|  | MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICESSHOW ME HEALTHY WOMEN (SMHW)**CLIENT / PATIENT NAVIGATION** | P.O. Box 570Jefferson City, MO 65102-0570(573) 522-2845 |
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| ENROLLMENT SITE / SATELLITE (NAME AND ADDRESS)      | NAVIGATOR NAME / DATE      |
| **A. PERSONAL DATA** |
| NAME (LAST, FIRST, MIDDLE INITIAL)      | PARTICIPANT ID      | ID TYPE (CHOOSE ONE)Choose an item. |
| DATE OF BIRTH (MM/DD/YYYY)      | CLIENT REFUSES NAVIGATION SERVICES[ ] Yes [ ] No | CLIENT (CHOOSE ONE)[ ]  Moved away [ ]  Deceased [ ]  Unable to locate [ ]  Lost to follow-up  |
| B. CLIENT ASSESSMENT |
| ASSESSMENT CONTACT TYPE(CHOOSE ONE)Choose an item. | DATE OF CONTACT (MM/DD/YYYY)      | CONTACT METHODS (CHOOSE ONE)Choose an item. | LENGTH OF VISIT (CHOOSE ONE)Choose an item. | DATE NEXT NAVIGATION VISIT OR CALL PLANNED (MM/DD/YYYY)      |
| ASSESSMENT CONTACT TYPE(CHOOSE ONE)Choose an item. | DATE OF CONTACT (MM/DD/YYYY)      | CONTACT METHODS (CHOOSE ONE)Choose an item. | LENGTH OF VISIT (CHOOSE ONE)Choose an item. | DATE NEXT NAVIGATION VISIT OR CALL PLANNED (MM/DD/YYYY)      |
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| TYPE OF NAVIGATION COMPLETED (CHOOSE ONE)Choose an item. | SERVICES NEEDED (CHOOSE ONE)Choose an item. |
| **BARRIERS** |
| SYSTEM BARRIERS (CHOOSE ALL THAT APPLY)[ ]  Healthcare provider is >50 miles [ ]  Housing issue / homeless [ ]  Lacks capacity to enroll in a health insurance plan[ ]  No healthcare provider [ ]  No phone / invalid phone number [ ]  Provider unable to bill insurance[ ]  Transportation schedule is inconvenient [ ]  Unable to schedule an appointment [ ]  Unable to take off work[ ]  Other  |
| FINANCIAL BARRIERS (CHOOSE ALL THAT APPLY)[ ]  Has dependents / is a caregiver [ ]  Insurance has high deductible [ ]  Lack of / cannot afford transportation[ ]  No health Insurance plan [ ]  Underinsured [ ]  Other  |
| PSYCHOSOCIAL BARRIERS (CHOOSE ALL THAT APPLY)[ ]  Cultural / faith-based concerns [ ]  Education level [ ]  Education required on cancer[ ]  Education required on lifestyle changes [ ]  Education required on refusing services / care / treatment[ ]  Education required on screening / diagnostics [ ]  Education required on self-care vs. medical care[ ]  Fear / denial [ ]  Has concerns about health[ ]  Other  |
| COMMUNICATION BARRIERS (CHOOSE ALL THAT APPLY)[ ]  Confused / overwhelmed [ ]  Cultural concerns [ ]  Does not understand (health literacy)[ ]  Needs interpreter [ ]  Unable to read[ ]  Other  |

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| **ACTION PLAN** |
| COUNSELING / COMMUNICATION / EDUCATION (CHOOSE ALL THAT APPLY)[ ]  Advocated on client’s behalf (specify) [ ]  Counseled regarding (specify) [ ]  Discussed client concerns [ ]  Discussed diagnostic plan options [ ]  Discussed options of available services[ ]  Discussed treatment plan options [ ]  Educated client on available resources[ ]  Educated client with “teach-back” method on (specify) [ ]  Notified Regional Program Coordinator (RPC) for assistance[ ]  Provided interpreter services (specify language) [ ]  Provided culturally appropriate brochure / information [ ]  Provided educational level appropriate brochure / information [ ]  Provided literacy level appropriate brochure / information[ ]  Other  |
| REFERRALS / APPOINTMENTS (CHOOSE ALL THAT APPLY)[ ]  Referred to SMHW Provider (specify) [ ]  Referred to breast and/or cervical care provider (specify) [ ]  Referred to other health care services (specify) [ ]  Referred to Breast and Cervical Cancer Treatment (BCCT) Program [ ]  Referred to transportation resources[ ]  Scheduled appointment for screening services [ ]  Scheduled appointment for diagnostic services[ ]  Scheduled appointment for transportation services [ ]  Referred to legal services[ ]  Referred to local agency for assistance (specify) [ ]  Other  |
| SERVICES ENROLLMENT (CHOOSE ALL THAT APPLY)[ ]  Enrolled for Navigation Only Services [ ]  Enrolled in SMHW Program [ ]  Facilitated enrollment in BCCT Program[ ]  Facilitated enrollment in health insurance plan [ ]  Facilitated enrollment in Medicare / Medicaid[ ]  Other  |
| **C. CLIENT MANAGEMENT** |
| DATE NEXT NAVIGATION VISIT OR CALL PLANNED (MM/DD/YYYY)      |
| CLIENT NOTIFIED OF ABNORMAL RESULTS (CHOOSE ONE)Choose an item. | CLIENT TRACKING METHOD (CHOOSE ONE)Choose an item. |
| DATE NAVIGATION / MANAGEMENT TERMINATED (MM/DD/YYYY)      | REASON FOR TERMINATION (CHOOSE ONE)Choose an item. |
| **D. COMMENTS** |
| BARRIERS / ACTION PLAN / MANAGEMENT / NAVIGATION NOTES      |
| **E. FINAL OUTCOMES** |
| FINAL OUTCOMES (CHOOSE ALL THAT APPLY)[ ]  Diagnostic work-up planned [ ]  Diagnostic work-up completed [ ]  Enrolled in BCCT Program[ ]  Enrolled in a health insurance plan [ ]  Enrolled in Medicare / Medicaid [ ]  Improved client adherence[ ]  Improved client satisfaction [ ]  Improved timeliness of care [ ]  Provided case management[ ]  Received a treatment plan [ ]  Reduced care fragmentation [ ]  Screening completed – breast [ ]  Screening completed – cervical [ ]  Treatment initiated – cancer [ ]  Treatment completed – released by MD[ ]  Other  |
| DATE NAVIGATION COMPLETED (MM/DD/YYYY)      |  |

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