|  | MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES SHOW ME HEALTHY WOMEN (SMHW)  **CLIENT / PATIENT NAVIGATION** | | | | | | | P.O. Box 570 Jefferson 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) | |
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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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