

Master•Care	Ops — Standard Operating Procedure		
Title	Master•Care Navigation Staffing Model		
Policy No.	7.10	Revision	0

Regional Manager

Home Office Team Members			Clinical Team Members			Regional (Field) Team	
Provider Relations Coordinators “PRC” Identifying & Building Relationships w/Non-Medical (CS) Providers	Billing & Accounting Specialists	(Remote) Care Navigators	Licensed Nurse Tele-Assess, Consult (PRN) & Chart Review	MSW Tele-Assess, Consult (PRN) & Chart Review	Pharmacist Med Review, Consult (PRN)	(Field) Care Navigators for In-Home & Face-to-Face Assessments	Provider Liaisons Ref. Source Relations (SNF, PCPs, Acute Care)
<ul style="list-style-type: none"> On-boarding new resources Updating rates, care types, amenities in our CRM Develop relationships with non-medical senior care to expedite referrals Identify county & community resources Develop relationships with county & community resources Vetting new resources to assure our provider standards are being met 	<ul style="list-style-type: none"> Monthly Patient care invoicing and A/R management Summary of share of cost responsibilities for each Patient Assisting our non-medical providers with proper billing processes, and / or providing direct billing services on their behalf Developing (with MCP) value-based pricing and / or shared-savings program Migration from FFS to VB compensation or shared-savings 	<ul style="list-style-type: none"> Assigned “Medium-to-Rising” (or ‘Enrolled’), “High” (or ECM ‘Engaged’) and “Unknown” risk Patients Responsible for engagement with Patient — Point of contact with Patient Documentation of all calls, video chats/virtual visit, emails or texts from Patient and providers associated with assigned Patient Communicating concerns and care changes with all responsible and/or decision-making parties so action can be taken Notification of all Care calls and reviews notes 	<ul style="list-style-type: none"> Chart review & consult PRN In coordination with Care Nav., reviews & approves complete Master•Care Plan Team Member Training 	<ul style="list-style-type: none"> Receives assessment with areas of concern highlighted Chart review & consult PRN Reviews family and social components Master•Care Plan Direct family or Patient engagement PRN Team Member Training 	<ul style="list-style-type: none"> Verify patient adherence, optimize medication use In coordination with Care Nav., reviews & approves Master•Care Plan Thorough med review of conditions & meds (OTC & Rx) Create action plans for each Patient reviewed Available for the additional consult PRN Quarterly Review of all Members on Service 	<ul style="list-style-type: none"> In-person and/or virtual assessments of all new ECM & CS Patients In-home assessments / In-Facility assessments (i.e. SNF) Local contact for patients In coordination with Remote Care Nav, yearly, and as needed, re-assessments of Patients Manage expectations of Patients with clear communication of comprehensive care plan Provider Communication 	<ul style="list-style-type: none"> Local community relations for SNF, PCP, acute care Education, encourages PCP engagement, helps to “close the loop” Responsible for devices and device tech-support in referral source locations Community Education (in-services)

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