

DREAM Atlanta
PROGRESS NOTE - DIABETES / HYPERTENSION

Select: **MONTH 2 / MONTH 3 / MONTH 4 / MONTH 5**

Follow-up: **2 1 2 1 2 1 2**

PARTICIPANT UID: _____

CHW NAME: _____ **CLINIC SITE:** _____

ENCOUNTER 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.A. 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. _____

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)

3.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

3.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.**]

COMMUNICATION/GUIDANCE FROM PCP

4. Since the last time we spoke, did your primary care provider give you any guidance or counseling regarding managing your diet, weight, or physical activity or referral to a specialist?

- ☐ N/A – Did not have a visit since the last time we spoke
- ☐ No
- ☐ Yes – If yes, what guidance did you receive?
 - ☐ Nutritional guidance
 - ☐ Physical activity guidance
 - ☐ Medication adherence
 - ☐ Referred to specialist (check all that apply)
 - ☐ Eye ☐ Kidney ☐ Dentist ☐ Other: _____

FOLLOW-UP ON PREVIOUS SERVICES

5a. Were you previously referred to a service by a CHW? ☐ Yes ☐ No (go to question 8)

5b. List service 1 _____

5c. Were you able to access service 1?

- ☐ 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

6a. Were you previously referred to another service by a CHW? ☐ Yes ☐ No (go to question 8)

6b. List service 2 _____

6c. Were you able to access service 2?

- ☐ 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

7a. Were you previously referred to another service by a CHW? ☐ Yes ☐ No (go to question 8)

7b. List service 3 _____

7c. 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:

8. 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

