

DREAM Atlanta
DIABETES/HYPERTENSION 1-on-1 IN-PERSON VISIT #2

PARTICIPANT UID: _____

CHW NAME: _____	CLINIC SITE: _____
ONE-ON-ONE DATE: _____ / _____ / _____ MM DD YYYY	

ENCOUNTER TYPE: ☐ By Phone ☐ In-Person

FOLLOW-UP ON CURRENT SHORT-TERM ACTION PLAN

REVIEW CURRENT PLAN WITH PARTICIPANT → *Review the current plan (from most recent follow-up):*

1. How did it go with your plan? [Recognize success/partial success; trouble-shoot barriers below.]

Check one: ☐ **Success** – Participant completed or exceeded the plan (*go to question 3.*)

☐ **Partial Success** – Participant completed the plan in part (*go to question 2.a*)

☐ **No Success/ Did Not Try** – Participant did not complete any part of the plan (*go to question 2.a*)

2.a. [If last plan was “Partial Success” or “No Success/Did Not Try”]: What challenge/s you are facing?

(check all that apply)

☐ Plan was too hard

☐ Own illness/injury/pain

☐ Weather related

☐ Other: _____

☐ Lack of time / Conflicted with schedule

2.b. Describe the solutions discussed with the participant to address each challenge faced.

1. _____
2. _____
3. _____
4. _____

3. How has your weight and blood pressure been? Let’s take some measurements:

BP: ____/____ ____/____ ____/____

Weight: _____ lbs

DEVELOPMENT OF NEW SHORT-TERM ACTION PLAN

Strategies (See guidance corresponding to participant's level of success with current plan:)

- ☐ **Success** – Great job with your last plan! Let's create a new plan for the next two weeks. What do you think about making some changes to be even healthier? *(e.g. Adding more vegetables and/or whole grains to your diet / Exercising more days per week and/or for longer each time)*
- ☐ **Partial Success** – Good try with your last plan. Let's create a new plan for the next two weeks. What do you think about making some changes to improve your chance for better success this time? *(Re-work plan to address barriers)*
- ☐ **No Success/ Did Not Try** – I'm sorry it didn't work out with your last plan. Let's create a new plan for the next two weeks. What do you think about making some changes to improve your chance for better success this time? *(Re-work plan to address barriers)*

4.a. Over the next 2 weeks, the participant selected to focus on:

- ☐ *Eat a healthy diet*
- ☐ *Be physically active*
- ☐ *Quit or reduce smoking, tobacco, or alcohol: Quit or reduce to: _____ per [choose: day / week*
number cig/times/drink(s)]
- ☐ *Manage stress*

4.b. Record of Participant Plan:

What I will do *(e.g. go for a 15 minute walk), if previous goal was physical activity-related, suggest increasing physical activity time*

When I will do it *(e.g. in the morning after breakfast)* _____

Where I will do it *(e.g. around the block)*: _____

How often I will do it *(e.g. M, W, F)*: _____

What might get in the way of my plan *(e.g. too cold outside)*: _____

What I can do about it *(e.g. use the treadmill in the community center)*: _____

Participant's Confidence Level in Reaching Goal: _____ *[fill in the number that participant selected,*
0 (not at all) – 10 (totally confident)]

*[Note: Use Brief Action Planning Guide to revise Participant Plan until confidence is **greater than 7.**]*

CHW Reviews: Medication Booklet, Cholesterol/Diet, Foot Check, Brushing/Flossing, Heart Attack vs Heartburn

5a. CHW reviewed the following topics with participant (check all that apply):

- ☐ Medications: Is participant properly taking their medications?
- ☐ Cholesterol: How to reduce cholesterol in diet
- ☐ Foot health: How to check your feet
- ☐ Proper Brushing Technique
- ☐ Proper Flossing Technique
- ☐ Heart attack vs Heartburn
- ☐ CHW did not review any of these with participant

5b. Did the participant have any questions to follow-up on after reviewing the information?

- ☐ Yes - Notes: _____
- ☐ No

Note to CHW: Please assist participant in scheduling and completing an A1c Test as per protocol.

6a. Are you scheduled to get an A1c test within the next 3 months?

- ☐ Yes- Date of appointment: _____ (go to question 5c)
- ☐ No
- ☐ Don't know / Not sure

6b. If no or not sure, would you like a CHW to assist you to set up appointment with your doctor?

- ☐ Yes - [Please document Next Steps for scheduling appointment for A1c Test]
- ☐ No:

6c. There are no costs to participate in this study. Are you aware of a cost to you to get your A1c tested?

- ☐ Yes- Amount: _____
- ☐ No (go to question 7)
- ☐ Don't know / Not sure

6d. If you are unsure, would you like a CHW to assist you to find out if you will have an additional cost for the test?

- ☐ Yes
- ☐ No

FOLLOW-UP ON PREVIOUS SERVICES

7a. Were you previously referred to a service by a CHW? ☐ Yes ☐ No (go to question 10)

7b. List service 1 _____

7c. Were you able to access [service 1]?

- ☐ Yes
- ☐ No – b. If no, what were the reasons for not following through with referred service?
 - ☐ Too far
 - ☐ Lack of time
 - ☐ Transportation issues
 - ☐ Service no longer wanted/needed
 - ☐ Do not trust service provider
 - ☐ Other (Describe): _____
- ☐ N/A

8a. Were you previously referred to another service by a CHW? ☐ Yes ☐ No (go to question 10)

8b. List service 2 _____

8c. Were you able to access [service 2]?

- ☐ Yes
- ☐ No – b. If no, what were the reasons for not following through with referred service?
 - ☐ Too far
 - ☐ Lack of time
 - ☐ Transportation issues
 - ☐ Service no longer wanted/needed
 - ☐ Do not trust service provider
 - ☐ Other (Describe): _____
- ☐ N/A

9a. Were you previously referred to another service by a CHW? ☐ Yes ☐ No (go to question 10)

9b. List service 3 _____

9c. Were you able to access [service 3]?

- ☐ Yes
- ☐ No – b. If no, what were the reasons for not following through with referred service?
- | | |
|--------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Too far | <input type="checkbox"/> Lack of time |
| <input type="checkbox"/> Transportation issues | <input type="checkbox"/> Service no longer wanted/needed |
| <input type="checkbox"/> Do not trust service provider | <input type="checkbox"/> Other (Describe): _____ |
- ☐ N/A

ADDITIONAL SERVICES/ASSISTANCE REQUESTED:

10. Do you need any additional services?

- ☐ No, participant did not request services
- ☐ Yes, participant requested services
- If yes, describe request and assistance provided by the CHW, as well as any necessary next steps or follow-up:

FOLLOW-UP PLAN

Next meeting scheduled for: Date: _____ Time: _____ ☐ By Phone
☐ In-Person Location: _____

Length of Encounter/Call: _____ minutes

