

Master•Care, Inc. Policies and Procedures Manual

Importance of The CareBook

The Company developed The CareBook to assist care navigation teams in delivering quality care. The CareBook is a proprietary care management platform that allows team members to:

- Securely communicate internally with team members and externally with customers
- Document all patient-related interactions, including assessments and Master•Care Plans, in a patient record and/or a provider record.
- Securely exchange data with managed care plans.
- Access a database of providers and resources.

The CareBook is the platform upon which a complete record of the patient's goals, challenges, options, communication, and resources are stored, accessed, and monitored.

Outreach

After receiving an ECM or CS referral, the FCN is responsible for setting up an initial meeting with a member in the place they are residing, which may be a home, assisted living, skilled nursing facility, hospital, or shelter. If a face-to-face meeting is restricted for health/safety reasons, the FCN can use a virtual meeting app (FaceTime, Zoom, Ring Central, WebEx) available to the patient.

Care navigation teams know of places to access these options in their area and make every attempt to ensure the patient can access them from their smartphone or via a shared device.

Refusal to be Assessed

If the member is unwilling or unable to be assessed, the FCN should contact involved parties to understand the underlying reason in an attempt to resolve any reluctance. If the reluctance is due to:

- Cultural or religious beliefs: consult the Company's cultural sensitivity policy, procedure, and resources for help.
- Language: use Company resources to find a translator, and offer, and provide translation services at no charge.
- Lack of access to phone or fear due to homelessness: consult the Company's homeless resources to find a safe alternative for the member to use a phone or meet.
- Fear, sense of invasion of privacy: consult and collaborate with the Company's social worker and other care navigation team members to find solutions.

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Because the population we serve is primarily older adults, our care navigation teams collaborate with Adult Protective Services, medical providers, and non-medical providers such as homeless and low-income programs to reach the member.

Outreach Attempts

The following are the minimum quantity of required attempts to connect with an ECM or CS member before they can be determined unable to contact. Outreach attempts beyond these minimums may be warranted. See the detailed Dispositions and Tasks required actions in the Process Manual.

TYPE	GUIDELINES
Phone: connected with patient or left VM	Must be a working number (not disconnected). If VM box is full or not set up, escalate to obtain further information.
Phone: connected with known party or left VM	Must be a working number (not disconnected). Known parties may be friends, family, caregivers, housing manager, or a community partner.
Email	Successfully sent
Postal mail	Physical address known and accepting mail.
In-person outreach: Physical location known	May be a known residence or a location frequented.

Care navigators begin outreach with a call to schedule an in-person assessment. Phone calls and texts are generated and logged in the CareBook. Full-text transcripts are captured in the member record. Translation services are available to text translated messages.

The goal of outreach is to help the member understand the benefits of enrolling in ECM and gain consent. Consent to enroll in ECM should be written. When written consent isn't possible, verbal consent can be recorded for documentation.

Meeting members where they are

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Care navigators are trained to meet members where they are emotionally and physically. Members may be experiencing homelessness, serious mental illness (SMI), substance use disorder (SUD), and other challenges. Meeting members where they stay or in places they frequent may be necessary. Empathetically connecting with members and building trust is critical to ECM and CS success.

Master•Care's New Team Member Onboarding and Training Manual includes outreach training that equips care navigators for successful outreach. Required outreach training includes motivational interviewing techniques, trauma-informed care, and other topics.

Comprehensive Assessment Process

Initial assessment

This process involves gathering detailed information based on the specific services to be provided. Information gathered may be medical, social, behavioral, financial, and environmental, and is gathered from multiple sources, including the managed care plan, the patient's medical and non-medical providers, and the patient.

The care navigation team assists FCNs with gathering, collecting, interpreting, and entering data from patient records, providers, family members, and caregivers.

ECM is a benefit that depends upon patient or responsible-party participation. Care navigation teams need to collaborate and strategize to find the best approach to engage patients and their families/caregivers. Daily stand-up meetings should include communication and engagement best practices.

Care navigation team engagement

Once an assessment has been completed, the care navigation team will coordinate with providers to ensure the best possible Master•Care Plan has been created. The team will:

- Assist in making appointments, appointment reminders, and ensuring transportation to appointments.
- Accompany patients to appointments as deemed necessary or if requested.
- Coordinate all relevant elements of the care plan with providers.
- Ensure the patient agrees to and understands the assessment, has participated in and created immediate, short-term, and long-term goals, and possesses a copy of their Master•Care Plan.
- Ensure caregivers and providers have a complete understanding of the Master•Care Plan and agree to help ensure patient compliance when cognition is an obstacle.