NYU SoM
IRB APPROVED

Date (M/D/Y)	__ /__ / __
Start Time **End Time**	__ :__ am/pm __ :__ am/pm
Location	
Measure Clinical Measurements as Requested	o Yes o N/A
Monitor medication adherence	o Record Medications/Dosage o Discuss problems with adherence o Discuss strategies for regular adherence o N/A –no prescribed medications.
Check health insurance status	o Has insurance o No insurance→ Connect to facilitated enroller
Check if connected to PCP	o No provider → Connect to facilitated provider o Has provider: (1) Record Name & Telephone, Visit(s), Problems, Assistance (2) Monitor Need for Appointment / Appointment Keeping
Check if connected to Eye Specialist	o No provider → Connect to facilitated provider o Has provider: (1) Record Name & Telephone, Visit(s), Problems, Assistance (2) Monitor Need for Appointment / Appointment Keeping
Check if connected to Foot Specialist	o No provider → Connect to facilitated provider o Has provider: (1) Record Name & Telephone, Visit(s), Problems, Assistance (2) Monitor Need for Appointment / Appointment Keeping
Check if connected to Kidney Specialist	o No provider → Connect to facilitated provider o Has provider: (1) Record Name & Telephone, Visit(s), Problems, Assistance (2) Monitor Need for Appointment / Appointment Keeping
Check if connected to Dentist	o No provider → Connect to facilitated provider o Has provider: (1) Record Name & Telephone, Visit(s), Problems, Assistance (2) Monitor Need for Appointment / Appointment Keeping
Assess Progress with … **Discuss barriers to achieving …** **Provide assistance or education on …**	o Diabetic Complications o Smoking Cessation o Weight Loss o Stress Management o Diet o Family Support o Physical Activity o Other: ____________________
Provide referral to other resources	o Social services o Worker's Issues o Mental health o Other: _____________________ o Domestic Violence
Set/monitor goals	o Diet o Cope with Stress o Physical Activity o Limit Alcohol o Monitor Blood Sugar o Cut down/quit smoking o Adhere to Medications o Other________

DATE OF CONTACT:
Date (M/D/Y)
___/___/____

START TIME: _________________ (AM/PM)

END TIME: _________________ (AM/PM)

LOCATION OF CONTACT:
____

TYPE OF CONTACT:
- **In-Person**
- **Via Phone**

COMPLETED BY:
___ **Gulnahar Alam**
___ **Mamnunul Haq**
___ **MD Taher**

OTHER PERSON(S) PRESENT?:
___ **No**
___ **Yes**
_________ **If "Yes", who?**

A. CLINICAL MEASUREMENTS AS REQUESTED BY PARTICIPANT:

Type of Measurement:	Result(s) of Measurement:
1. Blood Pressure	L1: / R1: / R2: /
2. Other: _________________________________	

B. Medications:

1. Medications reported	
2. Problems with adherence	
3. Assistance Provided	

C. Access to Care:

Health Insurance	Yes/No	If no, assistance provided:
1. Type:		2.

Access to Care (continued):

	Last Visit	Next Scheduled Visit	Problems Experienced	Assistance Provided
3. PCP Visit ***Name & Telephone:***			Couldn't get appt. Doesn't take my insurance No time	
4. Specialist – Eye ***Name & Telephone:***			Couldn't get appt. Doesn't take my insurance No time	
5. Specialist – Foot ***Name & Telephone:***			Couldn't get appt. Doesn't take my insurance No time	
6. Specialist – Kidney ***Name & Telephone:***			Couldn't get appt. Doesn't take my insurance No time	
7. Dentist ***Name & Telephone:***			Couldn't get appt. Doesn't take my insurance No time	

D. HEALTH, SOCIAL, & BEHAVIORAL ISSUES:

Issue	Yes/No	Amount/Type	Barriers to Action	Assistance Provided
1. Diabetes Complications (e.g. eye, foot, kidney, teeth)				
2. Maintaining a Healthy Weight			Can't maintain healthy diet Difficulty doing physical activity Don't know how	
3. Healthy Eating			Don't have time Cooking for others Don't know how	
4. Increase Physical Activity			No time No place to exercise Lack of motivation Don't know how	
5. Cut down/quit smoking or using tobacco			Too hard Don't know how	
6. Stress Management			Work / schedule Family Health	
7. Family Support			No family here Have family, not supportive Family wants to support, but can't	

E. <u>OTHER NEEDS</u>:

	Yes/No	Amount/Type	Barriers to Action	Assistance Provided
1. Social Service			Stigma Don't know where/how	
2. Mental Health			Stigma Don't know where/how	
3. Domestic Violence			Stigma Don't know where/how	
4. Worker's Issues			Stigma Don't know where/how	
5. Other: __________________				

DESCRIPTION OF INTERACTION AND FOLLOW-UP PLAN (Please describe your interaction with the participant and any follow-up that is necessary)

____
____
____
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F. **"Is there anything you would like to do for your health in the next week or two?"**

YES

NOT SURE

ASK PERMISSION TO SHARE IDEAS

"There are many things people can do to improve their health. Here are a few examples of what has worked for others … Or perhaps you have other ideas?"

NOT AT THIS TIME

"That's fine. If it's okay with you, I'll check back with you next time."

1. One way I want to improve my health is …(e.g. be more active): ____________________
2. My goal for this week is … (e.g. walk 2 times): ____________________
3. When I will do it (e.g. mornings before breakfast): ____________________
4. Where I will do it (e.g. at the park): ____________________
5. How often I will do it (e.g. Monday and Thursday): ____________________
6. What might get in the way of my plan (e.g. I have to take the children to school): ____________________
7. What I can do about it (e.g. I'll choose days when I don't take them to school): ____________________

"Great. Now just so we are clear, can you repeat back to me what your plan is."

8. "**How confident (on a scale of 0 to 10) do you feel about carrying out your plan? (Circle One)"**

Not at all		A Little			50/50			Very Sure		Totally Confident
0	1	2	3	4	5	6	7	8	9	10

Confidence < 7 | Confidence ≥ 7

"A ____ is higher than a zero, that's good. Any ideas about what might raise your confidence?"

MODIFY PLAN USING ABOVE STEPS.

REPEAT CONFIDENCE SCALE.

IF ≥ 7

"That's great!"

"It looks like you have a great plan in place. Follow-up support is important for you to be successful. When would you like me to check-in with you about the progress you've made on your plan?"

FOLLOW-UP DATE/TIME: ____________________

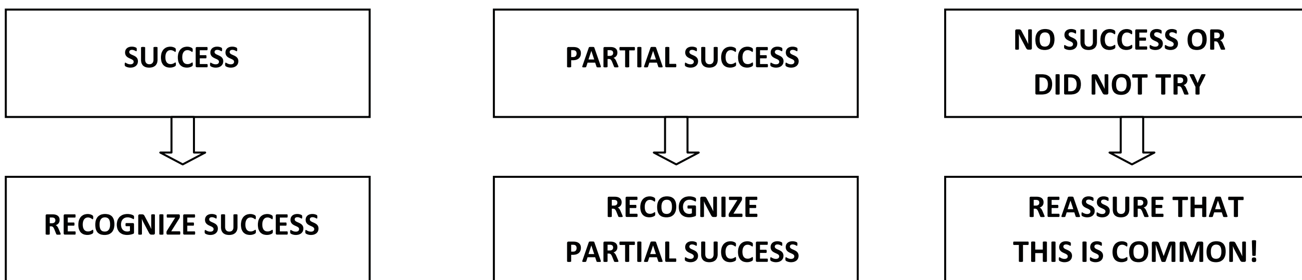
The following questions are to be answered by the Community Health Worker after the one-on-one visit:

To what extent do you agree with the following statements?	Strongly Agree	Agree	Disagree	Strongly Disagree	IF DISAGREE, DESCRIBE WHY
1. The participant was attentive during the session					
2. The participant understood what I said to him or her					
3. The participant was interested in the information I gave him or her					
4. The participant will be able to change their behaviors					
5. I was able to address any concerns the participant had.					

GOAL FOLLOW-UP: (Please record in encounter log as "Goal Follow-Up")

Date: ____________________

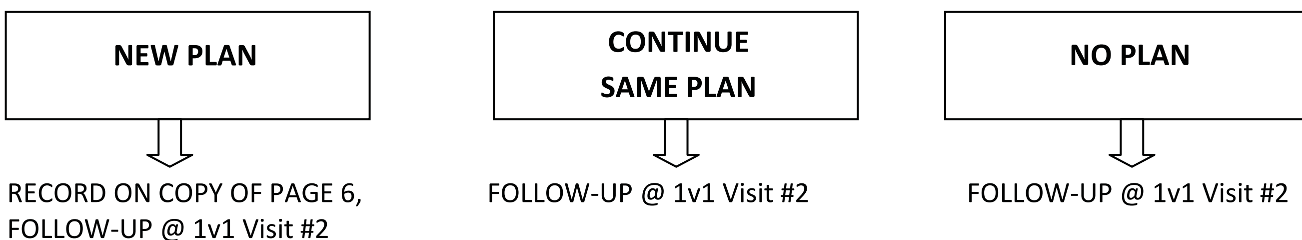
1. First ask, ***"How did it go with your plan?"*** (Circle One)



Description of progress with plan:

____
____
____
____
____

1. Then ask, ***"What would you like to do next?"*** (Circle One)



RECORD ON COPY OF PAGE 6, FOLLOW-UP @ 1v1 Visit #2

FOLLOW-UP @ 1v1 Visit #2

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