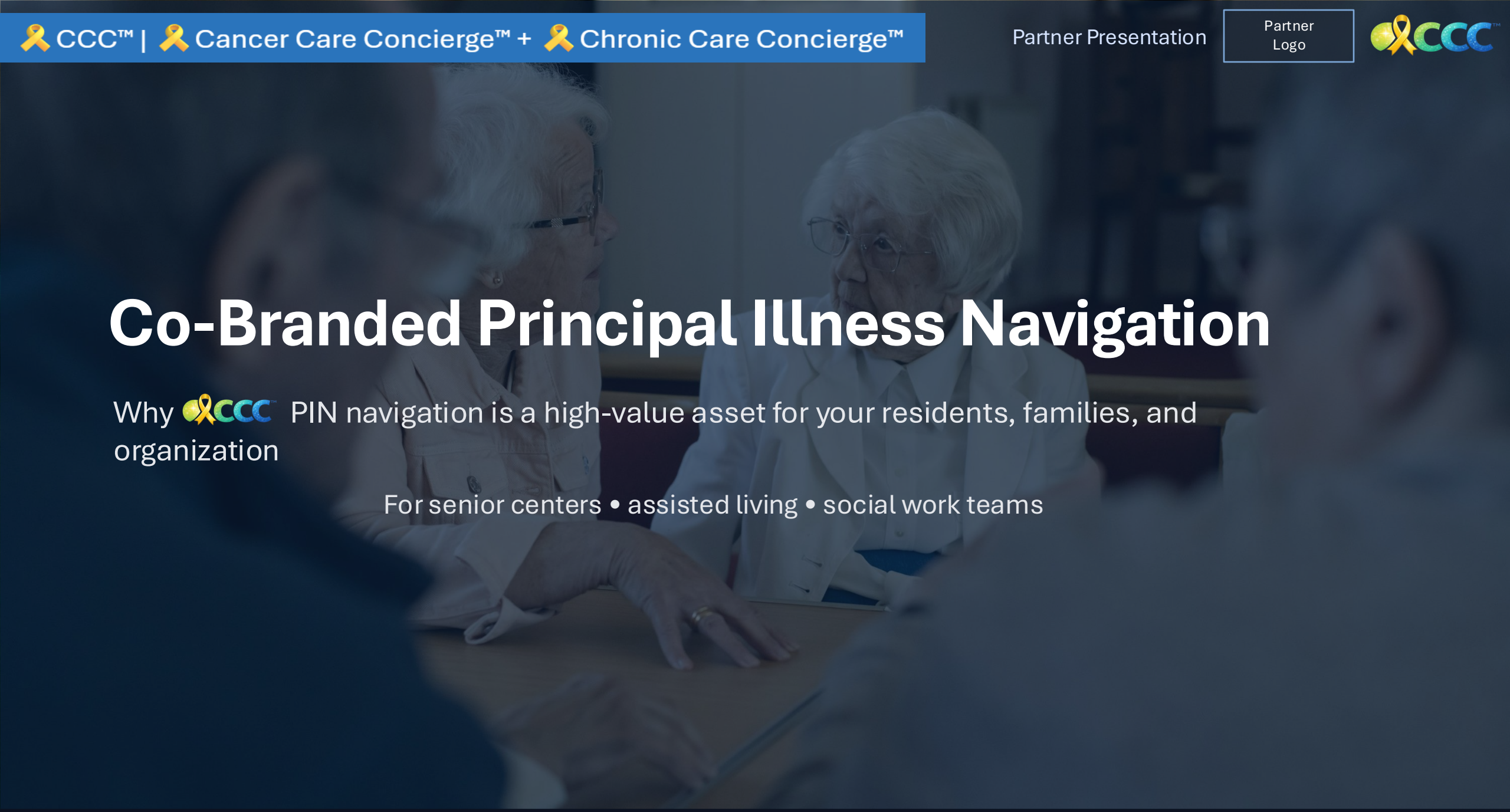


Co-Branded Principal Illness Navigation

Why CCCC PIN navigation is a high-value asset for your residents, families, and organization

For senior centers • assisted living • social work teams

Patient Advocate services may be described in Medicare policy as Principal Illness Navigation (PIN). Coverage varies by plan and setting.

Chronic illness creates a hidden workload in senior living

- Multiple specialists, tests, and referrals
- Medication changes and symptom tracking
- Transportation + appointment logistics
- Family updates and decision support
- Paperwork, portals, and follow-through

When residents are overwhelmed, staff and families become the "default coordinators."

CCC™ reduces missed steps by acting as a consistent hub—before, after, and between visits.

Without navigation, small gaps become big problems

Resident & family experience

- Confusion after complex visits
- Missed referrals / delayed scheduling
- Medication list errors and side-effect uncertainty
- Caregiver burnout and anxiety
- Lower confidence in the care plan

Operational impact

- More “chase down” calls and paperwork
- Escalations from concerned families
- Higher staff stress and time diversion
- Reputation risk when families feel unsupported

Navigation is a non-clinical lever that can improve experience and follow-through.

PIN navigation: plain-language support with policy alignment

Resident-facing term: “Patient Advocate”

Clear, human language for seniors—appointment prep, follow-up summaries, coordination, and caregiver alignment.

PIN services commonly include:

- Care plan understanding & follow-through
- Barrier reduction (logistics, resources)
- Coordination across clinicians and settings
- Caregiver support and communication

Policy term you may see: Principal Illness Navigation (PIN)

CMS describes PIN services billed under the Physician Fee Schedule with HCPCS G codes beginning Jan 1, 2024.

CCC™ can help residents and families understand what questions to ask the billing office—but we do not provide insurance or legal advice.

Why CCC™ is a strong fit for senior-serving organizations

CCC™ delivers the "4C" experience seniors want:

Clarity

Plain-language summaries; question coaching

Coordination

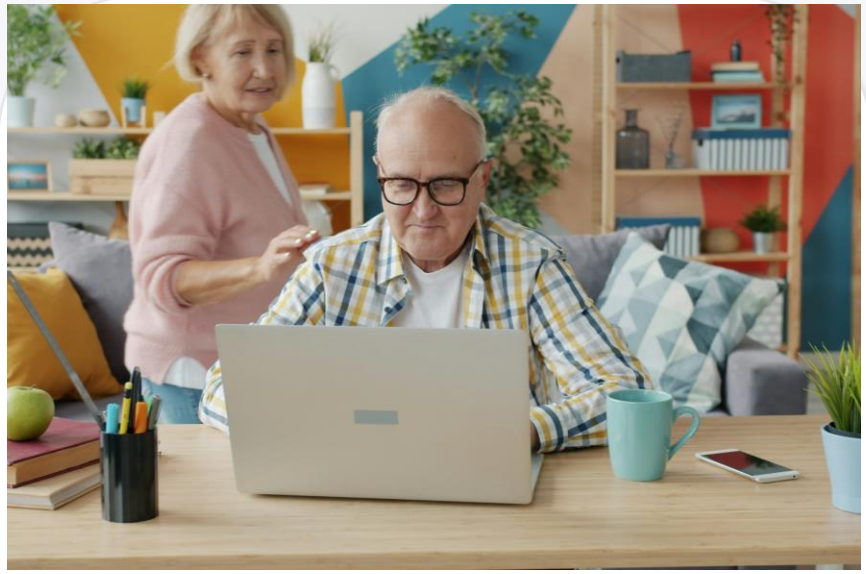
Scheduling, referrals, records, and reminders

Confidence

Prepared visits; shared decision support

Comfort

Practical + emotional support between visits



Residents get a consistent advocate.
Staff gets fewer escalations.
Families feel supported.

Patient Advocate services may be described in Medicare policy as Principal Illness Navigation (PIN). Coverage varies by plan and setting.

Example: A resident journey with CCC™

1 Referral & intake

We capture meds, concerns, family contacts, and goals.

2 Appointment prep

We build a question list and ensure records are ready.

3 Post-visit clarity

We summarize in plain language and track next steps.

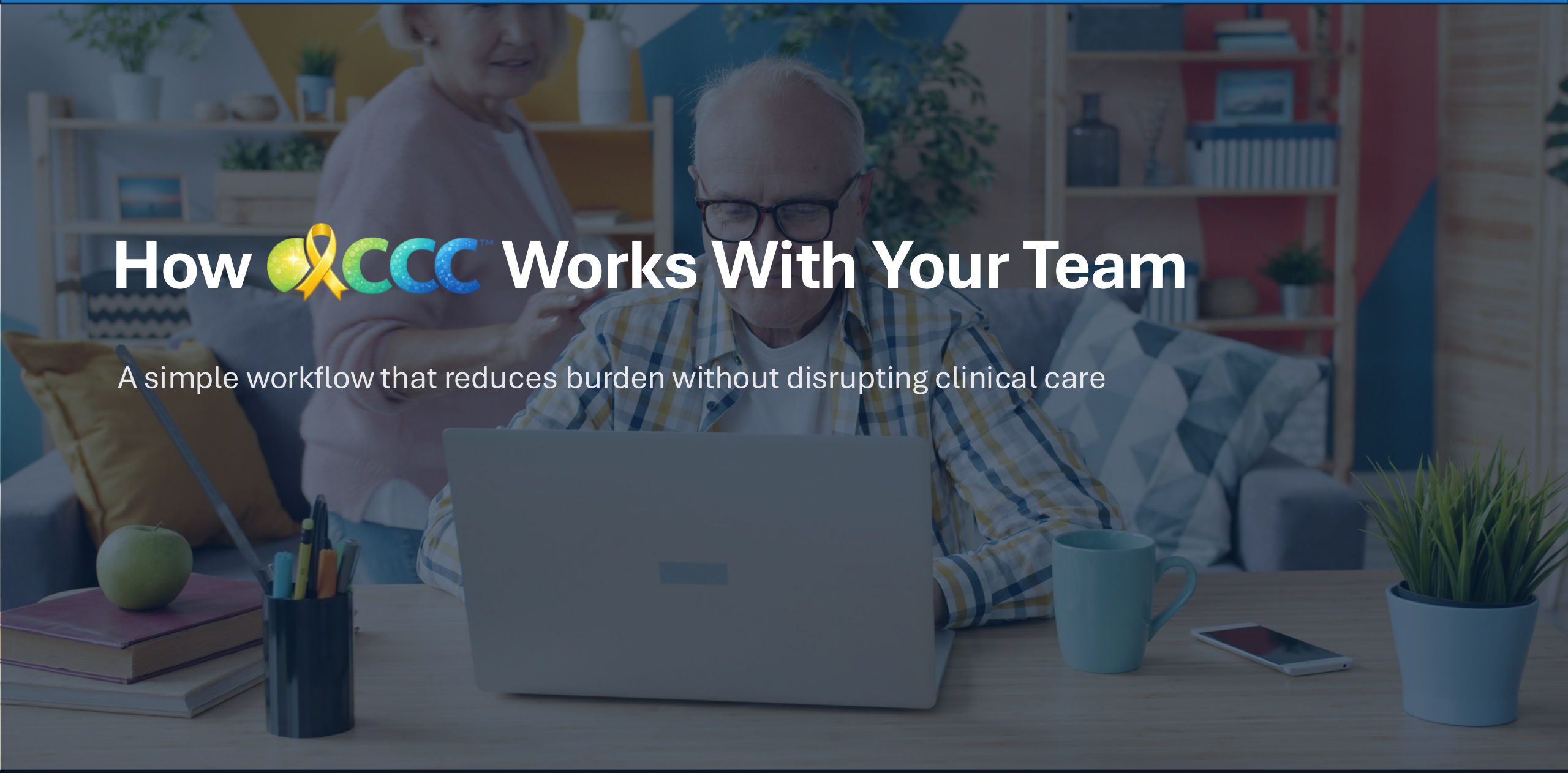
4 Between visits

We monitor symptoms, coordinate logistics, and align caregivers.

Outcomes you feel (not just "tasks"):

- Fewer missed steps
- Clearer communication
- Less caregiver stress
- More confidence in the plan

This example is illustrative; individual outcomes vary.



How CCC™ Works With Your Team

A simple workflow that reduces burden without disrupting clinical care

Workflow: referral → intake → ongoing support

Referral
Staff, resident, family, or provider referral

→

Intake
Goals, meds, symptoms, consent, caregiver contacts

→

Prep
Questions, records, logistics, transportation plan

→

Follow-up
Plain-language summary + task tracking

→

Between visits
Symptom log, reminders, coordination, updates

Built to be low-friction: CCC coordinates with your preferred contacts and documentation flow.

What CCC™ does (and does not do)

We do:

- Prep residents and families for visits
- Translate plans into plain language
- Track tasks: labs, imaging, referrals, meds
- Coordinate questions between offices
- Support caregivers between visits

We do not:

- Diagnose or prescribe
- Replace your nursing/clinical team
- Make treatment decisions for residents
- Provide legal/insurance advice

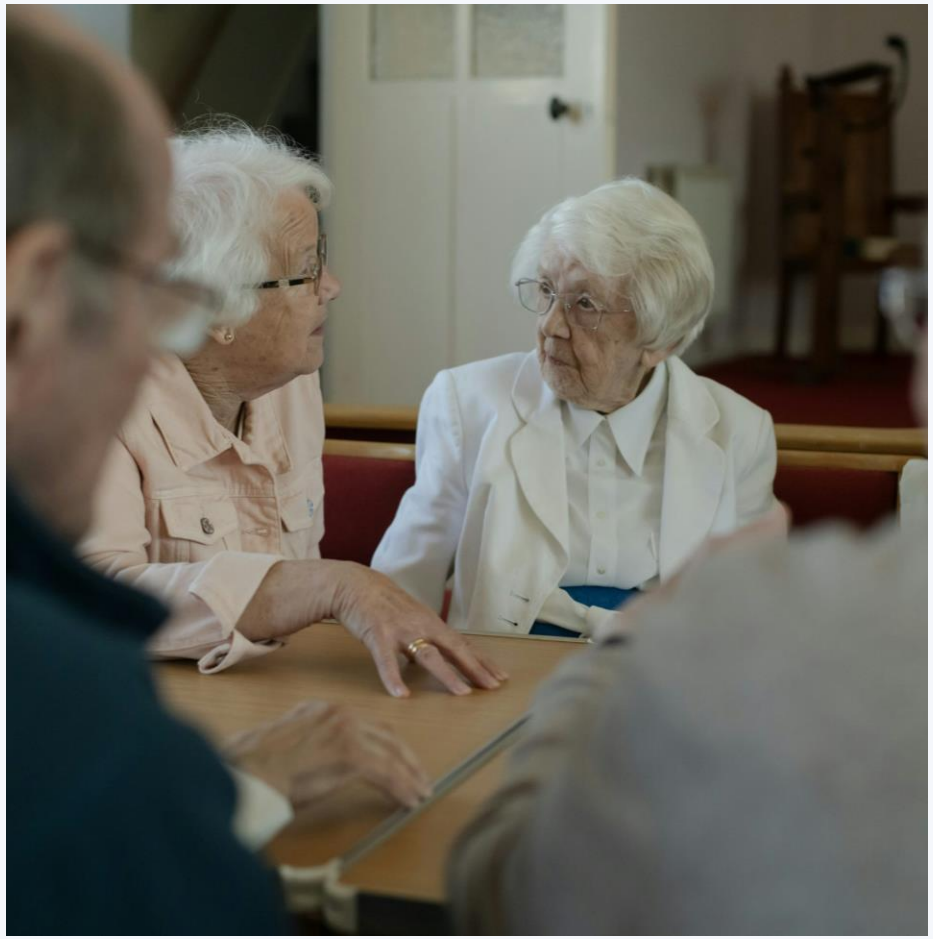
We amplify your team by keeping residents organized and supported.

Family alignment: fewer escalations, better trust

CCC™ helps families:

- Stay informed without overwhelming staff
- Prepare for shared decision-making
- Reduce confusion after complex visits
- Feel supported during caregiver strain

Result: more goodwill and fewer "high emotion" calls—because someone is consistently answering "what happens next?"



Evidence base: navigation improves experience and follow-through

What the literature commonly reports:

- Earlier or more timely initiation of treatment in many settings
- Improved adherence and reduced barriers (logistics, resources)
- Higher patient satisfaction and improved care experience
- Potential to reduce inequities driven by non-medical factors

CCC™ translates this model into a senior-friendly "Patient Advocate" service your organization can co-brand.

Patient Advocate services may be described in Medicare policy as Principal Illness Navigation (PIN). Coverage varies by plan and setting.

Privacy, consent, and coordination

We align with your process and resident preferences:

- Resident consent and caregiver permissions documented up front
- Preferred communication channels and escalation paths agreed with your team
- Clear boundaries: CCC supports navigation and understanding, not clinical decision-making
- We can coordinate with providers' offices for records, scheduling, and questions as authorized

Your team stays in control; CCC adds capacity and continuity.

Co-Branding Partnership

A marketing and community asset that improves resident and family satisfaction

Why co-branding with CCC™ is a high-value differentiator

For your residents and families

- A trusted advocate who helps them stay organized
- Less confusion and anxiety between appointments
- Better caregiver alignment and confidence

For your organization

- A visible benefit you can market (co-branded)
- Potential enrollment lift through differentiation
- Higher satisfaction → goodwill and referrals
- Reduced staff burden from nonclinical coordination

Positioning example: “We don’t just provide care—we provide a cancer navigation safety net.”

Co-branded marketing kit (done-for-you)

Assets we can provide:

- Co-branded flyer/brochure for residents & families
- Front desk + social work referral script (one-page)
- Landing page copy (your website + CCC™ page)
- Resident/family education talk (virtual or on-site)
- Community outreach language for newsletters and PR
- Simple referral form + intake checklist

We match your tone and brand so the offering feels native to your organization.

Implementation plan: 30–60–90 days

30 days

Align contacts, consent, and referral flow
Train key staff (social work, nursing, front desk)
Launch co-branded flyer + FAQ

60 days

Resident/family info session
Start pilot referrals
Collect early feedback + adjust

90 days

Broader rollout
Add to tours & marketing
Define success metrics and reporting cadence

Next steps

A simple path to launch:

- Choose pilot cohort (e.g., cancer care or chronic care)
- Confirm referral flow + key contacts
- Approve co-branded flyer and web copy
- Schedule staff briefing + resident/family session
- Start referrals and review feedback at 30 days

Contact: info@CCC.care | Phone: 330-298-5422 | Website: CCC.care

Optional: add your partner logo + CCC logo on every resident-facing asset.