

CHW Intervention– ACTION PLAN DEVELOPMENT FORM - DIABETES / HYPERTENSION

PARTICIPANT UID: _____

CHW NAME: _____

CLINIC SITE: _____

ACTION PLAN DATE: _____ / _____ / _____
MM DD YYYY

ENCOUNTER TYPE: ☐ By Phone ☐ In-Person

6-MONTH ACTION PLAN

Over the next 6 months, I will support you in developing and reaching a health goal, related to managing your diabetes and high blood pressure.

1. 6-Month Action Plan: Focus on 1 of the following Goals:

- ☐ **Blood Pressure:** Lower BP to below 130/80 or target goal set by PCP: _____/_____
- ☐ **Weight Goal:** Current weight: _____ lbs Current BMI: _____
- ☐ Lower Weight to: _____ lbs (*suggested weight loss is 5% if BMI is greater than 23*)
- or
- ☐ Maintain a healthy weight with a healthy diet and physical activity (*if BMI is in healthy range = 18.5 - 22.9*)

SHORT-TERM ACTION PLAN

Over the next 6 months, I will support you in developing short-term plans to help you reach your 6-month goal. I'll check in with you every 2 weeks to see how you are doing with your plan, and to see if you need any help.

2. Short-term Action Plan: 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
- ☐ Manage stress
- number cig/times/drink(s)

3. Record of Participant Plan:

What I will do (e.g. go for a 15 minute walk): _____

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.**]

4. COMMUNICATION/GUIDANCE FROM PCP

At your last doctor's visit, did your primary care provider give you any guidance or counseling regarding managing your diet, weight, or physical activity or referral to a specialist?

☐ Don't Remember

☐ No

☐ Yes – **4b. If yes, what guidance did you receive?**

☐ Nutritional guidance

☐ Physical activity guidance

☐ Medication adherence

☐ Referred to specialist (check all that apply)

☐ Eye

☐ Foot

☐ Kidney

☐ Dentist

☐ Other: _____

ADDITIONAL SERVICES/ASSISTANCE REQUESTED:

5. 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:

6. Is there anything else you would like to discuss?

FOLLOW-UP PLAN

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

Length of Encounter/Call: _____ minutes