Camden Coalition of Healthcare Providers

A DAP (Data, Assessment, Plan) note is to be filled out each time you meet with a patient for any Care Management Initiatives program. Please use the questions and statements listed below each section as a guide to what information needs to be included in order to ensure that this note is a complete explanation of the information shared during the patient encounter.

Data

Specific, FACTUAL information:

Where did the encounter take place?
What was said (Care team member and patient)?
What was the focus of the encounter? What goal did this relate to?

Assessment

Did patient appear within "normal range"?
Where is patient on the I Do/We Do/You Do scale?

Plan

Plan of action between this encounter and the next

Strategies that the care team member plans to use to support the patient to achieve their care plan, including referrals
State date, time, and location of next patient encounter
Restate patients overall care plan with goal priorities

Example DAP Note - could be sentences or bullet points

LSW Buckley and LPN Skinner visited pt at VOA's Anna Sample shelter. Pt stated did not receive medication from pharmacy and has not taken HTN medication in two days. LPN Skinner and pt called the pharmacy together and ensured medication would be delivered by end of day. Pt also expressed anxiety about staying in the shelter and asked about the process of Housing First. LSW Buckley explained the process of applying to units and completed DCA paperwork. Pt appeared within normal range and is at a "we do". Encounter related to pt's goals of achieving stable housing and medication adherence. LSW Buckley and LPN Skinner will meet pt at Anna Sample next Wednesday, 7/17, to continue to assist pt to achieve stated care plan goals: achieve stable housing, increase medication adherence, and better provider relationships.

Template

- [Title/License] [Last name] [talked on the phone or visited pt at (location)]. Pt stated _____. Care Team worked on (list relevant pt goals).
- Pt [did/did not] appear within normal range. Pt is at an I Do/We Do/You Do. (can be goal specific or overall status)
- [Care Team name] will (state next steps, including referrals).
- Care Team will call/meet patient at (time) at (location) in order to achieve pt's stated goals: (goal 1,), (goal 2), (goal 3).

This resource was shared as part of the *Complex care startup toolkit* from the National Center for Complex Health and Social Needs, an initiative of the Camden Coalition. Find the full toolkit at www.nationalcomplex.care/startup-toolkit.