and coordination gaps. Members experience greater care plan adherence and early escalation for changes in health status.

For more information regarding our care management programs, reach out to care@massadvantage.com.

Gerald's Whole Person Support in our Care Management Program