

Consent and Assessment

Consent

Enrollment and Consent Requirements

1. **Task** Lisa with checking eligibility once verbal enrollment has been completed. If patient wants to do in person consent and not verbal, then task Lisa when you schedule the assessment.
2. **KPI:** 30-45 Days to complete assessment after verbal enrollment (sooner is better!) At 60 days we are considered out of compliance and will have to dis-enroll the patient.

Verbal Enrollment Consent

Tell the outreach candidate that you are going to read a quick enrollment statement.

Read the following script:

- “This is [your name, “Care Navigator”] with Master•Care, I am verbally enrolling [patient’s name] into Enhanced Care Management and/or Community Supports.
- [Patient name], Do you authorize Master•Care to initiate services on your behalf, which includes scheduling an assessment with you at a location of your choosing? (Patient response)
- Do you further authorize the authorized Master•Care, to communicate with you in writing, electronically, or by telephone, as may be necessary for the purpose of your healthcare coordination and management? (Patient response)
- Do you authorize Master•Care to share data regarding your Healthcare service with other authorized providers in coordination with the services we provide? (Patient response)
- Do you understand that you may, AT ANY TIME and without consequence, withdraw your participation from the program at any time? (Patient response)
- Thank the patient and move on to scheduling the assessment.
 - Save and upload the recording
 - Document properly

Link

You will be assigned a e-sign link, that can be send via email or text

1. Once the patient clicks on it, they can e-sign it and it comes back to you for your signature
2. Once you sign it, the fully executed consent is sent to both you and the patient
3. Upload it to patient’s file
4. Document properly

In-person

Always keep paper copies of our consent with you.

1. Have the patient initial where appropriate
2. Have then chose and date the medical records portion
3. Have then sign the last page
4. Take pictures of each signed page (PDF scanner app)

5. You can leave the hard copies with the patient
6. Upload completed pdf of signed consent to patient profile
7. Document properly

ECM Assessment, Goal Setting and Care Planning

Key components include:

- In-Person Contact.
- Person-Centered.
- Comprehensive Assessment.
- Patient-Centered Care Plan.
- Patient care plan implementation- must give the patient a care plan
- Continuous and integrated care
- Treatment adherence- Health Promotion*use member website, Krames Online health library and other evidence based resources located in the Important Link Document,
- Communication
 - Fostered and on-going engagement with member
 - Timely reassessment.

Things to Remember

1. **KPI: 24-48 hours** to upload care plan and update notes and documentation regarding the assessment and goals.
2. **KPI: Minimum touches:** at minimum 1x per month more often initially and during any time where big goals are underway
3. **Goal Setting and Care Planning** happen at the assessment or can be scheduled for a later date. Try to leave with one attainable goal on the table, something you can follow up on, an open door for dialogue
4. **Add Task** before closing patient record: **No task = failure to follow through**

Completing the Assessment

A complete assessment is not only required by the Managed Care Plans but is how we create goals and The Master Care Plan

Remember your training:

- Motivational Interviewing- personable, approachable, conversational
- Trauma Informed Care- watch for clue of trauma triggering, be sensitive and be aware of your phrasing and use of words.