

ATTACHMENT 5E

**MYRX PARTICIPANT POST-INTERVENTION
DIABETES/HYPERTENSION/DIABETES AND HYPERTENSION**

POST INTERVENTION FOLLOW-UP FORM: HYPERTENSION

TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

Date: _____

Participant name (Last name, First initial): _____

Client ID #: _____

Pharmacist Conducting Post-Intervention Home Visit: _____

Post-Intervention Home Visit Date: _____

Section I. Participant Demographics

Pharmacist Step #1: Introduction and collect baseline information.

1. Blood pressure screening:

2. Wt: |__|__|__|
lbs.

3. Ht: |__| - |__|__|
feet inches

4. How long have you been diagnosed with high blood pressure?

5. What is your current household income per year?

- \$0 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 or more

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources,

gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

Section II. Hypertension Knowledge

Pharmacist Step #2: Ask the participant the following questions and mark their answers.

1. If someone's blood pressure is 120/80, it is...

- High
- Low
- Normal
- Don't know

2. If someone's blood pressure is 160/100, it is...

- High
- Low
- Normal
- Don't know

3. Once someone has high blood pressure, it usually lasts for ...

- A few years
- 5-10 years
- The rest of their life
- Don't know

4. People with high blood pressure should take their medicine...

- Everyday
- At least a few times a week
- Only when they feel sick

5. Losing weight usually makes blood pressure...

- Go up
- Go down
- Stay the same

6. Eating less salt usually makes blood pressure...

- Go up
- Go down
- Stay the same

7. High blood pressure can cause heart attacks.

- Yes
- No
- Don't know

8. High blood pressure can cause cancer.

- Yes
- No
- Don't know

9. High blood pressure can cause kidney problems.

- Yes
- No
- Don't know

10. High blood pressure can cause strokes.

- Yes
- No
- Don't know

Section III. Medication Use and Adherence

Pharmacist Step #3: Review the medications that the participant has OR has been prescribed. Create a medication chart with the participant. Fill out attached Appendix A Medication List with the participant.

Questions to ask:

- What medication are you taking including OTC and dietary supplement?
- Why are you taking the medication?
- When do you take this medication?
- When was your last dose?
- Do you have any special instructions for this medication?

11. Medication History:

Medication (Name/Strength)	Purpose	Schedule	Date of Last Dose	Special Instructions
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				

Hypertension

12. How often have you forgotten to take your medicine for blood pressure in the past week?

- Always
- Very Often
- Sometimes
- Rarely
- Never

13. How often do you stop taking your medicine for high blood pressure because you were careless?

- Always
- Very Often
- Sometimes
- Rarely
- Never

14. How often do you stop taking your blood pressure medicine because you feel better?

- Always
- Very Often
- Sometimes
- Rarely
- Never

15. How often do you stop taking your medicine for blood pressure when you experience side effects?

- Always
- Very Often
- Sometimes
- Rarely
- Never

16. Please find the statement that best describes the way you feel right now about taking your high blood pressure medication as directed.

- A. No, I do not take and right now am not considering taking my high blood pressure medication as directed. (Precontemplation)
- B. No, I do not take but right now am considering taking my high blood pressure medication as directed. (Contemplation)
- C. No, I do not take but am planning to start taking my high blood pressure medication as directed. (Preparation)
- D. Yes, right now I consistently take my high blood pressure medication as directed.

17. If the answer to question 16 is D, then ask: How long have you been taking your high blood pressure medication as directed?

- A. ≤ 3 months
- B. > 3 months to 6 months
- C. > 6 months to 12 months
- D. > 12 months

Section IV. Pharmacist Step #4: Pharmacist Assessment

If the answer to question 16 is D and the answer to question 17 is A or B, then the stage of change is action. If the answer to question 16 is D and the answer to question 17 is C or D, then the stage of change is maintenance.

Check the most appropriate stage according to readiness to change.

Area/Stage	<u>Precontemplati</u> <u>on</u>	<u>Contemplati</u> <u>on</u>	<u>Prepar</u> <u>e</u>	<u>Actio</u> <u>n</u>	<u>Maintenan</u> <u>ce</u>
Adhere to medication.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Blood pressure goal is: | | / |

Today blood pressure is / is not (circle one) at goal.

Assessment Notes:

Section V. Pharmacist Step #5: Participant Satisfactory Survey

Pharmacist Step #5: Ask the participant the following survey questions and mark their answers.

The statements below describe attitudes and beliefs you may have about the health program you participated in and about your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

Strongly	Somewhat	Somewhat
Strongly	disagree	disagree
disagree	Neutral	agree
Neutral	agree	agree

1. I learned new information that helped me to better manage my health condition.....
.....
2. I received useful information from this program.....
.....
3. I am putting what I learned from this program into practice.....
.....
4. I see positive changes in myself already from being in this program.....
.....
5. I am doing something to improve my health condition.....
.....
6. It is very important to take care of your health.....
.....
7. I'm ready to improve my health....
.....
8. What was important to you about this program?
 - a. Information was easy to understand
.....

b. Materials were easy to use.....

c. Materials were written in my language.....

d. The classes were taught by a trained professional (community health worker, health educator, pharmacist)....

e. The person who talked with me spoke in my language.....

f. The curriculum took my cultural practices into consideration.....

g. Someone called me to follow-up on what I learned and reminded me of what I should do to manage my health.....

h. Group classes.....

i. One-on-one sessions at my home.....

The statements below describe attitudes and beliefs you may have about the best ways for you to learn about your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

9. The best way for me to learn about my health condition is from a:

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
a. Brochure or pamphlet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Direct mail.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Toolkit of materials with a CD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Email.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Telephone text message.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Facebook posting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Webinar.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Group classes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. One-on-one sessions at my home.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please rate how satisfied or dissatisfied you are with these statements about this program by placing a check mark in the appropriate box.

<u>Very</u>	<u>Dissatisfied</u>	<u>Neutral</u>	<u>Very</u>
<u>dissatisfied</u>			<u>satisfied</u>

10. How satisfied are you that what you learned helps you to make good decisions about improving your health?.....

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

11. Overall, how satisfied are you with the program?.....

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

SERVICE DELIVERY FORM
TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY
HEALTH (PCCC) INITIATIVE

Directions: Complete this form at the end of post-intervention home visit. Pharmacist will send the completed form to the program coordinator.

Participant Name: _____

Pharmacist Name: _____

Post-Intervention Visit Date: _____

Participant Signature

Date

Pharmacist Signature

Date

POST INTERVENTION FOLLOW-UP FORM: DIABETES

TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

Date: _____

Participant name (Last name, First initial): _____

Client ID #: _____

Pharmacist Conducting Post-Intervention Home Visit: _____

Post-Intervention Home Visit Date: _____

Section I. Participant Demographics

Pharmacist Step #1: Introduction and collect baseline information.

1. Hemoglobin A1C screening:

2. Wt: |_____|_____|_____|
lbs.

3. Ht: |_____| - |_____|
feet inches

4. How long have you had diabetes?

5. What is your current household income per year?

- \$0 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 or more

Section II. Diabetes Knowledge

Pharmacist Step #2: Ask the participant the following questions and mark their answers.

1. People with diabetes have a higher risk for heart disease and stroke, compared with people who do not have diabetes.

True
 False

2. Warning signs of eye problems include which of the following:

Having double vision
 Seeing floating spots
 Having trouble seeing
 All of the above

3. You can help lower your risk for kidney problems by making the efforts to reach your targeted blood glucose level and blood pressure level.

True
 False

4. Exercise can lower your blood glucose levels.

True
 False

5. Carbohydrate counting is a method that helps you know what to eat and how much to eat.

True
 False

6. These foods are high in carbohydrates

Bread, biscuits, cornbread, tortillas, and crackers
 Corn, peas, potatoes, and sweet potatoes
 All of the above are correct

7. The A1C check:

- Tells you what your blood glucose has been over the last two to three months
- Tells you how well your diabetes treatment plan is working
- All of the above are correct

8. If your A1C is 7 or higher:

- You may need a change in your treatment plan
- Your diabetes plan is working well
- All of the above are correct

9. Blood glucose is too high when it is:

- Higher than 130 before meals
- 180 and higher 2 hours after meals
- All of the above are correct

10. Blood glucose is too low when it's below 70.

- True
- False

Section III. Medication Use and Adherence

Pharmacist Step #3: Review the medications that the participant has OR has been prescribed. Create a medication chart with the participant. Fill out attached Appendix A Medication List with the participant.

Questions to ask:

- What medication are you taking including OTC and dietary supplement?
- Why are you taking the medication?
- When do you take this medication?
- When was your last dose?
- Do you have any special instructions for this medication?

11. Medication History:

Medication (Name/Strength)	Purpose	Schedule	Date of Last Dose	Special Instructions
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				

Diabetes

12. How often have you forgotten to take your medicine for diabetes in the past week?

- Always
- Very Often
- Sometimes
- Rarely
- Never

13. How often do you stop taking your medicine for diabetes because you were careless?

- Always
- Very Often
- Sometimes
- Rarely
- Never

14. How often do you stop taking/injecting your medicine for diabetes because you feel better?

- Always
- Very Often
- Sometimes
- Rarely
- Never

15. How often do you stop taking your medicine for diabetes when you experience side effects?

- Always
- Very Often
- Sometimes
- Rarely
- Never

16. Please find the statement that best describes the way you feel right now about taking your diabetes medication as directed.

- A. No, I do not take and right now am not considering taking my diabetes medication as directed. (Precontemplation)
- B. No, I do not take but right now am considering taking my diabetes medication as directed. (Contemplation)
- C. No, I do not take but am planning to start taking my diabetes medication as directed. (Preparation)
- D. Yes, right now I consistently take my diabetes medication as directed.

17. If the answer to question 16 is D, then ask: How long have you been taking your diabetes medication as directed?

- A. ≤ 3 months
- B. >3 months to 6 months
- C. >6 months to 12 months
- D. >12 months

Section IV. Pharmacist Step #4: Pharmacist Assessment

If the answer to question 16 is D and the answer to question 17 is A or B, then the stage of change is action. If the answer to question 16 is D and the answer to question 17 is C or D, then the stage of change is maintenance.

Check the most appropriate stage according to the readiness to change:

Area/Stage	<u>Precontemplati</u> <u>on</u>	<u>Contemplati</u> <u>on</u>	<u>Prepar</u> <u>e</u>	<u>Actio</u> <u>n</u>	<u>Maintenan</u> <u>ce</u>
Adhere to medication.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hemoglobin A1C goal is: | | |

Today hemoglobin A1C is / is not (circle one) at goal.

Assessment Notes:

Section V. Pharmacist Step #5: Participant Satisfactory Survey

Pharmacist Step #5: Ask the participant the following survey questions and mark their answers.

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Strongly	disagree	disagree
disagree	Neutral	agree
Neutral	agree	agree

1. I learned new information that helped me to better manage my health condition.....
.....
2. I received useful information from this program.....
.....
3. I am putting what I learned from this program into practice.....
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4. I see positive changes in myself already from being in this program.....
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5. I am doing something to improve my health condition.....
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6. It is very important to take care of your health.....
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7. I'm ready to improve my health....
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8. What was important to you about this program?
 - a. Information was easy to understand
.....

b. Materials were easy to use.....

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d. The classes were taught by a trained professional (community health worker, health educator, pharmacist)....

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g. Someone called me to follow-up on what I learned and reminded me of what I should do to manage my health.....

h. Group classes.....

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The statements below describe attitudes and beliefs you may have about the best ways for you to learn about your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

9. The best way for me to learn about my health condition is from a:

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
a. Brochure or pamphlet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Direct mail.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Toolkit of materials with a CD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Email.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Telephone text message.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Facebook posting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Webinar.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Group classes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. One-on-one sessions at my home.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please rate how satisfied or dissatisfied you are with these statements about this program by placing a check mark in the appropriate box.

<u>Very</u>	<u>Dissatisfied</u>	<u>Neutral</u>	<u>Very</u>
<u>dissatisfied</u>			<u>satisfied</u>

10. How satisfied are you that what you learned helps you to make good decisions about improving your health?.....

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

11. Overall, how satisfied are you with the program?.....

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

SERVICE DELIVERY FORM
TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY
HEALTH (PCCC) INITIATIVE

Directions: Complete this form at the end of post-intervention home visit. Pharmacist will send the completed form to the program coordinator.

Participant Name: _____

Pharmacist Name: _____

Post-Intervention Visit Date: _____

Participant Signature

Date

Pharmacist Signature

Date

POST INTERVENTION FOLLOW-UP FORM: HYPERTENSION AND DIABETES

TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

Date: _____

Participant name (Last name, First initial): _____

Client ID #: _____

Pharmacist Conducting Post-Intervention Home Visit: _____

Post-Intervention Home Visit Date: _____

Section I. Participant Demographics

Pharmacist Step #1: Introduction and collect baseline information.

1. Hemoglobin A1C screening:

2. Blood pressure screening:

3. Wt: |__|__|__|
lbs.

4. Ht: |__| - |__|__|
feet inches

5. How long have you been diagnosed with high blood pressure?

6. How long have you had diabetes?

7. What is your current household income per year?

- \$0 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 or more

Section II. Knowledge Survey

Pharmacist Step #2: Ask the participant the following questions and mark their answers.

Hypertension

1. If someone's blood pressure is 120/80, it is...

- High
- Low
- Normal
- Don't know

2. If someone's blood pressure is 160/100, it is...

- High
- Low
- Normal
- Don't know

3. Once someone has high blood pressure, it usually lasts for ...

- A few years
- 5-10 years
- The rest of their life
- Don't know

4. People with high blood pressure should take their medicine...

- Everyday
- At least a few times a week
- Only when they feel sick

5. Losing weight usually makes blood pressure...

- Go up
- Go down
- Stay the same

6. Eating less salt usually makes blood pressure...

- Go up
- Go down
- Stay the same

7. High blood pressure can cause heart attacks.

- Yes
- No
- Don't know

8. High blood pressure can cause cancer.

- Yes
- No
- Don't know

9. High blood pressure can cause kidney problems.

- Yes
- No
- Don't know

10. High blood pressure can cause strokes.

- Yes
- No
- Don't know

Diabetes

11. People with diabetes have a higher risk for heart disease and stroke, compared with people who do not have diabetes.

True
 False

12. Warning signs of eye problems include which of the following:

- Having double vision
- Seeing floating spots
- Having trouble seeing
- All of the above

13. You can help lower your risk for kidney problems by making the efforts to reach your targeted blood glucose level and blood pressure level.

- True
- False

14. Exercise can lower your blood glucose levels.

- True
- False

15. Carbohydrate counting is a method that helps you know what to eat and how much to eat.

- True
- False

16. These foods are high in carbohydrates

- Bread, biscuits, cornbread, tortillas, and crackers
- Corn, peas, potatoes, and sweet potatoes
- All of the above are correct

17. The A1C check:

- Tells you what your blood glucose has been over the last two to three months
- Tells you how well your diabetes treatment plan is working
- All of the above are correct

18. If your A1C is 7 or higher:

- You may need a change in your treatment plan
- Your diabetes plan is working well
- All of the above are correct

19. Blood glucose is too high when it is:

- Higher than 130 before meals
- 180 and higher 2 hours after meals
- All of the above are correct

20. Blood glucose is too low when it's below 70.

- True
- False

Section III. Medication Use and Adherence

Pharmacist Step #3: Review the medications that the participant has OR has been prescribed. Create a medication chart with the participant. Fill out attached Appendix A Medication List with the participant.

Questions to ask:

- What medication are you taking including OTC and dietary supplement?
- Why are you taking the medication?
- When do you take this medication?
- When was your last dose?
- Do you have any special instructions for this medication?

21. Medication History:

Medication (Name/Strength)	Purpose	Schedule	Date of Last Dose	Special Instructions
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				

22. Medication Adherence

Hypertension	<u>Always</u>	Very Often Sometimes Rarely Never			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. How often have you forgotten to take your medicine for blood pressure in the past week?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. How often do you stop taking your medicine for high blood pressure because you were careless?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. How often do you stop taking your blood pressure medicine because you feel better?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. How often do you stop taking your medicine for blood pressure when you experience side effects?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diabetes

a. How often have you forgotten to take your medicine for diabetes in the past week?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. How often do you stop taking your medicine for diabetes because you were careless?.....

.....

c. How often do you stop taking/injecting your medicine for diabetes because you feel better?.....

.....

d. How often do you stop taking your medicine for diabetes when you experience side effects?.....

.....

Hypertension

23. Please find the statement that best describes the way you feel right now about taking your high blood pressure medication as directed.

- A. No, I do not take and right now am not considering taking my high blood pressure medication as directed. (Precontemplation)
- B. No, I do not take but right now am considering taking my high blood pressure medication as directed. (Contemplation)
- C. No, I do not take but am planning to start taking my high blood pressure medication as directed. (Preparation)
- D. Yes, right now I consistently take my high blood pressure medication as directed.

24. If the answer to question 13 is D, then ask: How long have you been taking your high blood pressure medication as directed?

- A. ≤ 3 months
- B. > 3 months to 6 months
- C. > 6 months to 12 months
- D. > 12 months

Diabetes

25. Please find the statement that best describes the way you feel right now about taking your diabetes medication as directed.

- A. No, I do not take and right now am not considering taking my diabetes medication as directed. (Precontemplation)
- B. No, I do not take but right now am considering taking my diabetes medication as directed. (Contemplation)
- C. No, I do not take but am planning to start taking my diabetes medication as directed. (Preparation)
- D. Yes, right now I consistently take my diabetes medication as directed.

26. If the answer to question 15 is D, then ask: How long have you been taking your diabetes medication as directed?

- A. ≤ 3 months
- B. > 3 months to 6 months
- C. > 6 months to 12 months
- D. > 12 months

Pharmacist will complete.

Section IV. Pharmacist Step #4: Pharmacist Assessment

Hypertension

If the answer to question 23 is D and the answer to question 24 is A or B, then the stage of change is action. If the answer to question 23 is D and the answer to question 24 is C or D, then the stage of change is maintenance.

Diabetes

If the answer to question 25 is D and the answer to question 26 is A or B, then the stage of change is action. If the answer to question 25 is D and the answer to question 26 is C or D, then the stage of change is maintenance.

Check the most appropriate stage according to the readiness to change:

Area/Stage	<u>Precontemplati</u>	<u>Contemplati</u>	<u>Prepar</u>	<u>Actio</u>	<u>Maintenan</u>
	<u>on</u>	<u>on</u>	<u>e</u>	<u>n</u>	<u>ce</u>

Hypertension

Adhere to hypertension medication.....

<input type="checkbox"/>				
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Diabetes

Adhere to diabetes medication.....

<input type="checkbox"/>				
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Blood pressure goal is: |_____|/|_____|

Today blood pressure is / is not (circle one) at goal.

Hemoglobin A1C goal is: |_____|/|_____|

Today hemoglobin A1C is / is not (circle one) at goal.

Assessment Notes:

Section V. Pharmacist Step #5: Participant Satisfactory Survey

Pharmacist Step #5: Ask the participant the following survey questions and mark their answers in the appropriate column.

The statements below describe attitudes and beliefs you may have about the health program you participated in and about your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
1. I learned new information that helped me to better manage my health condition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I received useful information from this program.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I am putting what I learned from this program into practice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I see positive changes in myself already from being in this program.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I am doing something to improve my health condition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. It is very important to take care of your health.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I'm ready to improve my health....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. What was important to you about this program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

a. Information was easy to understand	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Materials were easy to use.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Materials were written in my language.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
d. The classes were taught by a trained professional (community health worker, health educator, pharmacist)...	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
e. The person who talked with me spoke in my language.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
f. The curriculum took my cultural practices into consideration.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Someone called me to follow-up on what I learned and reminded me of what I should do to manage my health.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Group classes.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
i. One-on-one sessions at my home.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>

The statements below describe attitudes and beliefs you may have about the best ways for you to learn about your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

9. The best way for me to learn about my health condition is from a:

	Strongly disagree	Somewhat disagree	Somewhat Neutral	agree	Somewhat agree
a. Brochure or pamphlet.....	<input type="checkbox"/>				
b. Direct mail.....	<input type="checkbox"/>				
c. Toolkit of materials with a CD..	<input type="checkbox"/>				
d. Email	<input type="checkbox"/>				
e. Telephone text message.....	<input type="checkbox"/>				
f. Facebook posting.....	<input type="checkbox"/>				
g. Webinar.....	<input type="checkbox"/>				
h. Group classes.....	<input type="checkbox"/>				
i. One-on-one sessions at my home.....	<input type="checkbox"/>				

Please rate how satisfied or dissatisfied you are with these statements about this program by placing a check mark in the appropriate box.

<u>Very</u>	<u>dissatisfied</u>	<u>Dissatisfied</u>	<u>Neutral</u>	<u>Very</u>
<u>Satisfied</u>	<u>satisfied</u>			<u>satisfied</u>

10. How satisfied are you that what you learned helps you to make good decisions about improving your health?.....

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

11. Overall, how satisfied are you with the program?.....

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

SERVICE DELIVERY FORM
TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY
HEALTH (PCCC) INITIATIVE

Directions: Complete this form at the end of post-intervention home visit.
Pharmacist will send the completed form to the program coordinator.

Participant Name: _____

Pharmacist Name: _____

Post-Intervention Visit Date: _____

Participant Signature

Date

Pharmacist Signature

Date